Motivational Interviewing and The Community Reinforcement Approach

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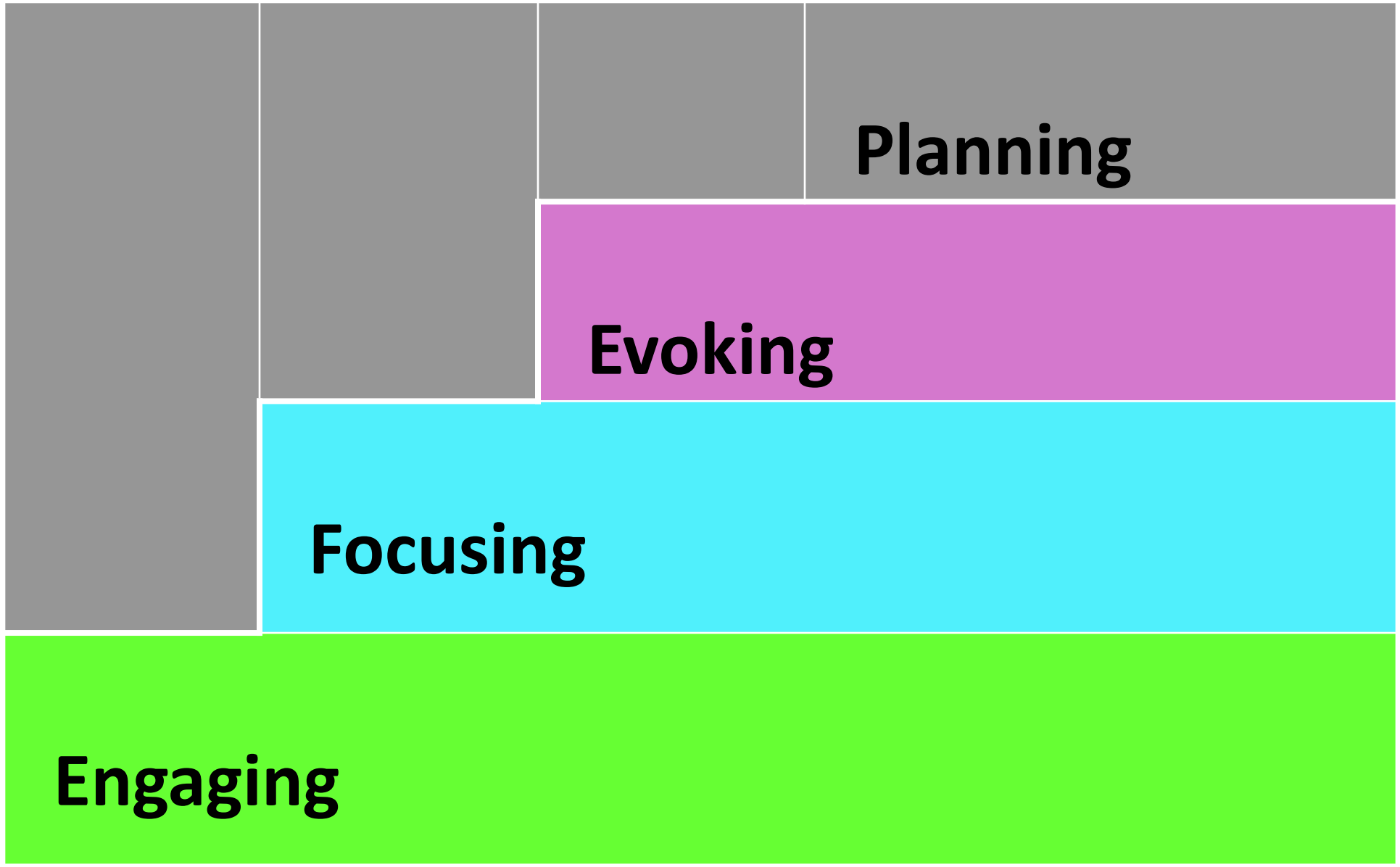
Revisiting MI

Four Foundational Processes

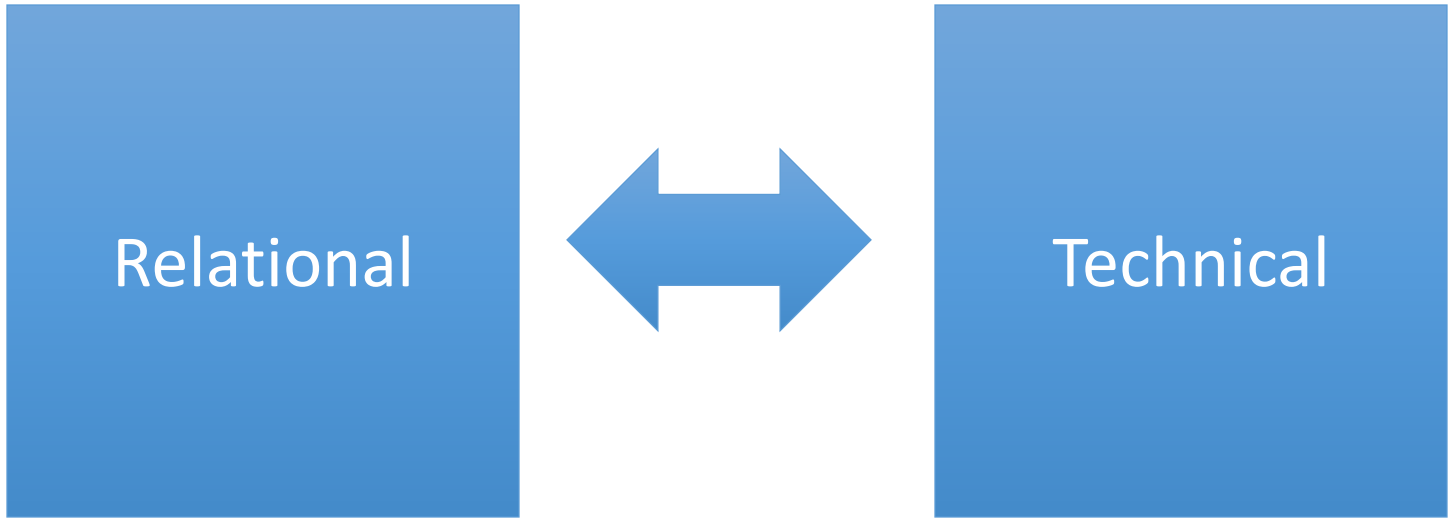


Assumptions of Motivational Interviewing

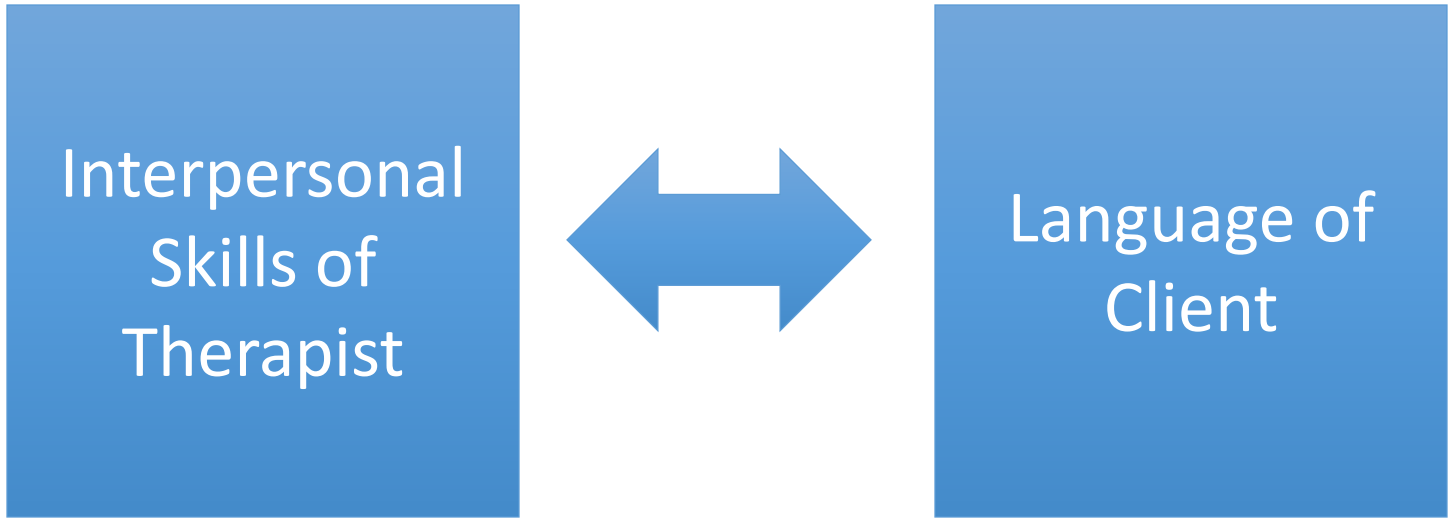
- Rests on a client-centered or humanistic foundation
- Clients inherently have “righting” resources
- Clinician’s job is to enhance the client’s motivation, not create it from scratch
- Therapists are useful to the extent that they create an experience in their interaction with the client that creates an opportunity for motivation to flourish
- This is most likely when therapists are empathic, supportive of autonomy and collaborative

Two Components to ML

Relational and Technical Components



Relational and Technical Components



#1. Motivational Interviewing is not about the content

- This does not mean that there is no content
- Emphasizing autonomy and choice
- Attention to client's values as source of motivation
- Creating discrepancy between current behavior and deeply held values
- Finding the client's own language about change

#1. Motivational Interviewing is not about the content

- But WHAT you do is not more important than HOW you do it

#1. Motivational Interviewing is not about the content

- Evidence at least as strong for relational as technical elements of MI
- MI is a process that happens ***with*** a client; it is not something you do ***to*** a client
- Training and evaluating MI must focus “equal time” on relational and process elements

#1. Motivational Interviewing is not about the content

- This does not mean that we can all relax because MI is easier than more content focused treatments

Empathy Matters

- What is empathy?
- An evidence-based treatment method
- Reliably measurable (not “nonspecific”)
- Highly variable (not a “common” factor)
- Learnable; improves with training
- Directly predicts client drop-out, resistance, and outcomes
- Low empathy counselor worse than none

#1. Motivational Interviewing is not about the content

- Does the clinician have the ability to convey empathic understanding of the client's perspective?
- Does the clinician honor the client's autonomy and choice concerning changes?
- Does the clinician share power and expertise in the interaction with the client?
- Does the clinician actively and persistently attempt to evoke the client's own ideas and values concerning change?
- Does the clinician focus on the change that is "on the table" or wander around in other therapeutic tasks at the expense of a clear direction?

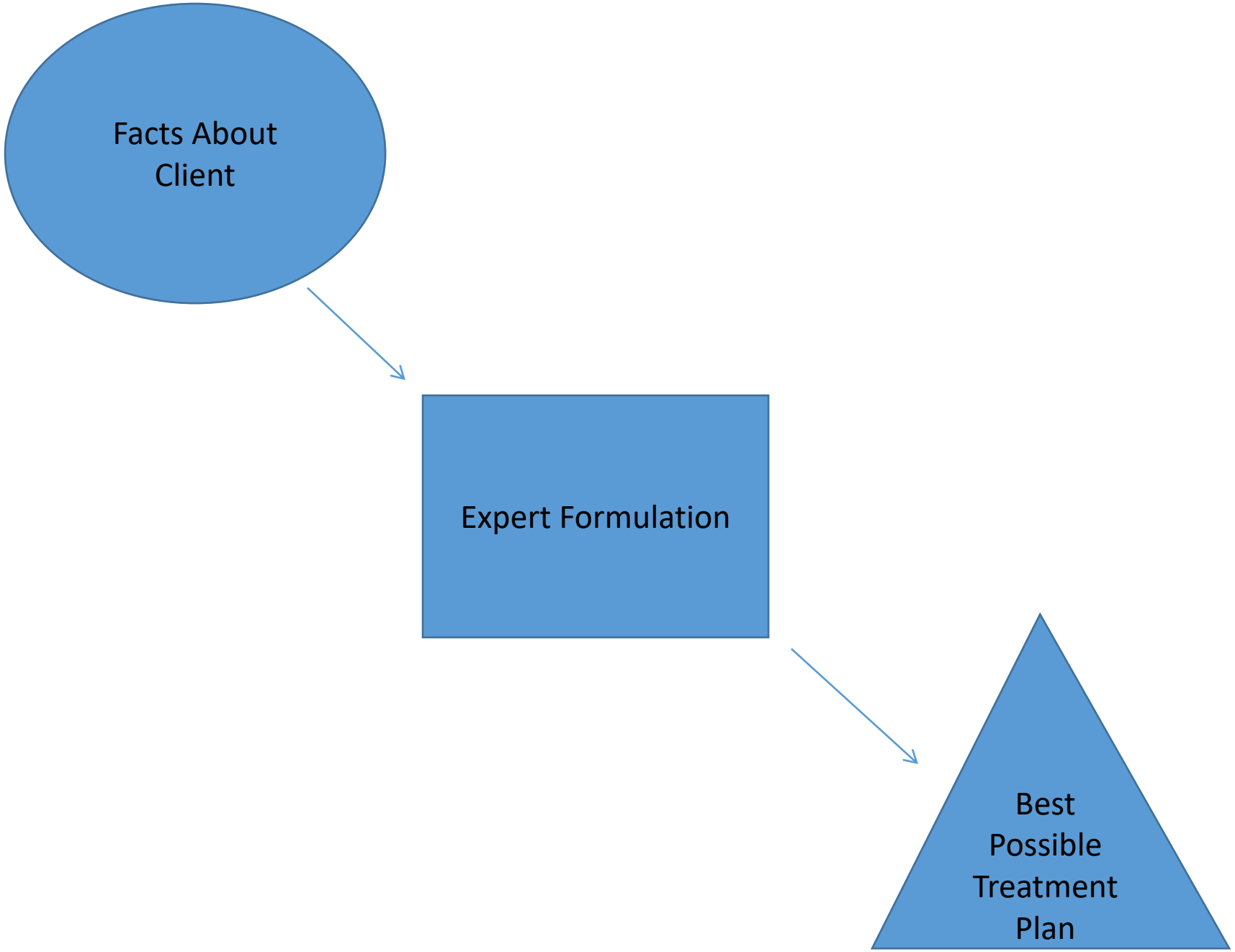
#2. Assessment of the client is not needed in order to use MI successfully

Please Notice

- Not saying “Assessment isn’t needed”
- Assessment isn’t needed “to use MI”

#2. Assessment of the client is not needed in order to use MI successfully

- Front-loading a detailed assessment before motivation is addressed implies an expert model:


Facts About Client
Expert Formulation
Best Possible Treatment Plan

#2. Assessment of the client is not needed in order to use MI successfully

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- MI focuses on an evoking process
- This involves helping the client bring forward what they ***already know*** about why they would change
- An assessment implies that the clinician, as the expert, will tailor treatment based on the information that is gathered
- MI implies that the client already knows how and why to change, but needs help resolving ambivalence about ***whether*** to change

#2. Assessment of the client is not needed in order to use MI successfully

- This is a different way of thinking about why client's are "stuck in their ways" and how to go about helping

#3. Giving information to the client may or may not be good practice in MI

#3. Giving information to the client may or may not be good practice in MI

- Knowledge rarely helps people change self destructive behaviors about which they are ambivalent
- Objective feedback may be useful to create ambivalence
- MI often confused with Motivational Enhancement Therapy (MET) from Project MATCH
- Does giving the information provoke discord?

What about personalized feedback?

- Might be most appropriate for creating ambivalence (Precontemplation?)
- Not needed for MI

But seriously, don’t you need some information?

- What do you need to BEGIN?
- Assessment sandwich

#4. MI is not the right thing for every client

#4. MI is not the right thing for every client

- MI most useful for clients who are ambivalent
- Clinicians need a wide variety of skills and treatments for situations where clients are either not ambivalent yet or have already resolved ambivalence and want to move forward (here is where assessment is useful)
- MI is a skill that can be used in certain situations and put down when not needed
- Sometimes clinicians want to “keep” the spirit

#5. MI is an empirically-supported treatment but its efficacy is highly variable

#5. MI is an empirically-supported treatment but its efficacy is highly variable

- In some RCT's it works, in others not.
- Within trials it works at some sites and not others
- We know next to nothing about why this is so
- A good bet would be therapist effects
- As with other treatments, therapist effects in MI are often larger than the impact of the treatment itself (MATCH; COMBINE)

#5. MI is an empirically-supported treatment but its efficacy is highly variable

- May be related to active ingredients not being specified
- May be related to quality of the intervention
- Better quality of MI associated with better outcomes

Measuring the Quality of MI

- Necessarily involves measuring the nature and quality of the interpersonal interaction
- Content, not so much

#6. MI can be learned, but not by everyone

#6. MI can be learned, but not by everyone

- Four RCT's directly addressing the training of MI
- More than 600 substance abuse therapists with various different learning strategies
- Outcomes verified by audio recordings of doing MI with clients in their work settings after training
- Various measures used: Percent complex reflections, ratio of reflections to questions (R:Q)

Rule of thirds

- A third are “easy learners”
- A third struggle but make substantial gains
- A third improve only a bit or not at all
- Nothing we know about clinicians ahead of time predicts learning, including experience
- Most clinicians do not improve until they have enrichments to their initial learning

Types of enrichments that boost learning of MI

- Expert consultation on a regular basis in the period just after training occurs (about six weeks)
- Numbers from an objective rating system
- Direct observation with feedback
- What kinds of innovative methods might be used to offer these enrichments?
- Distance learning paradigms, virtual patients, etc

#7.Supervising MI requires direct observation of clinicians

#7.Supervising MI requires direct observation of clinicians

- What clinicians say about what happens in MI sessions has a ***very low*** correlation with what actually happens
- Clinicians are not lying: what they don’t notice is often what is most important
- Objections to observation can be overcome with patience and a safe environment
- More than one right way to do this observation

#8. Sometimes the outcome of MI is that the client realizes they don’t need you to change

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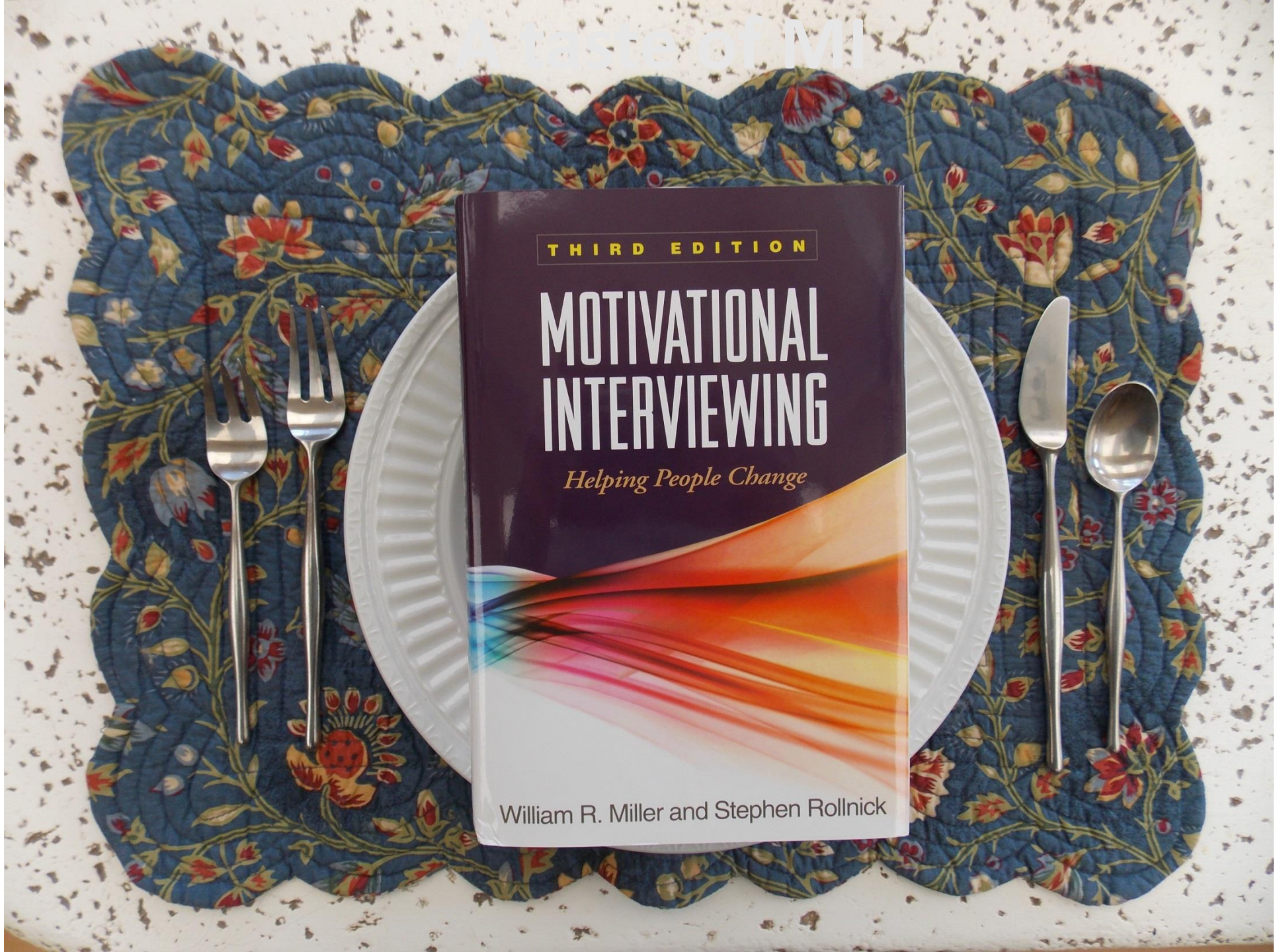
- MI emphasizes client autonomy
- This means that clinicians must be willing to accept that clients may
  - 1) choose not to change
  - 2) choose to change using methods we don't like
  - 3) fail (and hopefully try again; maybe with us)
- Influence is earned and often depends on client characteristics over which we have little control
- Often it is systems, not clinicians, who fail to grasp these points

A taste of MI


THIRD EDITION
MOTIVATIONAL INTERVIEWING
Helping People Change
William R. Miller and Stephen Rollnick

Refresher: A Taste of MI

- Work with one other person
  - If you end up with a group of 3; one person will be the observer
  - If you end up with a group of 4; divide in to 2 groups of 2
- One person will be the speaker and the other will be the listener

The Speaker

- Topic: Something about yourself that you
  - Would like to change
  - Need to change
  - Should or ought to change
  - Have been thinking about changing
  - But you haven’t changed yet
  - This is something you are AMBIVALENT about
  - It can be an opportunity (new job, having a baby, etc.)

The Listener

- Listen carefully with a goal of understanding the dilemma

- Ask these four questions:
  - What part of you wants to make this change?
  - What are the three best reasons for you to do it?
  - How might you go about it, in order to succeed?
  - On a scale from 0 to 10, how important is it to you to make this change
    - Follow up question: Why are you at _____ and not zero?

Listener

- Offer a short summary of the speaker’s motivations for change
- Than ask “So what do you think you’ll do?”
- Listen with interest

CRA

Community Reinforcement Approach

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A Brief History: The Theory

- Blending of Operant Conditioning and Social Learning
- Operant Model (Skinner): Behavior that is reinforced tends to be repeated, behavior that is not reinforced tends to weaken.
- Social Learning Theory (Bandura): Behavior is formed in a reciprocal manner with influence from cognitions, behaviors and the environment.
- Significant because it was not based on a theory of moral or spiritual fortitude.

What is the goal of CRA?

"…to rearrange the vocational, family, and social reinforcers of the [substance user] such that time-out from these reinforcers would occur if he began to [use]." (Hunt & Azrin, 1973)

A Brief History: The Pivotal Studies

- Initial CRA Study evaluated effectiveness of the treatment for males in hospital at a state mental institution who were diagnosed with alcoholism (Hunt & Azrin, 1973).
- CRA understood as a “treatment package” in which a menu of techniques is available for the therapist. These can be individualized in content and order to meet the need of each specific patient.
- Second major trial with revisions including new components, shortened amount of time in counseling and utilizing groups (Azrin, 1976).

A Brief History: The Pivotal Studies

- Third trial significant for several reasons: first time to apply CRA in outpatient population; first trial that included females; first test of relative importance of disulfiram compliance procedures; first test of significantly shortened time in treatment (Azrin, Sisson, Meyers, & Godley, 1982).

A Brief History: The Results

- 1973: Comparison of CRA to Control Group (education + AA) at 6 months after discharge
  - ✓Time Spent Drinking: Control (79%) vs CRA (14%)
  - ✓ Time Unemployed: Control group percentage 12x greater than CRA group
  - ✓ Time Away from Home: Control group percentage 2x greater than CRA group
  - ✓Time Institutionalized: Control group percentage 4x greater than CRA group
- 1976: Comparison of CRA to Control Group at 6 months after discharge
  - ✓Time Spent Drinking: CRA (2%) vs Control (55%)
  - ✓Time Unemployed: CRA (20%) vs Control (56%)
  - ✓Time Away from Family: CRA (7%) vs Control (67%)
  - ✓ Time Institutionalized: CRA (0%) vs Control (45%)
  - ✓ Results were well maintained at 2 year follow-up as well

A Brief History: The Results

- 1982: Similar outcomes to earlier studies with important new information.
  - ✓ Effectiveness of Disulfiram component
  - ✓ Particular impact of spouse's role in treatment
- 1982 and beyond: Larger samples; Different Populations; Refinements.
  - ✓(Azrin et al., 1994, 1996) Effectiveness with other groups including adolescents
  - ✓(Higgins et al., 1991, 1993) Effectiveness with drug abusers
  - ✓ (Smith, Meyers & Delaney, 1998) Effectiveness with homeless substance users

"THE TRUTH IS:

THE BRAIN CAN BE REPROGRAMMED.

YOU JUST HAVE TO BE DELIBERATE ABOUT IT."

Dr. Nathan Azrin

CRA: Core Concepts

- Positive and Enthusiastic Approach
- Use of simple, straightforward language
- Flexibility
- Role of Meaningful Reinforcers for the Individual
- Importance of Learning New Skills with practice occurring in session
- Importance of continued practice between sessions
- Importance of significant others to enhance treatment outcome

CRA: Core Components

- Functional Analyses
  - ✓ Functional Analysis of Substance Using Behavior
  - ✓ Functional Analysis of Non-using Behavior
- The Happiness Scale
- Goals of Treatment
- Skills Training
- Significant Others and their role

CRA Components: The Functional Analysis

- An interview that examines the antecedents and consequences of a behavior
- “Roadmap”
- Functional Analyses can be used for 2 kinds of behaviors:
  - A problem behavior
  - A healthy, fun behavior

Functional Analysis for Substance Using Behaviors

- Objective: To work toward decreasing or stopping the problem behavior
- Outline individual's triggers for substance use
- Clarify consequences (positive & negative) of substance use for client

Functional Analysis of Substance Use: Initial Assessment

- External triggers
  - Who, Where, When
- Internal triggers
  - Thinking, Feeling (emotionally, physically)
- Short-term positive consequences
- Long-term negative consequences

Introducing the Functional Analysis to the Client

- Provide a rationale
- Determine which episode to focus on:
  - Ask for a description of a common/ typical substance-using episode OR
  - Ask for a description of a recent or specific episode & make sure it is common/typical
- Show client the Functional Analysis chart

FUNCTIONAL ANALYSIS FOR SUBSTANCE USE BEHAVIOR

External Triggers

1. Who are you usually with when you use?

2. Where do you usually use?

3. When do you usually use?

Internal Triggers

1. What are you usually thinking about right before you use?

2. What are you usually feeling physically right before you use?

3. What are you usually feeling emotionally right before you use?

Using Behavior

1. What do you usually use?

2. How much do you usually use?

3. Over how long a period of time do you usually use?

Short-Term +Consequences Good things (rewards)

1. What do you like about using with (who)?

2. What do you like about using (where)?

3. What do you like about using (when)?

4. What are the pleasant thoughts you have while using?

5. What are the pleasant physical feelings you have while using?

6. What are the pleasant emotions you have while using?

Long-Term -Consequences Not so good things

1. What are the negative results of your using in each of these areas:

a) Interpersonal:

b) Physical:

c) Emotional:

d) Legal:

e) Job:

f) Financial:

g) Other:

Functional Analysis Practice

- Play roles (therapist, client, observer)
- Don’t play your “worst client ever”!
- Try to “get the story” rather than just filling in the blanks
- Client may also have Functional Analysis sheet
- Incorporate your own style of interviewing

Client Language in MI Sessions: why it matters

#8. Client Language During Sessions Might Explain why MI works

- Assumptions of language focus in MI
- Human beings often create intentions and motivation to change through their social interactions with others
- Language can create and consolidate intention when it occur spontaneously in an empathic interaction with another person
- Change talk is client language in favor of change that emerges spontaneously in an empathic, supportive and collaborative interpersonal interaction

#8. Client Language During Sessions Might Explain why MI works

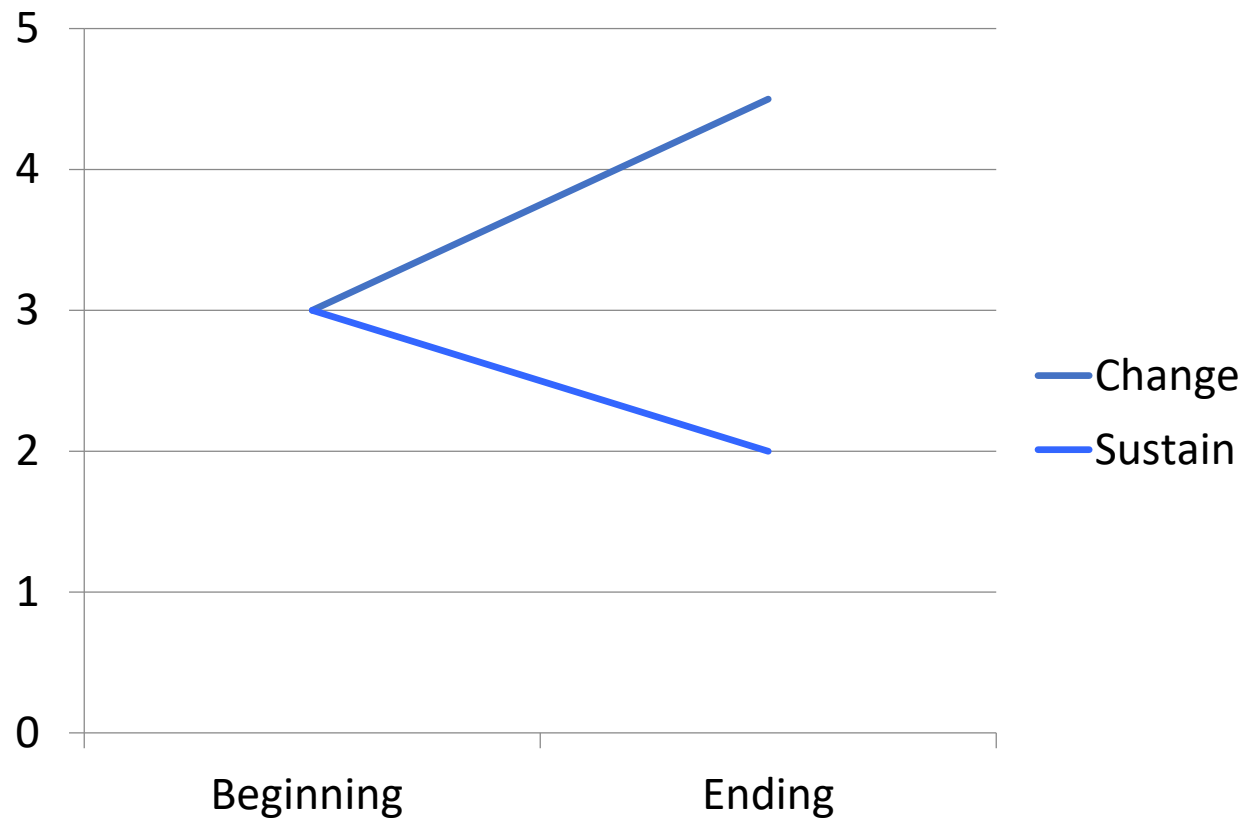
- Sustain talk is language that speaks in favor of the status quo
- Sustain talk is not the same as discord in the relationship between the client and clinician
- I’m not going to quit drinking (sustain talk)
- I’m not going to quit drinking and there is nothing you can do make me (discord)

#8. Client Language During Sessions Might Explain why MI works

- Stronger and more frequent change talk associated with better outcomes
- Stronger and more frequent sustain talk predicts worse outcomes

- Language Focus in MI
  - Interviewers attempt to increase and strengthen client language in favor of change (Change Talk) and decrease and weaken language in favor of the status quo (Sustain Talk)

In a perfect MI world



What does change talk look like?

What Change Talk Is Not

Chanting

What change talk is not

Deceptive

What change talk is not

Unconscious

What change talk is not

Effortless

It is the public, spontaneous and interpersonal nature of this language that matters.

But why should the client's language ***cause*** change?

Why would client language during treatment sessions facilitate change?

- Facilitates awareness and insight (Engle & Arkowitz)
- Enhances emotional salience (Wagner & Ingersoll)
- Persuades speaker of what they believe when ambivalence is prominent – self persuasion theory (Miller & Rollnick)
- Obligates listener through public commitment (Amrhein)
- Public declaration of intent and plan to protect (Gollwitzer)

#8. Client Language During Sessions Might Explain why MI works

- One hypothesis is that ambivalent clients decide they intend to change as they hear themselves voice arguments in favor of it
- This is the value of an intervention that focuses specifically on ambivalent clients
- Important to use MI with the right clients and NOT clients who are “ready to change”

It Is a Marker of Some Other Process

But do clinicians have anything to do with what clients say during sessions?

#9. Clinicians have a lot to do with what clients say during sessions

- Ok, client language predicts outcome, but maybe it is just people saying what they already are going to do
- But we can influence that

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Full length article

A randomized controlled trial to influence client language in substance use disorder treatment

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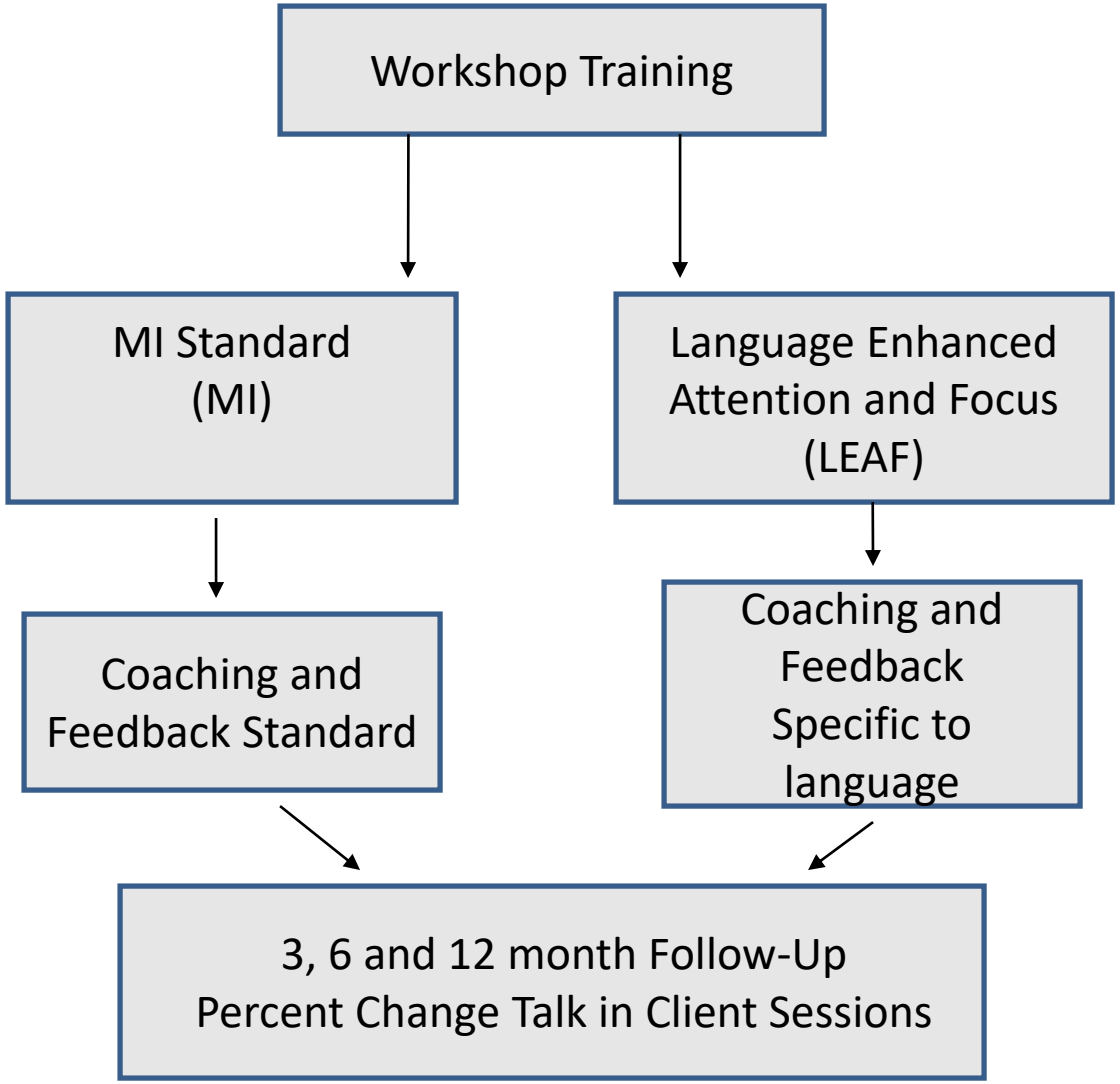
ABSTRACT

Background: Client language is hypothesized to be a mechanism of action in motivational interviewing (MI). Despite the association of change and sustain talk with substance treatment outcomes, it not known whether providers can intentionally influence this language as hypothesized.
Objective: This is a randomized controlled trial to investigate whether substance use providers can be trained to influence client language.
Methods: Treatment providers specializing in substance use disorders (n = 190) were randomly assigned to standard training in MI (MI-AU) or training emphasizing an influence of client language (MI-LEAF). Treatment sessions with actual clients were evaluated 3, 6 and 12 months after training by masked raters. Frequencies of client change and sustain talk were the outcome variables.
Results: Sustain talk, but not change talk, was significantly lower in clients whose providers had received the specialized training (b = −0.175, SE = 0.087, p=0.046, CI[−0.348 to 0.002], d = −0.325). Mediation analyses supported a causal chain between a) training, b) providers' attempts to minimize sustain talk in treatment sessions via directive reflective listening and c) client sustain talk in the treatment session (κ^2 = 0.0833, bootstrap SE = 0.0394, 95% CI [0.0148, 0.1691]).
Conclusions: With specialized training, providers can reduce the amount of opposition language their clients offer when considering a change in their substance use. Demonstrating that client language is under partial control of the provider supports the feasibility of clinical trials to investigate the impact of shaping client language on treatment outcomes.

1. Introduction

Motivational Interviewing (MI) is a psychotherapeutic method commonly used for helping clients resolve ambivalence about psychosocial interventions, MI lacks definitive experimental support for specific causal mechanisms, leaving open the possibility that the lack of reliability in client outcomes is caused by including extraneous procedures or omitting critical processes entirely.

Evaluating Language in Clinician Interviewing Training: Project ELICIT



NIDA 021227

LEAF Condition

- Recognize, reinforce and evoke client change talk; decrease attention to sustain talk
  - More attention (asking questions, reflecting) to client language about changing
  - Less attention to client language about “downside” of changing
  - Strategically arranging conversations so that client more likely to offer change talk and less likely to speak in favor of keeping things as they are (sustain talk)

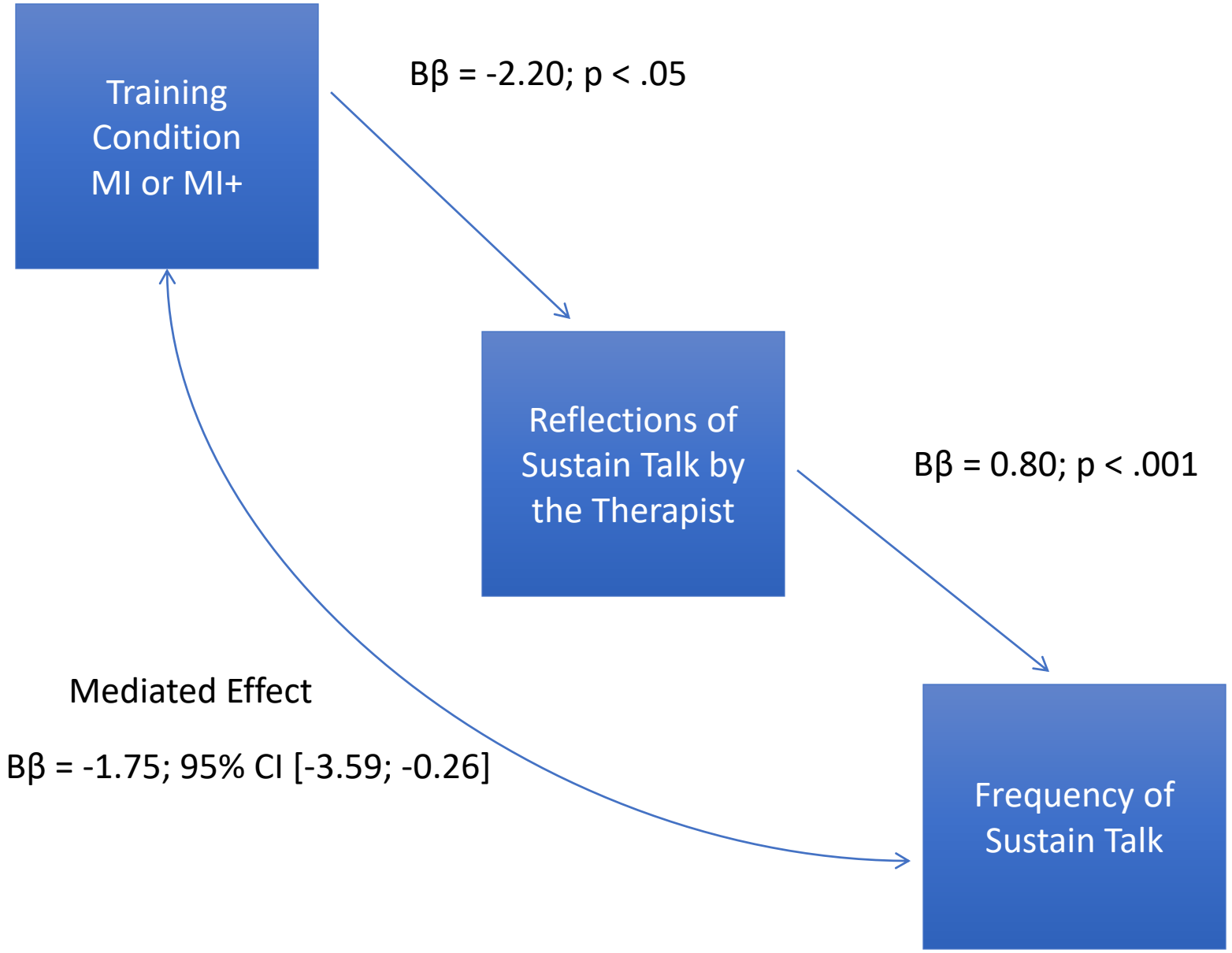
- Client language should shift toward more change talk and less sustain talk only in the MI+ group

Outcome Variables

- Therapist:
  - Reflections of Change Talk
  - Reflections of Sustain Talk

- Clients
  - Change Talk
  - Sustain Talk

Frequencies adjusted for session length


Training Condition MI or MI+
Bβ = -2.20; p < .05
Reflections of Sustain Talk by the Therapist
Bβ = 0.80; p < .001
Frequency of Sustain Talk
Mediated Effect
Bβ = -1.75; 95% CI [-3.59; -0.26]

Overall Impact of Training on Client Language

- Using an HLM that accounts for all follow ups simultaneously
- Significant effect of training condition on the frequency of client sustain talk (Coeff = -2.21; $p < .05$) $d = .34$

Conclusions

- Ability to train clinicians to manipulate client language can be learned
- This training results in differences in the amount of sustain talk from clients
- Differences in client language are not accounted for by changes in general counseling skills in MI

Change Talk Jeopardy

CRA Components: The Happiness Scale

- The Rationale
  - ✓ Allows the client to see how satisfied he/she is with different areas of life
  - ✓ Identifies areas where client may be functioning adequately
  - ✓ Identifies areas the client wants to address in treatment
  - ✓ Monitors progress over time
- The Presentation
  - ✓ Categories included (may change to adapt to population or culture)
  - ✓ Introduces idea that therapy focus will not be exclusively on substance use
  - ✓ Reinforces idea that therapy is individualized

HAPPINESS SCALE

This scale is intended to estimate your current happiness with your life in each of the ten areas listed. You are to circle one of the numbers (1 – 10) beside each area. Numbers toward the left end of the 10- unit scale indicate various degrees of unhappiness, while numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each life area: "How happy am I today with my partner in this area?" In other words, state according to the numerical scale (1 – 10) exactly how you feel today. Try to exclude all feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not allow your feelings in one category influence the results of the other categories.

	Completely Unhappy									Completely Happy
Drinking/Sobriety	1	2	3	4	5	6	7	8	9	10
Job or Educational Progress	1	2	3	4	5	6	7	8	9	10
Money Management	1	2	3	4	5	6	7	8	9	10
Social Life	1	2	3	4	5	6	7	8	9	10
Personal Habits	1	2	3	4	5	6	7	8	9	10
Marriage/Family Relationships	1	2	3	4	5	6	7	8	9	10
Legal Issues	1	2	3	4	5	6	7	8	9	10
Emotional Life	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
General Happiness	1	2	3	4	5	6	7	8	9	10

Robert J. Meyers and Jane Ellen Smith, 1995

CRA Components: The Happiness Scale

Happiness Scale Practice

- Play roles (therapist, client, observer)
- Don’t play your “worst client ever”!
- Stay positive and upbeat
- Incorporate your own style
- Use one category to demonstrate

Blending MI and CRA

Why blend MI & CRA

- Treatments are based on different theories about how people change problem drinking

Motivational Interviewing

- Drinkers cannot resolve ambivalence that comes from a behavior with both costs and benefits
- What helps people change is an internal shift in motivation that galvanizes intent
- That shift can be caused by:
  - A collaborative, autonomy supportive interaction
  - An felt sense of discrepancy
  - An increasing sense of ability
- What facilitates that shift is:
  - Hearing your own arguments for change
  - Within an empathic interpersonal context

Community Reinforcement Approach

- Problem drinking is maintained by how the environment of the drinker is arranged
- Drinking is rewarded and abstinence/moderation is not
- What helps people change is to
  - Decrease reinforcement for drinking
  - Increase reinforcement for abstinence/moderation
  - Acquire new behaviors (and avoiding old)
  - Practice in a real-life, real-world setting

- Motivational Interviewing
  - What happens in the interpersonal interaction between therapist and client is ESSENTIAL in fostering change

- Community Reinforcement Approach
  - What happens in the interpersonal interaction FACILITATES learning of new behaviors that foster change

So, why blend?

- Both have strong empirical support
- Neither appears more effective than the other*
- There are no studies to tell us *how* to choose one or the other for any particular patient
- Skills-building and family involvement supported outside CRA
- Relationship and change talk supported outside MI

A blended treatment: Advantages

- Potentially allows the benefit of active ingredients from both “brand names”
- Treatment can be standardized by consistency in the process of how modules are chosen rather than the content of them (functional analysis)
- Likely to appeal to a broader spectrum of clients
- Allows therapists to focus on relationship elements in beginning, which theoretically increases engagement for skills building

A blended treatment: Disadvantages

- How to carry relationship elements from MI forward into skills building modules?
  - No “model” for decision making when treatments diverge
    - Example: “I didn’t do my homework because it seemed stupid to me”
- Blended treatments are longer and more complex, requiring increased therapist skill