Motivational Interviewing in the Treatment of Substance Use Disorders

Peter H. Musser, Ph.D.
Independent Practice Columbia, MD
Ashley Addiction Treatment

7/17/2017
Glossary of Terms

**Commercial Interest** - The ACCME defines a “commercial interest” as any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

**Financial relationships** - Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities from which remuneration is received, or expected. ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.
Glossary of Terms (con’t)

**Relevant financial relationships** - ACCME focuses on financial relationships with commercial interests in the 12-month period preceding the time that the individual is being asked to assume a role controlling content of the CME activity. ACCME has not set a minimal dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship. The ACCME defines “‘relevant’ financial relationships” as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.

**Conflict of Interest** - Circumstances create a conflict of interest when an individual has an opportunity to affect CME content about products or services of a commercial interest with which he/she has a financial relationship.
Why Consider MI as Therapists?

• Research Outcomes – Evidence based intervention
  • @ 1,300 publications at this point
  • Project MATCH

• Increases Likelihood of Behavior Change

• Increases Treatment Involvement

• Decreases Therapist Burnout

• Conducive to our continued growth as “Professional Facilitators of Change”
From the work of Dr. Daniel Siegel:

- The mind is not the brain. “The mind is a self-organizing process that regulates the flow of energy and information both within us and between us.” (Siegel, 2017)

- An optimized system is:
  1. Flexible
  2. Adaptive
  3. Coherent
  4. Energized
  5. Stable
Structural and Functional Brain Changes as Function of Social Connection

  - Bio-Psycho-Social-Spiritual definition of the “Mind”
  - Attunement & Integration – “Feeling-Felt” best predictor of outcome
  - Importance of relationship in shaping mind and narrative-Sense of “The Self” predicated on attachment
Structural and Functional Brain Changes as Function of Social Connection

  • Information above integrated and discussed in psychotherapeutic context
  • Neuroplasticity from context of early attachment and trauma as well as healing of psychotherapy and safe attachment
  • Ambivalent attachment to harmful objects
MI as a Novel Intervention
(Consider substance abuse intervention at the time?)

• Miller and Stephen Rollnick-1991, 2013 (Miller & Rollnick, Motivational interviewing: Preparing people to change addictive behaviors, Guilford Press)
• Research and applications have mushroomed and include: Drug abuse, gambling, eating disorders, anxiety disorders, chronic disease management (e.g. diabetes, heart disease), health related behaviors.

- Changing to thrive: Using the strategies of change to overcome the top threats to your health and happiness; Prochaska, J & Prochaska, J; 2016. Hazelden Publishing.
Applications of MI (cont.)

- Useful for any healthcare practitioner who encourages clients/patients to consider behavior change
- Nurses, doctors, dieticians, psychologists, social workers, counselors, health educators, dentists, dental hygienists, physical and occupational therapists, podiatrists
- Sometimes even the **people who answer the office phones/Front Office (SPIRIT)**.
What is it?

- Motivational Interviewing is an effective way of talking with people about change
MI: Definition & Spirit

**Definition:** MI is a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

**Spirit:** Collaboration, Evocation, Autonomy
Spirit

Skills

Spirit
MI: Spirit

- Collaboration – Partnerships
- Evocation – Listening & Eliciting
- Autonomy – The ability to choose (really getting this both increases likelihood of beh. change and DECREASES BURNOUT!)

It is the professional’s responsibility to respect the client’s ability to choose.
MI: Role of Therapist

- Guide
- Instructo\_r
- Listener
Nonspecific Factors in Psychotherapy

- Expectations – Self-fulfilling prophecy
- Therapeutic Relationship: Decades of research has continued to indicate NO single variable predicts more variance in treatment outcome
  - Bond
  - Task
  - Goal
    - WAI (Horvath & Greenberg, 1989)
- Hawthorne Effect (Roethilsberger & Dickinson, 1939):
  - Attention impacts the results of therapy.
Therapists Influence Client Outcomes

- Empathic therapists have better outcomes.
- Expectations influence outcomes (Counselor’s perceived prognosis, self-efficacy)
- Counselor style influences outcome (at least as much as the particular approach or school of thought)
- Differences in drop-out rates
- Differences in outcome rates (confrontation led to more drinking one year after treatment)
- Simple actions influence drop-out rates (e.g. Notes)
The Change Process: Important Elements of MI

- Change
- Motivation
- Ambivalence
- Stages of Change
Motivation & the Change Process

• A Working Definition of Motivation
• The probability that a person will enter into, continue, and comply with change-directed behavior
• Clients are not unmotivated. They are just motivated to engage in behaviors that others (and themselves) consider harmful and problematic
• Motivation belongs to clients: However motivation can be enhanced, or hindered, interactions with others
• Motivation is best viewed as the client’s readiness to engage in and complete the various tasks that are outlined in the stages of change
Ambivalence

- Ambivalence is normal
- A state of mind in which a person has coexisting but conflicting feelings, thoughts and actions about something
- GOAL: To create and amplify discrepancy between present behavior and broader goals.

**How?**

- Create cognitive dissonance between where one is and where one wants to be.
- **In fact**, when a client is dealing with ambivalence they are moving closer to lasting change
Might This Help With Empathy?
Micro-Skills (OARS)

• Open ended questions

• Affirm the person- build self-confidence and a sense of self-efficacy

• Reflect what the person says- Probably the most important--statements not questions- promotes empathy and understanding

• Summarize perspectives on change- long reflections of more than one statement
To Appreciate and Understand MI, Must Understand TTM

- Transtheoretical model of behavior change (TTM) (Prochaska & DiClemente, 1984)
  - Change does not happen all at once
  - Change is a process not an event
  - Change takes time and energy (ambivalence)
  - Common characteristics of successful change
  - Five distinct stages of change:
Precontemplation

- No acknowledgement that there is a problem behavior that needs to be changed
- Not ready or interested in help
- Defensive
Contemplation

• Acknowledging that there is a problem
  • Not ready or sure of wanting to change it

• Aware of personal consequences of behavior

• Ambivalent
Preparation / Determination

• Beginning to consider behavior change
  • May be bargaining involved
    • “I will quit the drinking but still going to use cocaine periodically.”

• Information gathering

• Possibly already taking small steps toward change
  • “This is serious, I’ve got to do something”
  • “Something has to change, what can I do”
Action

• Actual behavior Change Begins

• Belief in ability to change is present

• Actively involved in changing their use
  • Showing up for treatment appointments
  • Going to 12-Step meetings
  • Making calls to create a healthy network
Maintenance

- Changes are Maintained
- Particularly with SUD-Continued work
- Emotional sobriety is NOT Terminal
Relapse / Recycle

- Returning to old behaviors and abandoning the new changes
- Extremely common
- Includes feelings of failure and discouragement
Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse
Principles of Motivational Interviewing (Four Processes)

Express empathy (Engaging)

Roll with resistance (Engaging)

Develop discrepancy (Focusing, Evoking)

Promote self-efficacy & change (Evoking, Planning)
Express Empathy

• Acceptance facilitates change

• Skillful reflective listening is fundamental

• Ambivalence is normal rather than seen as pathology or pernicious defensiveness
Traps / Pitfalls

- Question – Answer
- Confrontational – Denial
- Expert Trap
- Labeling Trap
- Premature Focus
- Blaming Trap
Dealing with Resistance  (Categories of Resistant Behavior)

- Arguing
- Interrupting
- Denying
- Ignoring
Responding to Resistance

- Reflections on Resistance:
  - Simple Reflection (Simple acknowledgment of the person’s disagreement).
  - Amplified Reflection (Reflect back what they have said in an amplified form. Must be done empathetically).
  - Double-Sided Reflection (Capture both sides of the ambivalence) (Use “and” statements instead of “but”).
Responding to Resistance (cont.)

- Shifting Focus – Going around barriers rather than trying to climb them.
- Reframing – Validate client but offer different perspective.
- Agreeing with a twist – offer initial agreement but with a slight twist or change in direction.
- Coming Alongside – Defend the counterchange side of the argument.
Develop Discrepancy

• Cognitive Dissonance – uncomfortable feelings.
• The client rather than the counselor should present the argument for change.
• Elicit self-motivational statements.
• Change is motivated by a perceived discrepancy between present behavior and important personal goals or values.
Support Self-Efficacy

• A person’s belief in the possibility of change is an important motivator.
• The client, not the counselor, is responsible for choosing and carrying out change.
• The counselor’s own belief in the person’s ability to change becomes a self-fulfilling prophecy.
Difference With Other Approaches

• Vs. Confrontational approaches, MI
  • Is based on supportive empathy
  • Uses collaboration and respects client autonomy
  • Views denial in light of stages of change
    • Ambivalence is a normal feature of pre-action stages
  • Views resistance as a two person phenomenon

• Question – If someone is ambivalent, what happens to the dialogue when we argue for one side of the ambivalence?
More on Confrontation

• Question – If we label someone as being in denial, is this a patient or a counselor (professional attempting the intervention) issue?

• How do we “confront” this?
  • Confrontational counseling has been associated with high dropout rates and relatively poor outcomes.
  • Miller et al. (1993) were able to predict clients’ ETOH consumption 1 year after trt. from a single counselor behavior: The more that counselor “confronted,” the more that client was drinking.
Differences With Other Approaches (cont.)

• Vs. CBT, DBT
  • Places greater emphasis on the client-directed change process.
  • Is less prescriptive, e.g. provides a menu of options rather than a therapist derived change plan.
  • Relies less on therapist expert knowledge.
  • Was designed for earlier stages of change (CBT mostly for action stage).
Differences With Other Approaches (cont.)

• Vs. Rogerian Therapy, MI
  • Is explicitly directive
    • Includes techniques beyond reflection and empathy (e.g. for handling resistance).
  • Provides advice, change planning, and menu of change strategies when appropriate.
What Causes a Client to be Judged as Motivated? “the good client”

• Agree with the therapist’s view.
• Accepts self-label or view of self as “sick.”
• States desire for help.
• Shows distress, depends on therapist
• Complies with recommendations and treatment prescriptions.
• Has a successful outcome (what we deem as successful).
Two Phases of MI

• Phase I: Building Motivation
  • Feedback
  • Beginning and maintaining use of skills we discussed

• Phase II: Strengthening / Maintaining commitment to change
  • Supporting persistence

• Flexible Revisiting
  • Replanning, Reminding, Refocusing, Reengaging
People often recycle through the stages before becoming successful in making a lasting behavior change.

Understanding the stages of change is integral

- Change is a dynamic process
- The change process is individual
Summary

• Four principles and OARS are the basics of MI.

• Counselor characteristics do facilitate or hinder motivation and behavior change.

• Knowing how to address a client’s ambivalence can strengthen your ability to promote change.
Summary

- Empathy and reflective listening are useful to facilitate motivation and behavior change.
- Resistance is NOT a liability regarding behavior change.
Resources

Resources (cont.)

Resources (cont.)