



Motivational Interviewing: Practical Applications of Knowledge and Research

Jennifer Frey, Ph.D.

Topics

Practical information on:

- Facilitating and sustaining the practice of Motivational Interviewing (MI) through supervision.
- Improving outcome measures through implementation of MI to address compliance with treatment.
- Increasing adherence to treatment for medical conditions.
- Modifying MI techniques for people who are diagnosed with co-occurring disorders (COD).

2

MI Definition

MI is a semi-directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

3

MI and COD

Motivational Interviewing has been used to help clients who are diagnosed with co-occurring disorders successfully:

- Engage into services
- Participate in treatment
- Transition to another level of care

4

MI and COD (con.)

- Two sessions of MI more than doubled the rate of treatment engagement (42 vs. 16%) among clients transferred from inpatient to outpatient treatment services (Swanson, et al., 1999).
- A preadmission single session of MI resulted in improved rates of program attendance and involvement compared to a standard psychiatric intake (Martino et al., 2000).

5

MI and COD (con.)

- A three session MI intervention tailored for co-occurring disorders resulted in significantly reduced drinking days and daily alcohol consumption compared to a three session psychoeducational intervention (Graeber et al., 2003).

6

MI and Homelessness

MI techniques show promise with clients who are homeless as an effective approach to:

- Changing health behavior (Yahne et al., 2002; Robles et al., 2004)
- Initiating abstinence from heroin and cocaine
- Improving alcohol treatment outcomes and increasing participation in sober social supports

7

MI and Homelessness (con.)

- Brief MI has been used in health clinics by peer workers to initiate abstinence from heroin and cocaine (Bernstein et al., 2004).
- MI/CBT Group combined with peer support and contingency management has been used in a soup kitchen to improve alcohol use outcomes and participation in self-help meetings (Rosenblum, et al., 2005).

8

MI and Supervision

- Motivational Interviewing Assessment: *Supervisory Tools for Enhancing Proficiency (MIA: STEP)*
- Adds a 20-minute MI enhancement to the beginning and end of an agency's usual assessment interview
- Shown to improve client engagement and retention during the first four weeks of treatment.

9

MI and Supervision (con.)

- MIA: STEP supports ongoing feedback and mentoring to improve staff skills in using MI.
- MIA: STEP includes:
 - A review of the clinical trials research
 - Guidelines for conducting assessment
 - Tools to enhance counselor skills
 - Instructions for assessing and rating counselor proficiency in MI.

10

MI and Supervision (con.)

- The MIA: STEP Package can be downloaded from:
<http://www.mid-attc.org/mia.htm>

11

Measuring Individual Client Compliance

Compliance may be defined as:

- Abstinence
- Attendance at self-help meetings
- Medication adherence
- Between session practice of recovery tasks

(Daley & Zuckoff, 1999)

12

Measuring Individual Client Compliance (con.)

Compliance can be measured by:

- Client self-report
- Significant other report
- In session review of between session tasks
- Urinalysis, breathalyzer to detect alcohol or drug use
- Blood tests to check for therapeutic levels of medication (i.e., lithium)

(Daley & Zuckoff, 1999)

13

MI and Improving Treatment Compliance

Early warning signs of poor compliance:

- Lateness for sessions
- Failure to work on between session tasks
- Missing self-help meetings
- Failure to take medications as prescribed

(Daley & Zuckoff, 1999)

14

MI and Improving Treatment Compliance (con.)

Response to early warning signs of poor compliance:

- Discuss compliance problems immediately
- Determine reasons for the client's behavior
- Establish strategies to improve compliance and address ambivalence.

(Daley & Zuckoff, 1999)

15

Compliance Outcome Measures

- Compliance rates can be compared for each counselor or program (e.g., percentage of sessions attended by each client).
- If clients are distributed randomly to all counseling staff, the compliance rates should be fairly equal across counselors.
- Intervention is needed when compliance rates for a particular counselor or program are significantly below the average or identified threshold.

(Daley & Zuckoff, 1999)

16

Compliance Outcome Measures (con.)

- Outpatient treatment programs can monitor the percentage of clients who attend:
 - Their initial evaluation
 - The early phase of treatment (e.g., specific number of sessions, specific length of time in treatment)

(Daley & Zuckoff, 1999)

17

Compliance Outcome Measures (con.)

- Inpatient or residential programs can monitor compliance through:
 - Completion rates
 - Early dropout rates
 - Follow through with initial aftercare sessions

(Daley & Zuckoff, 1999)

18

MI and Improving Treatment Compliance

Improve outcomes by:

- Increasing attendance to initial evaluation
- Increasing retention in early phase of treatment
- Increasing completion rates
- Increasing follow through with initial aftercare sessions

(Daley & Zuckoff, 1999)

19

Increase Attendance to Initial Evaluation

Goals:

- Increase willingness to explore problems related to substance use and other behaviors
- Decrease resistance
- Increase self-efficacy

(Daley & Zuckoff, 1999)

20

Increase Attendance to Initial Evaluation (con.)

FRAMES

- Feedback
- Responsibility
- Advice
- Menu of Options
- Empathy
- Supporting client's sense of self-efficacy

21

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Feedback

- Ask about negative consequences of substance use and mental health disorder
- Ask about other life concerns

(Daley & Zuckoff, 1999)

22

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Responsibility

- Reflect level of concern client has about substance use and mental health disorder
- Emphasize personal responsibility for decision
- Ask about what the client wants to do
 - If they express a wish for change or a need for help continue to advice
 - If they express resistance (minimizing the seriousness, etc.), elicit objections, reflect responses and highlight ambivalence, restate reasons for concerns, continue to advice

(Daley & Zuckoff, 1999)

23

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Responsibility (con.)

- Ask about what the client wants to do
 - If they express a wish for change or a need for help continue to advice
 - If they express resistance (minimizing the seriousness, etc.), elicit objections, reflect responses and highlight ambivalence, restate reasons for concerns, continue to advice

(Daley & Zuckoff, 1999)

24

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Advice

- Affirm decision to explore options
- Offer that others have successfully addressed similar problems with professional assistance
- Suggest that they attend a full evaluation of their situation to explore specific options
- Offer to schedule appointment
- Elicit obstacles and offer help or suggest options

(Daley & Zuckoff, 1999)

25

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Menu of Options

- Describe what the client can expect (e.g., how to get to the appointment, hours of operation, after evaluation they will be given options to consider, the client will decide what they need)
- Ask if the client has any questions

(Daley & Zuckoff, 1999)

26

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Empathy

- Express empathy about client's situation and affirm willingness to have this conversation with you
- Reflect client's response
- Affirm client's participation in this conversation

(Daley & Zuckoff, 1999)

27

Increase Attendance to Initial Evaluation (con.)

FRAMES:

Supporting client's sense of self-efficacy

- Affirm client's participation in this conversation
- Express confidence in their ability to follow through
- Reflect their response, especially confidence and commitment to follow through
- Make a positive statement about looking forward to seeing them at the appointment

(Daley & Zuckoff, 1999)

28

Increase Retention in Early Phase of Treatment

- Elicit the purposes and unintended consequences of their behavior
- Develop trust through exploring problems and concerns from the client's perspective
- Identify ambivalence about change
- Empathize with difficulty of making a change while maintaining focus on conflict
- Support belief in ability to make a change

(Daley & Zuckoff, 1999)

29

Increase Completion Rates

- Offer education and advice when the client asks
- Accurately identify when the client is ready to make a change
- Elicit solutions to the problem and identify the solution that is most feasible and likely to succeed
- Elicit commitment to a plan for action
- Affirm ability to carry the plan through and communicate optimism about the potential for success

(Daley & Zuckoff, 1999)

30

Transition to Continuing Care from Inpatient Settings

- Many clients appear motivated following participation in an intensive residential treatment program and fail to follow through with aftercare treatment
- Clients may underestimate how difficult the transition to ongoing recovery will be outside the inpatient setting
- This may result in decreased self-efficacy upon discharge and a return to substance use instead of engaging in aftercare treatment

(Daley & Zuckoff, 1999)

31

Transitional Motivational Counseling Session

A single-session intervention that increases follow through on the aftercare plan.

- Set the agenda
- Establish the context of the current treatment episode
- Make the connection to past treatment experiences
- Consider aftercare
- Provide information
- Offer hope and an invitation

(Daley & Zuckoff, 1999)

32

Transitional Motivational Counseling Session (con.)

Set the agenda.

- Elicit the client's understanding of the purpose of the meeting
- Explain your desire to discuss the client's transition from inpatient treatment to the aftercare program
- Request permission to have this conversation for the next half hour or so

(Daley & Zuckoff, 1999)

33

Transitional Motivational Counseling Session (con.)

Establish the context of the current treatment episode.

- Elicit events that led up to their admission
- Reflect the most important elements
- Shift the focus to their current treatment experience
- Elicit and affirm the new strategies they've learned and how the strategies will support their recovery
- Empathically reflect rejection of the program to communicate that you understand

(Daley & Zuckoff, 1999)

34

Transitional Motivational Counseling Session (con.)

Make the connection to past treatment experiences.

- Elicit information about past admissions
- Elicit information about past aftercare
- Make the connection between aftercare and life improvement
- If the client decided not to attend aftercare ask them to describe how things went
- Identify factors that influenced their decision and identify other ways to manage them

(Daley & Zuckoff, 1999)

35

Transitional Motivational Counseling Session (con.)

Consider aftercare.

- Elicit the client's hopes, plans, and expectations for life after discharge and link these to how aftercare can help them achieve their goals
- Anticipate roadblocks to following through with aftercare and recovery

(Daley & Zuckoff, 1999)

36

Transitional Motivational Counseling Session (con.)

Provide information.

- Provide detailed information about the aftercare program
- Answer any questions the client may have.
- Match program options to client goals and concerns
- Educate the client about the differences between inpatient treatment and aftercare to help the client appreciate how their lives are about to change

(Daley & Zuckoff, 1999)

37

Transitional Motivational Counseling Session (con.)

Offer hope and an invitation.

- Affirm that the aftercare program offers the client a realistic hope of achieving their goals
- Express appreciation for the client's participation in the discussion
- Invite the client to come to the aftercare program. If this somehow seems out of place or the client refuses, it might be worthwhile to ask about the reason for the hesitation and address this further.

(Daley & Zuckoff, 1999)

38

MI and Medical Treatment

- Use reflections and summaries to respond to client's reasons for considering change in health-related behaviors
- Identify steps client would take, who would help him/her, obstacles and how he/she would know the plan is working
- Use Importance/Confidence Readiness Ruler to elicit and reinforce change talk
- Monitor client's progress with plan

39

MI and COD

The symptoms of a thought disorder interact with a substance use disorder such that substance use may:

- Lessen negative symptoms (e.g., emotionally flat, slowed thinking and speech production, diminished motivation, energy, and pleasure, social isolation)
- Reduce discomfort caused by positive symptoms (e.g., delusions, hallucinations, disordered thinking, circumstantial or tangential speech)
- Facilitate social interactions
- Mask psychotic symptoms as substance induced

(Martino & Moyers, 2008)

40

MI and COD (con.)

- Understanding how the client's thought disorder and substance use disorder interact and treating the disorders at the same time improves the client's functioning
- Increasing adherence to antipsychotic medication and other treatment needs (e.g., medical, dental, vocational, financial, and housing) involve engagement and retention in a variety of services

(Martino & Moyers, 2008)

41

MI and COD (con.)

Open-Ended Questions

To elicit information about the relationship between substance use and psychiatric symptom:

- "What effect does your drinking have on your voices?"
- "Tell me about what happens to your symptoms when you smoke crack."

(Martino & Moyers, 2008)

42

MI and COD (con.)

Asking Evocative Questions

To elicit change talk relevant to the way substance use is related to psychiatric symptoms:

- “How do you think stopping your crack use would effect your feelings of depression?”
- “Other than using alcohol or drugs, what has helped you feel less suspicious in the past?”

(Martino & Moyers, 2008)

43

Cognitive Impairment

- Clients with thought disorder may have difficulty with word generation, abstract reasoning, mental flexibility, attention and concentration, verbal learning, and working memory.
- Substance use disorders contribute to cognitive impairment through difficulties problem solving, abstraction, visual-spatial abilities, perceptual motor functioning, mental flexibility, speed of information processing, and learning and memory.

(Martino & Moyers, 2008)

44

Modifications to MI for Cognitive Impairment

- Simplify reflective statements and questions by addressing smaller chunks of information:

“Tell me about the main reasons you were hospitalized.”

- Use frequent, clear reflections and summaries to help clients attend to, remember, and organize the conversation.

(Martino & Moyers, 2008)

45

Modifications to MI for Cognitive Impairment (con.)

Simplify and structure the decisional balance:

- Identify one or two negative consequences that strongly effect the client
- Focus on the positive and negative consequences of changing behavior
- Focus on reasons for changing and reasons for not changing
- Record reasons to stop using substances on red cards that clients carry with them and look at when they feel an urge to use

(Martino & Moyers, 2008)

46

Modifications to MI for Cognitive Impairment (con.)

Simplify and structure clarification of goals and values:

- Identify up to 3 goals related to recovery for both disorders that the client would like to accomplish (e.g., employment, feel better)
- Ask about how quitting substance use would help them attain each goal
- Ask about how treatment adherence would help them attain each goal (e.g., medication adherence, case management services, program enrollment)

(Martino & Moyers, 2008)

47

Addressing Positive Psychotic Symptoms

Paraphrase intended meaning to create reality-based understanding when auditory hallucinations, delusions, and disordered thinking interfere with communication:

Counselor: “Tell me about what’s led you to seek treatment in our program.”

Client: “I’m not seeking treatment, treatment is seeking me.”

Counselor: “It’s not that you want to come here for treatment, someone has made you come here.”

(Martino & Moyers, 2008)

48

Addressing Positive Psychotic Symptoms (con.)

Reflect paranoid symptoms when delusions are not fixed.

Client: "They are after me, they are partners in crime. What right do they have to tell me I have to come here?"

Counselor: "You didn't drink, and even if you did, it's none of their business."

Client: "I did drink, but not much."

Counselor: "You don't want to be forced into treatment for drinking, you want to choose what you will do in treatment."

Client: "Yeah, I get angry, I don't trust other people. I might want to work on that."

(Martino & Moyers, 2008)

49

Addressing Positive Psychotic Symptoms (con.)

- If a client rigidly adheres to delusional beliefs and becomes increasingly paranoid when their beliefs are reflected, it is inappropriate to continue reflecting the beliefs
- Instead, simply acknowledge the beliefs and shift focus to other areas where opportunities to increase motivation for behavior change might exist

(Martino & Moyers, 2008)

50

Addressing Unusual Behavior

Incorporate unusual behavior into understanding of the client's experience.

Counselor: "You are having trouble concentrating and it's hard to see getting back to the place you were with your job."

Client: (*Gets up, opens and slams the door and looks confused.*)

Counselor: "You're not sure if the door has been shut for you to return to your job. You want to do what you can to open it, but you are not sure what to do."

Client: "What can I do?" (*sits down*).

Counselor provides information about medication, drug abstinence, therapy, and minimizing stress to help him cope with his current situation.

(Martino & Moyers, 2008)

51

Addressing Intensely Negative Emotion

Intensely negative emotion may lead to cognitive disorganization, delusional thinking, increased hallucinations, or hostility. To address negative emotions:

- Repeat or rephrase feelings as expressed by the client
- When asked, offer information about how to cope with distressing negative emotional states, self statements, and life events

(Martino & Moyers, 2008)

52

Addressing Intense Ambivalence

Intense ambivalence may also be difficult for the client to manage:

- Carefully attend to the client's increased discomfort related to one side of their ambivalence relative to the other
- Given the choice, reflect the side of the ambivalence that is more recovery oriented to increase the amount the client talks about it
- Move more quickly to summarizing the ambivalence and use strategies to elicit change talk

(Martino & Moyers, 2008)

53

Addressing Negative Symptoms

Clients with negative symptoms may:

- Have low internal motivation to manage co-occurring disorders.
- Have few reinforcing supports
- Produce low amounts of speech during session

(Martino & Moyers, 2008)

54

Addressing Negative Symptoms

The challenge for the counselor is to stimulate discussion and generate material that may facilitate motivational enhancement.

- Paraphrase implied information frequently
- Allow sufficient time for client to consider and respond to reflections
- Affirm participation when it might otherwise go unnoticed
- Use structured tasks within each session

(Martino & Moyers, 2008)

55

Addressing Negative Symptoms (con.)

Structured tasks within sessions might include:

- Using assessment procedures like the decisional balance or the Alcohol and Drug Consequence Questionnaire to help clients identify reasons to use or not use substances
- Offering lists of goals to prime clients to generate and discuss personal goals
- Discuss how substance use and treatment nonadherence may conflict with goal attainment

(Martino & Moyers, 2008)

56

Assessing Whether MI is Working

Counselors should pay careful attention to how clients respond to MI strategies and adjust accordingly.

- If a client becomes more disorganized in response to reflections, switch to a more highly structured intervention (e.g., case management, problemsolving, social rehabilitation, medication interventions)
- If a client becomes less symptomatic, more organized and logical in speech and has enhanced capacity to recall and participate in response to reflections, then MI is appropriate

(Martino & Moyers, 2008)

57

When Not to Use MI

When psychiatric symptoms seriously impair the client's capacity to:

- Make informed decisions
- Function autonomously, or
- Maintain their own or others' safety

Counselors should change their approach to:

- Mental status exams and risk assessments
- Provide appropriate treatment (e.g., crisis intervention, hospitalization).

(Martino & Moyers, 2008)

58

Other Treatment Interventions

Clients who are homeless and diagnosed with co-occurring disorders benefit from other interventions in addition to Motivational Interviewing:

- Case management services
- Social skills training and relapse prevention
- Vocational rehabilitation
- Family counseling
- Housing
- Health care
- Finances

59

References

- Bernstein, J., Bernstein, E., Tassiopoulos, K., Heerend, T., Levenson, S., Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*, 49–59.
- Carey, K.B., Purnine, D.M., Malisto, S.A. & Carey, M.P. (2001). Enhancing readiness-to-change substance abuse in persons with schizophrenia. *Behavior Modification, 25*, 331–384.
- Cunningham, J.A., Sobell, L.C., Gavin, D.R., Sobell, M.B., & Breslin, F.C. (1997). Assessing motivation for change: Preliminary development and evaluation of a scale measuring the costs and benefits of changing alcohol and drug use. *Psychology of Addictive Behaviors, 17*, 101–114.
- Daley, D.C. & Zuckoff, A. (1999). Improving Treatment Compliance. Hazelden, MN.
- Graber, D. A., Moyers, T.B., Griffith, G., Guajardo, E., & Tonigan, S. (2003). A pilot study comparing motivational interviewing and an educational intervention in patients with schizophrenia and alcohol use disorders. *Community Mental Health Journal, 39*, 189–202.
- Martino, S., Carroll, K., Kostas, D., Perkins, J., & Rounsaville, B. (2002). Dual Diagnosis Motivational Interviewing: a Modification of Motivational Interviewing for Substance-Abusing Patients With Psychotic Disorders. *Journal of Substance Abuse Treatment, 23*, 297–308.
- Martino, S., Carroll, K. M., O'Malley, S. O., & Rounsaville, B. J. (2000). Motivational interviewing with psychiatrically ill substance abusing patients. *American Journal of Addictions, 9*, 88–91.
- Martino, S. & Moyers, T.B. (2008). Motivational Interviewing with Dually Diagnosed Patients. In: Arkowitz, H., Westra, H.A., Miller, W.R., and Rollnick, S. (Eds). *Motivational Interviewing in the treatment of Psychological Problems*. The Guilford Press, New York.
- Robles, R. R., Reyes, J. C., Colon, H. M., Sahai, H., Marrero, C. A., Matos, T. D. et al. (2004). Effects of combined counseling and case management to reduce HIV risk behaviors among Hispanic drug injectors in Puerto Rico: a randomized controlled study. *Journal of Substance Abuse Treatment, 27*, 145–152.
- Swanson, A. J., Pantalon, M. V., & Cohen, K. R. (1999). Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. *Journal Nervous and Mental Disease, 187*, 630–635.
- Yahne, C. E., Miller, W. R., Irvin-Vitela, L., & Tonigan, J. S. (2002). Magdalena Pilot Project: motivational outreach to substance abusing women street sex workers. *Journal of Substance Abuse Treatment, 23*, 49–53.

60