Time for action

cutting edge

Mike Ashton on new research which shows that while it helps many, motivational interviewing can actually make it harder for some to get off drugs.

Ask British drug and alcohol counsellors to cite a therapeutic approach they use, and the chances are they will name motivational interviewing. The approach of choice for bolstering the resolve of the ambivalent or resistant patient, above all it aims to avoid making things worse by confronting them.

It seems, then, the safe option. Maybe it won't help those already resolved to change, but it won't harm them either, and in reality, there are few dependent substance users who don't have some regrets about the life they are losing or doubts about the new one they are trying to start.

MAKE WORSE

Motivational interviewing was originally designed by Bill Miller to prepare people for treatment. Typically one or two motivational sessions aim to deepen engagement with treatment and thereby improve outcomes.

Drug and Alcohol Findings reviewed its performance in this role and found that often this was indeed the result – but not always. From four studies emerged a pattern which seemed to explain sometimes disappointing results. In these, motivational interviewing actually *did* make some people worse than doing nothing, or nothing special. These were balanced by the people it helped, with no net benefits across the caseload.

As Bill Miller commented: "The clinical sense I can make of it is that when clients are ready to go, it is not time to be reflecting on whether they want to do so."

BLOCKING PROGRESS

What he was referring to was a feature shared by all four studies. In each, therapists mandated by a manual directed clients to engage in set activities and take set decisions at predetermined stages. Among these was a 'decisional balance' exercise, during which patients reviewed what for them are the pros and cons of changing substance use or becoming involved in treatment or aftercare.

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The procedure enables ambivalence to be acknowledged and worked through, and for patients who needed this, it had the intended effects on retention, commitment to change and/or substance use. The problem was, it seemed also to retard the progress of patients already committed to change.

The first of these studies was carried out in Houston, where 105 cocaine users started a ten-day outpatient 'detoxification'. Most were black, poor, unemployed and smoking crack. Patients who achieved abstinence could transfer to aftercare. The issue was whether starting detoxification with a motivational interview would improve transfer rates.

With or without the interviews, about half the patients qualified for transfer. But this masked very different impacts on different patients. Motivational sessions improved completion rates among subjects 'still thinking' about whether they needed to curtail substance use. But it had the *opposite* effect in those who saw themselves as having already embarked on this process - they actually did worse.

Among a different set of dependent cocaine users in Rhode Island, a similar thing was seen. Over seven in 10 of the 165 patients smoked crack, but two-thirds were employed and nearly 90 per cent white. Half were randomly allocated to an initial motivational interview and half to meditation and relaxation.

DIFFERENT STROKES

At issue was whether the motivational sessions would improve on the supposedly inactive relaxation approach. The answer was a surprising 'No'. Patients as a whole did well, but the motivational interview did not improve retention or outcomes.

As in Houston, this was not because the interviews themselves were inactive, but because they had opposing impacts on different patients. Consistently they worsened cocaine use outcomes among patients who saw themselves as actively tackling their drug use, while improving outcomes among those still thinking about whether they needed to tackle drug use.

A third study concerned alcohol dependent patients admitted for inpatient detoxification, again in Rhode Island. Randomly selected intakes were allocated to one of two types of induction. The first was five minutes of advice which comprehensively contravened motivational principles. Patients were told they had a significant drink problem and that abstinence was very important, then were directly advised to get involved in AA/NA.

The second type of session was a one-hour motivational interview. It also advised abstinence and AA, but not in the unambiguous manner of the more abrupt intervention. Instead patients were led through exercises weighing the pros and cons of abstinence and AA and asked to contrast their drinking with longer-term goals. Finally, they were

asked to choose their own goals for attending AA meetings. Those unwilling to embrace AA were told of alternative sources of support.

PUZZLE

Over a six-month follow-up, as long as patients least committed to AA had been through these motivational exercises, and those most committed had been directed to abstain and attend AA, on average each sustained near 100% abstinence and drank little when they did. When this matching was reversed, outcomes were far worse. Most prominent was the large negative impact of an hour's motivational therapy on patients who did better after five minutes' unsophisticated advice.

In all three studies, the puzzle is not why the least committed benefited (expected), but why the most committed reacted badly. The explanation might be what to the patient could seem an undermining backward step to re-examine the pros and cons of whether they really did want to stop using drugs or commit to therapy, when they had already decided to do so and started the process.

Another study - from Bill Miller's team in Albuquerque - enables us to see how such effects can occur. Half the 208 dependent drug users were randomly allocated to normal treatment, half to an additional motivational interview. Despite considerable experience supplemented by 16 hours' training and feedback on their videoed performances from Bill Miller, who personally certified their competence, the motivational therapists failed to improve retention or outcomes.

In this study, so tightly was the interview programmed, and so diligent, well trained and closely supervised were the therapists, that they introduced the same topics at roughly the same point with all their clients. It enabled what clients and therapists said to be matched to the topics addressed in each succeeding tenth of each session.

RESISTANT

The agenda included getting the client to weigh the pros and cons of their substance use based on feedback from a prior assessment, then to formulate a plan to change this, and finally to anticipate and prepare for potentially derailing influences.

Linguistic analysis of session videotapes showed that for clients already committed to change, this worked fine. The problem was with 'resistant' clients who did not see their former drug use as all bad. It cropped up first when they were landed with what in the event was almost uniformly negative assessment feedback, prompting the classic counter-reaction against curbing substance use.

Counter-productive reactions also occurred when later they were asked to commit to change and then to defend their change plan, seemingly before its motivational underpinnings had been secured. In each case, the effect was to weaken commitment to curtailing drug use, followed by the predictable outcomes in terms of actual drug use.

The analysts cautioned that "a prescribed and less flexible approach to MI (as can occur with manual-guided interventions) could paradoxically yield worse outcomes among initially less motivated clients". Leading the client to review the good side of their drug use is, they thought, particularly risky; by fostering an 'It wasn't all bad' perception, it might pave the way for resistant reactions to assessment feedback.

STICK TO THE MANUAL?

All these studies featured motivational interviews undertaken according to the manual. The research rationale is to standardise 'inputs' so these can be related to outcomes, the clinical justification, that it enables proven treatments to be replicated.

An alternative view is that such detailed programming cramps client participation and clinical judgement, and focuses attention on techniques rather than ways of relating which cut across therapies. If these are what matters, then the baby could be exiting with the bathwater. Prescriptiveness seems particularly risky for motivational interviewing, whose essence is to respond to cues from across the table.

What's the take-home message? For *Findings* it was that true-to-type motivational interviewing not only requires sensitivity and social skills, it is the application of sensitivity and social skills, and that these can be cramped by over-prescriptive implementations, no matter how expertly drafted.

Instead, the research argues for a return to the modus operandi of the successful early studies, when principles took precedence over a set agenda, and to the client originally envisaged – not one already convinced they must change or determined on a way to get there, but unsure or ambivalent. •

This article is based on the "The motivational hello" by Mike Ashton published in 2005 in issue 13 of Drug and Alcohol Findings and available for free download from **www.drugandalcoholfindings.org.uk**

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