How Motivational Interviewing Began
A Second-Year Practicum   1972

Susan Gilmore

Leona Tyler

Carl Rogers
Milwaukee, Wisconsin  1973  Uncommon alcoholics
Eugene, Oregon
1975

Why did the control group get better?
Study Design

Miller, Gribskov & Mortell, 1981
*International Journal of the Addictions*, 16:1247-54

Problem drinkers randomly assigned to:

Counselor-Delivered Behavioral Self-Control Training (10 Weeks) or Self-Help Advice + “Bibliotherapy” (1 Session)

Both groups self-monitored with weekly drinking diary
Drinking Outcomes

![Graph showing drinking outcomes over time for Therapist-Directed and Self-Directed groups. The graph plots Drinks per Week on the y-axis and Intake, 3 months, 6 months, and 12 months on the x-axis. The Therapist-Directed group shows a sharper decline, while the Self-Directed group levels off after a few months.]

- Therapist-Directed
- Self-Directed
Albuquerque, New Mexico  1976
Replicated in New Mexico:

- 1978
- 1979
- 1980
Was it just an artifact of time or self-monitoring?
Study Design

Harris & Miller, 1990
Psychology of Addictive Behaviors, 4, 82-90

Problem drinkers randomly assigned to:

- Counselor-Delivered (10 Weeks)
- Self-Help Manual (1 Session)
- Waiting List (10 Weeks)
Drinking Outcomes

Intake

Therapist-Directed
Self-Directed
Waiting List (2 groups)
Many controlled trials now show that relatively brief interventions can be effective in reducing problem drinking.
And why do counselors’ clients have such different outcomes when receiving the same treatment?
Problem drinkers were randomly assigned to bibliotherapy or to one of nine outpatient counselors, all delivering the same treatment: behavioral self-control training.

3 supervisors rated counselors’ levels of accurate empathy (Truax & Carkhuff scale) with high inter-rater reliability.
Counselor Empathy and Client Outcomes

% Positive Outcomes at 6 months

Therapist Empathy

- Therapists
- Bibliotherapy
Client Drinking Outcomes Accounted for by Therapist Empathy

6 months  
\( r = .82 \)  
67%

1 year  
\( r = .71 \)  
52%

2 years  
\( r = .51 \)  
26%

Miller & Baca (1983) *Behavior Therapy* 14: 441-448
1982 - A barbershop in Norway
Basic Concepts

- The person, rather than the clinician, should be making the arguments for change
- Evoke the person’s own concerns and motivations
- Listen with empathy
- Minimize resistance; don’t oppose it
- Nurture hope and optimism
- Called it “motivational interviewing” (MI)
- Thought of MI as preparation for treatment

Back in New Mexico
Testing Motivational Interviewing

Problem drinkers were randomly assigned to:

Immediate motivational interview

or a 6-week waiting list group

And again without further treatment . . .
Steve Rollnick

1989

Sydney, Australia
And motivational interviewing took off
Diffusion of MI
Google Scholar Articles by Year

- Annual
- Cumulative
Current Status of Motivational Interviewing

- More than 1,200 controlled clinical trials
- Over 100 meta-analyses and systematic reviews
- Being used in many professional fields
- >3,000 trainers through the MI Network of Trainers
- In at least 55 languages around the globe

- But it *started* in treating alcohol problems
Motivational Interviewing
What is it?

A person-centered counseling style for strengthening a person’s own motivation and commitment to change

Four processes: Engaging, Focusing, Evoking, Planning
The Underlying Spirit of MI
Ambivalence
A central issue in substance use disorders

- People are *normally* ambivalent about change
- They have inside them arguments *for* and *against* change
- If you tell/advise/argue *for* change, the client’s *normal* response is to defend the status quo ("Yes, but . . .")
- MI helps people to *talk themselves into* change
Research on MI with Alcohol Problems

1. **MI is more effective than advice or no intervention**
Controlled trials: MI vs. Control/Comparison

- 26 systematic reviews and meta-analyses
- Typically one MI session
- Significant, small to medium effect size
- Odds ratio 2.0 (twice as likely to reduce alcohol use)
- In primary care, emergency departments, with college students, adolescents and adults
- Also effective with smoking and gambling
- Two examples:
Heather et al., 1996
Drug & Alcohol Review, 15:29-38

- **Design**: Block assignment
- **Population**: General hospital inpatients
- **Nation**: Australia
- **N**: 174 adult heavy drinkers
- **MI**: 1 30-40 minute session
- **Comparison**: Skills training or usual treatment
- **Follow-up**: 6 months
Heather et al., 1996

Percent Reduction in Drinking

<table>
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<tr>
<th></th>
<th>MI</th>
<th>Skill Training</th>
<th>TAU</th>
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<tr>
<td>All Cases</td>
<td>44</td>
<td>34</td>
<td>29</td>
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<tr>
<td>Not-Ready</td>
<td>42</td>
<td>18</td>
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Monti et al., 1999
Journal of Consulting and Clinical Psychology, 67:989-994

- **Design**: Randomized clinical trial
- **Population**: Emergency room
- **Nation**: US (Providence, RI)
- **N**: 94 adolescents (18-19)
- **MI**: 1 session (35-40 min)
- **Comparison**: Standard care
- **Follow-up**: 6 months
Monti et al., 1999

Outcomes Over 6 Months

- Drinking & Driving: 62%, 85%
- Moving Violations: 3%, 23%
- Alcohol-Related Injury: 21%, 50%

Significance:
- $p < .05$
- $p < .05$
- $p < .01$
Research on MI with Alcohol Problems

1. MI is more effective than advice or no intervention
2. When compared with other/longer interventions, MI is often just as effective on average
Project MATCH, 1997

Design  Randomized clinical trial
Population  Outpatient and aftercare
Nation  US (9 sites)
N  1,726 adults
MI  4 session MET
Comparison  12 session CBT or TSF
Follow-up  15 months post-treatment
Project MATCH Outcomes over 15 Months

[Graph showing percent days abstinent over 15 months for different interventions (CBT, MET, TSF)]
MATCH: 3 Year Follow-up

% Days Abstinent

- CBT
- MET
- TSF
U.K. Alcohol Treatment Trial
MET vs. Cognitive-Behavioral/Family Therapy

Percent Days Abstinent

Baseline | 3 Months | 12 Months
--- | --- | ---
29.5 | 42.3 | 45.4
29.5 | 43.2 | 46.6

MI | SBNT
Research on MI with Alcohol Problems

1. MI is more effective than advice or no intervention
2. When compared with other/longer interventions, MI is often just as effective on average
3. **When delivered early in treatment, MI can substantially improve client outcomes**
Three Randomized Trials of MI at Intake

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<th>% Abstinent</th>
<th>% Remission</th>
<th>%DA All Drugs</th>
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<td>56</td>
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<td>Brown 1993</td>
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<td>Aubrey 1998</td>
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Adult Outpatient

Adult Inpatient

Adolescent Outpatient

MI vs No MI
Research on MI with Alcohol Problems

1. MI is more effective than advice or no intervention
2. When compared with other/longer interventions, MI is often just as effective on average
3. When delivered early in treatment, MI can substantially improve client outcomes
4. **When MI is added to another active intervention, the impact of both is larger and longer-lasting**
Effect Size of MI Over Time
(Hettema et al, 2005, Annual Review of Clinical Psychology, 1, 91-111)
The most common use of MI in recent trials has been in combination with other evidence-based treatment methods. MI as a way of doing what else you do.
Treating Less Severe Alcohol Use Disorders

- A common source of conflict in American treatment programs is insistence on lifelong abstinence.
- People with lower-severity alcohol problems/dependence are more likely to drink moderately than abstain.
- People with higher-severity alcohol dependence are most likely to succeed with abstinence.
  - Many discovered that they preferred abstinence!
Remember: Clients were successful working on their own with one session + self-help guidance.

In summary, motivational interviewing:

- Was originally developed to treat alcohol problem
- Evidence-based: 26 systematic/meta-analytic reviews
- Is typically brief: 1-3 sessions
- Is more effective than advice, confrontation, no treatment
- Is as effective, on average, as longer treatments
- Significantly improves outcomes when added to a program
- Combines well with many other treatment methods as “a way of doing what else you do” and increases efficacy
- Can be used to treat less severe alcohol use disorders
And a few cautions:

- Effectiveness varies widely across studies, sites, and therapists
- The method is simple and learnable, but not easy
- As with any complex skill, proficiency requires more than reading and workshop training
- Self-perceived competence is unreliable
- There is extensive research on learning, training, and quality assurance of MI