Published in final edited form as:

J Contemp Psychother. 2015 September ; 45(3): 167–176. doi:10.1007/s10879-014-9280-1.

Client and Therapist Views about Intensive and Standard Motivational Interviewing

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Abstract

Although motivational interviewing (MI) is a widely used intervention for alcohol and drug problems, little is known about client and therapist experiences. Client and therapist views could help better understand how MI works and what factors are important. This paper investigates experiences of clients and therapists who participated in a study that examined a standard single session of MI (MI 1) and a more intensive 9-session model (MI 9) for methamphetamine dependence. Qualitative methods included open ended questions presented to 184 clients at 2-month follow-up and 189 clients at 6-month follow-up. In addition, a focus group consisting of two therapists who delivered the interventions and two adherence monitors who listened to audiotape recordings of sessions was conducted. Clients in both conditions felt supportive, nonjudgmental therapist attitudes were helpful. Most clients in the MI 9 condition but few receiving MI 1 volunteered that feedback and advice were helpful. A strong majority in both conditions desired more sessions. Expert panel members emphasized: 1) multiple benefits of a nonjudgmental stance, 2) finding the right balance among different MI interventions, and 3) understanding the interaction of supportive and directive interventions. Panel members also emphasized that one advantages of MI 9 over MI 1 was that it enabled client change plans to be implemented over time.

Keywords

Methamphetamine; Motivational Interviewing; Randomized Clinical Trial; Psychotherapy; Treatment Dose; Client Views; Therapist Views

Although motivational interviewing (MI) is a well-known and extensively studied intervention for alcohol and drug problems (Lundahl & Burke, 2009) relatively little is known about client and therapist experiences during its implementation (Orford, 2008). Articulation of these experiences could inform clinical practice. The purpose of the current paper is to report client and therapist views about two MI-based interventions, one of which

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was a single session of MI (MI 1) and one of which was a relatively more intensive 9-session model (MI 9).

History of Motivational Interviewing

MI was initially developed as a brief intervention (typically 1–3 sessions) for the treatment of problem drinkers (Miller & Rollnick, 2002). The general approach of MI is to strategically combine supportive and directive interventions as a way to increase motivation. Examples of supportive interventions include reflections, open questions, summary statements, identifying pros and cons of drinking, and affirmations. Directive interventions include feedback, developing discrepancies between substance use and life goals, and change planning.

Systematic reviews of the alcohol treatment literature have consistently shown standard MI to be effective for treating alcohol use disorders (Hettema, Steele, & Miller, 2005).

However, when MI interventions have targeted more severely impacted persons, such as those dependent on illicit substances, the results have been mixed (Carroll, et al. 2006).

Development of Intensive Motivational Interviewing

Some authors have argued that a higher dose of MI is needed for populations with more serious and pervasive problems, such as those with illicit drug problems or co-occurring psychiatric disorders (Polcin, Galloway, Palmer & Mains, 2004). The development of MI 9 for the treatment of methamphetamine dependence was based on this premise. Instead of one or two sessions at the beginning of treatment, MI 9 entails nine sessions conducted over two months. This enables the client and therapist to address the variety of problems methamphetamine dependent clients often present (e.g., use of multiple substances, HIV risk, co-occurring psychiatric disorders, dysfunctional primary relationships, financial problems, etc.). A major advantage of MI 9 relative to MI 1 is that the client and therapist collaboratively address the process of change plan implementation over time. Thus, the therapist and client are able to share the successes of goal achievement, ongoing struggles to address goals not met, and development of alternative approaches to problems.

Initial pilot testing of MI 9 conducted on 30 methamphetamine dependent individuals showed significant reductions in methamphetamine use over 2 months Galloway Polcin, Kielstein, Brown & Mendelson (2007). A randomized clinical trial comparing MI 9 with MI 1 for methamphetamine dependence found both interventions were associated with reductions in methamphetamine use, but MI 9 was more effective in reducing psychiatric problems (Polcin, et al., in press) and co-occurring alcohol problems among women (Korcha, Polcin, Evans, Bond, & Galloway, 2014).

Understanding How Motivational Interviewing Works

Most attempts to understand how MI works have used quantitative methods designed to substantiate or refute theoretic principles underlying MI (Morgenstern & McKay, 2007). It is surprising that researchers rarely ask clients and therapist what they viewed as helpful and counterproductive in therapy sessions. An exception is the UK Alcohol Treatment Trial

(UKATT) (Orford, et al., 2009) where the investigators used qualitative interviews to investigate client experiences of therapy and found that clients attributed change more to general factors (e.g. determination and feeling comfortable talking) than intervention specific factors. Orford (2008) explicitly called for additional qualitative studies to better understand experiential and contextual factors that influence outcome.

METHODS

Qualitative methods were used within the context of a randomized clinical trial of 217 methamphetamine dependent clients assigned to MI 9 or MI 1. Potential confounding of study conditions by different therapists was decreased by having therapists treat clients in both conditions. To achieve time and attention equivalence between the two study conditions the MI 1 group also received eight sessions of nutrition education. In addition to study interventions participants received standard outpatient group treatment three times per week for 8 weeks. Toward the end of the final year of the study an expert panel format was used to elicit views about the process and outcome of MI 9 and MI 1 from two study therapists and two adherence monitors. To elicit client views and experiences on MI process and factors influencing outcome we used focused open questions. Qualitative assessments with clients were conducted at the end of study interventions (2 months after entering treatment) and at the final follow-up interview (6 months after entering treatment).

Aims and Procedures

The *first aim* was to convene an expert panel of practitioners familiar with the MI 9 intervention. We recruited two study therapists from the current study and two adherence monitors from the current study who had also participated as therapists in previous studies of MI 9. Open ended questions focused the panel toward discussion about the following issues: a) types of clients that did and did not respond well to MI 9 and MI 1; b) views about therapist behaviors that were seen as important in establishing a therapeutic relationship; c) comparative strengths and weaknesses of MI 1 and MI 9; d) differences between early, middle and later sessions when using MI 9; and e) the mix of supportive and directive MI interventions. The principal investigator of the study facilitated the panel's discussion about each of these domains and coded a written transcription of the meeting that identified dominant themes within each domain.

The *second aim* was to investigate client experiences of MI 9 and MI 1 at completion of treatment (2 months) and 6-month follow-up. At the end of treatment, research interviewers asked open ended questions addressing issues such as what was helpful about MI 1 and MI 9 sessions and what was not helpful or even counterproductive. They were asked specifically what they did and did not like about their therapists and how sessions did or did not contribute to their recovery. Clients in both study conditions (MI 9 and MI 1) were asked whether the number of sessions was too many, too few or about right. At 6-month follow-up clients were asked to reflect back on their treatment and identify what was most helpful to them since they left treatment, what was not helpful, and what they wished would have been different. All of the responses from clients were recorded in writing by research interviewers in face to face meetings. Later, the study coordinator and a research interviewer reviewed all

written responses and coded them into the thematic categories that can be seen in Tables 1 and 2.

RESULTS

Demographic Characteristics

The expert panel consisted of four individuals who were invited to participate because of their expertise in MI generally and their familiarity with the MI 9 intervention used in the study. All four were white and two were male. All were licensed mental health providers, two with master's degrees and two with doctorates. The client sample was drawn from our study of MI 9 for methamphetamine dependence (N=217). There were slightly more men (N=110) than women (N=107) recruited and most were white (67.3%). The mean age was 38.5. For this qualitative component we interviewed 184 participants (85% of the sample) at 2 months and 189 participants (87% of the sample) at 6 months.

Aim 1: Expert Panel

Types of Clients Who Responded to MI 1 and MI 9—Overall, the panel noted few differences between clients who responded to MI 1 versus MI 9. This finding was consistent with our quantitative findings (Polcin et al., in press), which showed clients in both study conditions made significant reductions in methamphetamine use. The one difference noted in the quantitative findings was that clients in the MI 9 group made more significant improvement on psychiatric symptoms than clients in the MI 1 condition. The panel did not report this difference between the two study conditions, but they did note that clients with more severe psychiatric problems had greater difficulty benefiting from treatment than other clients. Other types of clients that had difficulty benefitting included those who enrolled in the study primarily for the financial incentives they received for participating (up to \$270 over the course of 6 months), those with extreme narcissism, and those who evidenced strong antisocial or manipulative behaviors. One study therapist reported difficulty with some criminal justice clients who were often disingenuous, *“presenting this perfect thing, ‘oh yeah I’m doing great.’ And every week it’s the same...it’s like a sealed box.”*

There was a consensus among panel members that some types of clients that were able to form therapeutic alliances nonetheless continued to use methamphetamine. One example included clients whose use of methamphetamine was integral to their relationships with intimate partners. One panel member stated:

...the ones that really make the least amount of change are the ones that are in... relationships where it is dependent on them using... If they’re in that strong relationship, those people really had a hard time.

Another type of client that was often able to engage in the therapeutic process but did not make as much progress in terms of reducing methamphetamine use was the client who used methamphetamine *“in a low level way, just as a way to kind of function on a regular basis, very hard to make end roads there...there aren’t serious legal consequences necessarily or even ongoing health consequences.”* Panel members noted that those with the most serious methamphetamine problems were not necessarily the most difficult to engage or treat. As

one panel member observed, “*the interesting thing is we’re not bringing up like the IV drug users...that’s not what’s standing out for us.*”

Nonjudgmental Attitudes and Supportive Interventions—Panel members identified a number of factors they felt were essential to the process of implementing MI 9 and MI 1. Foremost was the importance of maintaining a supportive, nonjudgmental attitude toward the client:

The perception on behalf of the client of supportiveness and being heard and appreciated for who they are. Whether they’re living in a box or whether they come from a family you know and to be able to meet them at their level. And even use the language that they use and things like that.

The dynamics of how support operates clinically was hypothesized by one therapist this way:

“taking the pathology out of why we do the things we do really helps us to own the behavior and consider changing it. When we don’t understand the adaptive reasons for our maladaptive behaviors, then we feel shame. This shame impedes our ability to see our own behavior clearly and to feel the internal sense of possibly changing it.”

The MI techniques that the panel emphasized most were reflections and summarizing. Although reflection is sometimes viewed as a simple intervention merely reflecting back what the client has stated, the panel had a more complex view. They emphasized that reflections needed to include accuracy of content and emotional tone. One panel member commented:

It’s not empathy. It’s accurate, accurate, accurate empathy. And I can’t put my finger on it but there were times when it was just these under or over reflections that seemed to kind of lose something.

Beyond accuracy of content, panel members felt reflections were best when they were framed in terms of the client’s own language and addressed issues of immediate relevance. As one panel member put it, “*Staying close to the client’s concerns in order to convey a sense of their needs mattering.*”

A similar concern was brought up around therapist use of affirmation. When affirming strengths and accomplishments the panel felt the therapist needed to be careful to not go too far beyond the client’s experience. There was a danger that the client could feel misunderstood or the therapist acknowledgement could be experienced as disingenuous:

...sometimes I feel like when I’m trying to give some positive feedback to the client I’m stretching to find something....but they’re eager to feel kind of positively reinforced somehow. So I wonder like does it sometimes feel inauthentic.

A related task brought up was the balance that was needed between believing in and acknowledging the client’s capacity to change, but rolling with resistance when the client rejected options for change.

As the therapist I held the belief that the client could make changes in their life. I maintained a hopeful and positive attitude about the problems...I didn't keep pushing if I sensed the client's resistance...[but] sometimes when I did push the client to see some discrepancy between behavior and verbalized goals/values, the client was able to appreciate it and take a different perspective. I think the client's openness really depended on their trust I wasn't trying to shame them.

Direction and Structure—The expert panel also expressed support for the provision of direction and structure. They felt an important role for the therapist was to provide some sense of direction and supportive authority and that doing so facilitated a sense of safety and containment for clients:

There's something about establishing that framework in the first two minutes of the first session or the brief session [MI 1] ... There's something very safe, there's something very secure....the therapist is in some way communicating a kind of authority that is somewhat different from the authority that people are usually expecting to encounter.

The structure of each of the first three MI 9 sessions was viewed as helpful because it provided direction toward exploration of client experiences. The first session of the MI 9 manual focuses on problem identification from the client's point of view and structured worksheets completed by the client are used to facilitate the process. Regarding session one, panel members made comments such as, "...there's not a lot of pressure on accomplishing stuff so you're getting to stay very close to the person's problems as they see them." One of the study therapists commented:

And you're also setting it [direction] with the first worksheet you know that you give them. It's focusing them right away...I feel it's containment.

Panel members viewed session two in a similar manner. Like session one, there is a worksheet that directs the client into the theme of the session, which in this case is the pros and cons of using methamphetamine and making a change in their use. There was consensus among the panel that the predetermined focus of the session and worksheets addressing pros and cons facilitated open disclosure.

A helpful aspect of the structure of session two was the way that it prepared clients for developing a change plan in session three. One panel member noted, "*And then people actually really look forward to the idea of making some change plans.*" Another member described how addressing the pros of using helped prepare clients for the obstacles they would encounter as they attempted to implement their change plans, "*For some clients the pros and cons work is the most helpful factor because it really consolidates the challenge around making changes.*"

Panel member comments about change planning in both the MI 1 and MI 9 indicated it played an extremely important role. However, there were differences between MI 1 and MI 9 in implementation and enactment of the plan. Regarding change planning in MI 9 one panel member noted:

I think the MI short and the MI sessions one to three [in MI 9] are the most significant in terms of setting the stage for change. But MI four through nine are really the substance of the work. Within the therapeutic relationship the client is taking active steps toward making changes.

Another consideration about change planning was the importance of noticing incremental movement even though the client might not be achieving all of their goals. Examples included significant reductions in the amount of methamphetamine used even though abstinence was not achieved. Panel members noted that even when clients were not making changes in their methamphetamine use they were sometimes making important changes that might eventually lead to less methamphetamine use. Examples included getting out of a destructive intimate relationship, reducing the number of drug related friends, starting school, or seeking employment.

Balancing Directive and Supportive Interventions—There was consensus among panel members that facilitation of change plan implementation in MI 9 required a balance between maintaining an accepting therapeutic stance on one hand and challenging clients to consider new changes on the other. One study therapist noted, *“It’s like that consistent positive but still pushing...what could you do? What would you be willing to try?”* Implementation of change planning often instilled hope and excitement, but also difficult experiences including insecurities and fear. The therapeutic challenge was to balance these two competing tasks and roll with resistance when necessary.

Overall, there was consensus that implementation of the change plan as well as other directive interventions needed to be strategic. To be effective, it was felt that therapists needed to consider the level of therapeutic alliance and client’s capacity to reflect on issues toward which the therapist had directed them... *“I’m continually working with the line between challenging the client to expand/change versus maintaining the bond of connection.”*

Feedback and Discrepancies—Feedback and developing discrepancies were the directive interventions that were the most emphasized among panel members. New insights about oneself as a result of the therapist providing feedback or pointing out discrepancies between substance use and goals or values were viewed as extremely important. Important in delivery of these interventions was the need for therapists to assess what the client was ready to hear, tolerate and digest. As one panel member put it:

Being made aware of an inconsistency that you have between your values and your goals is a little uncomfortable for people...But if they can tolerate that discomfort... they’re likely to have something happen as a result.

Extensive therapist feedback or elaboration about discrepancies was generally not viewed as helpful because they were not collaborative. Rather, *“smaller chunks of feedback”* that could be more readily processed in the sessions were more likely to be accepted. Particularly counterproductive were sessions where the therapist was passive during much of the session and then ended with extensive feedback and advice.

Standard versus Intensive MI—Panel members offered strong support for both MI 1 and MI 9 as interventions for methamphetamine dependent clients. The MI 1 condition consisted of a single 90-minute session and therapists were stuck by how much productive work was able to be achieved in one session:

There's so much that gets done in those. And it's just so fruitful I mean there's just so much in terms of what you cover....It condenses everything...it's three in one.....

Although the MI 1 intervention was thought to be extremely helpful, panel members were clear that many clients needed more sessions and many of the clients assigned to the MI 1 condition expressed disappointment after the session that they could not continue. There was consensus among panel members that MI 9 allowed for enhanced development and implementation of change planning. Several panel members felt MI 9 enabled implementation of the change plan as a process rather than a static event. It *"gives time to integrate things, trying some of their old ways and some of the new ways."* *"It's an assimilation process."*

Aim 2: Client Feedback

Clients who participated in the study were asked a short list of open questions at two and six months to obtain feedback about their experiences and views. Client responses to questions were coded as themes and quantified as frequencies. It is important to emphasize that response frequencies were generated by use of open questions, not survey questions with forced categorical choices or scales. Thus, expression of a particular view does not necessarily mean others disagreed with that view or held different views. It simply means they did not express that view when presented unstructured, open questions. The one exception was an item about number of sessions, which include forced choices of fewer, about right and more. Results were tabulated and frequencies are indicated in Tables 1 and 2.

Two Months—During the 2-month interview open ended questions were used to elicit client views about what they liked most and least about their therapy sessions and the characteristics of their therapist. Frequencies and percentages for codes generated from the 2-month interview can be found in Table 1 along with statistical comparisons between MI 1 and MI 9.

Relative to directive characteristics, supportive characteristics were more often cited as something liked by clients in both study conditions. However, there were also differences between the MI 1 and MI 9 groups. For example, half of the clients receiving MI 1 indicated their therapist was a good listener. However, an even larger percentage (66%) in the MI 9 condition indicated their therapist was a good listener ($X^2=4.8$, $p<.05$). Other supportive characteristics that were mentioned by larger proportions in the MI 9 condition than the MI 1 condition included supportiveness of the therapist ($X^2=8.9$, $p<.01$) and caring ($X^2=2.9$, $p<.10$). However, significant numbers of clients in both groups reported liking some characteristics, including friendly/agreeable, nonjudgmental, and therapy as a safe place to

vent/express feelings. Table 1 indicates percentages for all liked characteristics that were mentioned by study condition.

Clients also reported liking some directive aspects of the therapy, particularly those receiving MI 9. A majority (52%) of those in the MI 9 condition but only 19% in the MI 1 condition commented that they liked feedback and advice from their therapist ($X^2=22.1$, $p<.001$). While 14% of those in MI 1 indicated the therapy helped them think about themselves and their issues, the proportion of those in MI 9 who made similar comments was 27% ($X^2=4.1$, $p<.05$). Although mentioned by fewer clients in both conditions, there were similar differences between MI 1 and MI 9 on goal setting/priorities ($X^2=3.9$, $p<.05$) and learned skill/tools (Fisher's Exact Test, $p<.001$). The two study conditions had similar proportions commenting that their therapist was knowledgeable and professional, 22% for MI 1 and 24% for MI 9.

When we asked participants about things they did not like or would change over a third in each of the study conditions commented there was nothing they disliked or would change. Twenty-one percent of the clients who received MI 1 indicated one session was not enough and 20% indicated they could not remember much about the single MI 1 session they received at the beginning of treatment. Participants in the MI 9 condition most frequently mentioned they wished they had attended more of the nine MI 9 sessions offered (14%). When we asked a forced choice question about whether participants wanted more sessions, fewer sessions or the number felt about right, 80% of the participants in both conditions wanted more sessions.

Six Months—At the 6-month interview questions assessed how the therapy sessions during treatment affected recovery. This included ways the sessions were helpful as well as suggested changes. We also asked participants to describe the roadblocks they encountered in the recovery process.

When asked about the effect of treatment on recovery, 27% of the clients in MI 1 and 34% of the clients in MI 9 commented that overall they thought the sessions were helpful or supportive. Other participants, particularly those in MI 9, responded to this line of inquiry by describing how the sessions facilitated recovery.

One of the ways the sessions had a sustained impact on recovery according to participants was that they helped clients think about themselves and achieve new realizations. Nineteen percent made these types of comments in the MI 1 condition, but a more substantial and 33% made them in the MI 9 condition ($X^2=3.9$, $p<.05$). Other comments about ways the sessions helped were sparse among participants in MI 1 but more common among those in MI 9. While 28% of those in the MI 9 condition indicated they learned skills and tools that helped their recovery, only 10% indicated this in the MI 1 condition ($X^2=3.9$, $p<.01$). Similarly, help with realistic goal setting was mentioned as helpful by 18% in the MI 9 condition but only 2% in the MI 1 condition (Fishers Exact Test, $p<.001$).

The most often indicated roadblocks to recovery had to do with substance using peers and other negative characteristics of the social environment, which was indicated by 15% or the

clients in both study conditions. Similar to the 2 month interview, the most commonly suggested change at 6 months had to do with a desire for more sessions among clients receiving MI 1. Thirty two percent indicated that one session was not enough and 28% indicated they did not remember much about the session. Among clients in MI 9, 37% commented there was nothing they would change, which was significantly higher than the 19% indicating nothing they would change in MI1 ($X^2=7.5$, $p<.01$). Other changes desired by clients in MI 9 included a wish that sessions would last longer than the standard 50 minutes (20%) and a regret that they had not attended sessions more consistently (11%). Participants in both groups indicated as desire for more sessions (88% in MI 1 and 76% in MI 9) and both groups felt their experience made them more likely to seek treatment in the future (72% for MI 1 and 75% for MI 9).

DISCUSSION

The current study represents one of very few that draws upon client and therapist experiences to identify factors that are important to the process and outcome of MI-based interventions. While some of the central tenets of MI were affirmed, such as the importance of maintaining a supportive, nonjudgmental therapeutic stance, some aspects of MI that have received limited attention in the literature were viewed as critically important. These included factors such as finding the right balance of supportive and directive interventions, recognizing how supportive and directive interventions interact, recognizing the complexity of seemingly simple interventions such as reflections, identifying types of clients that are difficult to engage, and identifying clients who have difficulty benefitting despite seeming to be engaged. Although recent work by Miller and Rollnick (2013) downplays the importance of the decisional balance (i.e., pros and cons), our expert panel viewed it as useful in terms of helping clients consider potential changes and establishing a nonjudgmental tone.

Findings from the current study also add to the MI literature by identifying perceived advantages of MI 9 over MI 1, particularly the advantage of implementing the change plan over time. Although MI was developed as a brief intervention, clients expressed a clear desire for longer treatment, even when they received the higher dose of 9 sessions of MI 9. All of these and other issues are addressed in more detail below, beginning with client and panel comments about supportive and directive interventions.

Therapeutic Factors

When we asked clients at the end of treatment what was helpful to them about their therapy sessions, the most common answers had to do with the therapist being a good listener, friendly, and nonjudgmental. That was true for participants in MI 9 as well as MI 1, although larger proportions of clients receiving MI 9 made these types of comments. The expert panel emphasized a nonjudgmental and supportive stance as an essential component and they noted how some clients appreciated this attitude as a welcome alternative to prior types of treatment they had received.

The experiences clients reported of feeling heard, supported, and respected were facilitated by therapist use of supportive interventions, such as reflections, summarizing, open questions and affirmations. While these techniques have been recognized as integral to MI,

they are sometimes presented as fairly simple interventions. Our expert panel presented a different view. For example, for reflections and summary statements to be effective, the panel emphasized they had to be implemented skillfully, with accurate content and tone. There was discussion of how reflections were best when they stayed close to the experiences and language of the client, something narrative therapist Michael White (2007) referred to as “experience near” statements.

Another point emphasized by our expert panel was how supportive interventions prepare the client for directive interventions. Although less frequently mentioned than supportive characteristics during discussions about factors that were helpful, clients as well as panel members acknowledged the value of directive interventions such as feedback, goal setting, and comments that challenged clients to think about their drug use from a different perspective. However, expert panel members noted that these directive interventions were usually helpful only when the client was able to first have established a sense of safety in the therapeutic relationship. For the most part this seems to have occurred, especially for clients receiving MI 9. Over half (52%) of the clients in the MI 9 condition commented that feedback was helpful.

The expert panel emphasized there were other ways therapist direction facilitated supportive interventions. There was a sense among the panel that clients felt reassurance when the therapist was able to lay out plans for the structure of the first three sessions. There was also a view that the structure quite naturally led to open discussion of issues that invited use of supportive interventions.

Study therapists on the panel were clearly conscious of the balance between feeling hopeful about the client on one hand and not pressuring the client to improve on the other. This raises important questions that need more research. How does the therapist acknowledge the sense of powerlessness and hopelessness that clients sometimes feel and still bring a sense of hope into the therapeutic work? Under what conditions and for what types of clients should therapist focus on empathic understanding about the client’s powerlessness versus challenging them to consider options and ways they could improve their situation? A similar, more general question about MI-based interventions is how the therapists should use supportive and directive interventions. Therapists currently judge this intuitively based on their perceptions about the client, their own therapeutic style and the type of training they received. However, research-based guidelines that inform how to mix supportive and directive interventions could be extremely helpful.

Advantages of MI 9

Strong support was expressed for the helpfulness of both MI 1 and MI 9 by clients and expert panel members. The expert panel noted the richness of the single session of MI 1 and how much could be accomplished in one 90-minute session. However, relative to clients receiving MI 1, clients receiving MI 9 more often reported specific ways they benefitted from therapy. They more often reported learning new skills, developing new ways of thinking about themselves, and setting more realistic goals. Participants receiving MI 1 were far less likely to report use of concrete ways their MI 1 session helped after treatment.

Panel members emphasized that one advantage of MI 9 was that change planning was markedly different. Rather than being a static event that ended once the plan was formulated, clients in MI 9 were able to process obstacles and successes over time. Thus, there was a collaborative processes of sharing implementation of the plan that was absent in MI 1. There was also an advantage in the way the first two sessions of MI 9 prepared the client to construct the change plan by helping to identify problems and engage ambivalence.

There was a striking desire for more MI sessions among large proportions of clients in both study conditions. Clients apparently liked and benefited from the therapy and they may have wanted ongoing help for continued distress related to their addiction and other related issues. The view is consistent with the increasing conceptualization of addiction as a chronic process in need of ongoing care and it raises interesting questions about whether and how MI might be used as a long-term invention to assist clients as they deal with the process of addiction over many years.

Implications for Understanding Mechanisms of Action

Studies assessing how MI works have typically employed linear models of mediation and causality: “A” leads to “B,” which in turn results in better outcome “C.” An example would be the kind of research conducted by Moyers et al (2005), where MI consistent interventions were associated with increased change talk, and increased change talk was associated with stronger therapeutic alliances. Importantly, they did examine a number of mediators and found interesting caveats. For example, MI-inconsistent interventions, such as confrontation, facilitated the therapeutic alliance when delivered by therapists with a high degree of MI skill. However, what if causality is more complex and dependent on multiple therapist, client, and situational factors? For example, our qualitative findings suggest that the right mix of supportive and directive interventions at the right time with the right type of client might be critically important. Within given therapeutic moments the therapist must decide the right mix of supportive and directive interventions. In our study these decisions were based largely on subjective assessment of the client and the therapeutic alliance. The balancing of directive and supportive interventions is an issue in need of more research. We suspect that achieving the right mix with individual clients could help facilitate consideration of potential changes and concurrent increases in change talk, which is gaining increased attention in the MI literature (Miller & Rollnick, 2013).

Limitations

This study was conducted within the context of a broader quantitative study so we only asked a limited number of questions. For the most part, we captured overall experiences rather than the nuances that occur in therapy. It would be interesting to conduct in-depth qualitative interviews or focus groups eliciting more complexities about client experiences. For example, the vast majority of participants in both study conditions indicated they wanted more sessions. It would have been interesting to hear what they hoped for those sessions. How did they imagine they would help? It would also have been interesting to hear how clients reacted to specific therapist behaviors during different points in therapy. It would also be interesting to study whether the views and experiences of clients addicted to other substances were similar to our sample of persons dependent on methamphetamine.

There were also limitations to our expert panel. The panel was small, consisting of four therapists including the study principal investigator. However, these practitioners had experience conducting and monitoring MI 9, a new intervention that was not familiar to other MI practitioners. In addition, panel members spoke generically about their experiences rather than about specific clients with whom they worked.

Conclusions

Client and therapist views about our MI-based interventions and their experiences participating in our study emphasized the following points:

1. Supportive, non-judgmental attitudes are essential. However, maximizing the impact of supportive interventions such as reflections is more complex and requires more skill than commonly believed. The use of “experience near” language is particularly important.
2. Strategic use of decisional balance (i.e., pros and cons) can facilitate open dialogue and a nonjudgmental tone.
3. Feedback and advice might be most helpful in longer-term MI interventions, such as our MI 9 manual.
4. Clients desire longer term MI interventions that go beyond MI 1 and even MI 9.
5. An important therapeutic skill is finding the right mix of supportive and directive interventions for specific clients in specific situations. There is a need for more research in this area.
6. Strategic, skilled use of supportive and directive interventions leads to interactions between them that facilitate the effectiveness of both.
7. MI 9 has an important advantage over traditional brief MI in that obstacles encountered during implementation of the client change plan can be addressed over time. MI 9 allows for modification and reformulation of the change plan based on the client’s experiences.

Acknowledgement

This work was supported by NIDA grant #R01 DA024714.

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TABLE 1

Client Feedback at 2 Months by Study Condition

	<u>Intensive MI</u> (N=94) N(%)	<u>Intensive MI</u> (N=94) N(%)	<u>Chi Square</u>
<u>Liked Characteristics</u>			
<i>Supportive:</i>			
Good Listener	45(50)	62(66)	4.8 *
Friendly/Agreeable	37(41)	35(37)	0.3
Nonjudgmental/Objective	28(31)	39(41)	2.1
Vent/Express Feelings	25(28)	29(31)	0.2
Supportiveness	10(11)	27(29)	8.9 **
Caring	7(10)	15(16)	2.9 +
Honest/Sincere	10(11)	11(12)	0.0
<i>Directive:</i>			
Knowledgeable/Professionals	20(22)	23(24)	0.1
Good Feedback/Advice	17(19)	49(52)	22.1 ***
Think about Self/Issues	13(14)	25(27)	4.1 *
Structure/Approach	8(9)	14(15)	1.6
Goal Setting/ Priorities	6(7)	15(16)	3.9 *
Learned Skills/Tools	3(3)	19(20)	*** (FET)
<u>Disliked Characteristics</u>			
Nothing Did Not Like/Would Change	33(37%)	37(39%)	0.1
One Session Not Enough	19(21)	--	*** (FET)
Don't Remember the session(s)	18(20)	2(2)	*** (FET)
Wish I Attended More	--	13(14)	*** (FET)
<u>Number of Sessions</u>			
More	72(80)	75(80)	0.0
Fewer	--	1(1)	NS (FET)
About Right	11(12)	16(17)	0.8

+ p<0.10,

* p<0.05,

** p<0.01,

*** p<0.001

FET=Fisher's Exact Test

TABLE 2

Client Feedback at 6 Months by Study Condition

	<u>Standard MI</u> (N=96)	<u>Intensive MI</u> (N=93)	<u>Chi Square</u>
	N(%)	N(%)	
<u>Effect of Sessions on Recovery</u>			
Helpful/Useful/Supportive	26(27)	32(34)	1.2
No Impact/Not Helpful	13(13)	6(6)	2.6
<u>How Sessions Helped</u>			
Think about Self/Realize Things	18(19)	31(33)	5.2 *
Learned Skills/Tools	10(10)	26(28)	9.4 **
Realistic Goal Setting	2(2)	17(18)	*** (FET)
<u>Roadblocks to Recovery</u>			
Not Sober: Peers/Environment	14(15)	14(15)	0.0
Not Sober: Mental Health Problems	7(7)	5(5)	0.3
<u>Suggested Changes</u>			
One Session Not Enough	31(32)	1(1)	*** (FET)
Don't Remember Much	27(28)	8(9)	11.9 **
Nothing I Would Change	18(19)	34(37)	7.5 **
Longer Sessions	12(13)	19(20)	2.2
Wish I Attended More	8(8)	10(11)	0.3
<u>Number of Sessions</u>			
More	84(88)	71(76)	4.0 *
Fewer	1 (1)	2(2)	NS (FET)
About Right	8(8)	17(18)	4.1 *
<u>Likelihood of Seeking Future Treatment</u>			
More	69(72)	70(75)	0.3
Less	6(6)	3(3)	NS (FET)

*
p<0.05,**
p<0.01,***
p<0.001

FET=Fisher's Exact Test