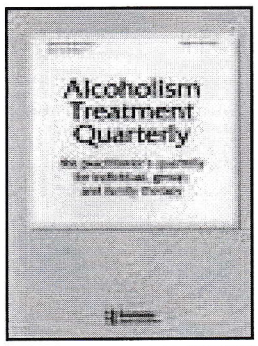

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Should Substance Use Counselors Choose a Direction for Their Clients? Motivational Interviewing Trainers May Be Ambivalent

David P. Forman [a,b] and Theresa B. Moyers[a,b]

[a]Department of Psychology, University of New Mexico, Albuquerque, USA; [b]Center for Alcoholism, Substance Abuse, and Addictions

ABSTRACT

Motivational Interviewing (MI) is comprised of a client-centered relationship and a clear intention on the part of the practitioner to influence behavior change. This study explores MI trainers' decisions about their use of directionality in MI as they instruct others in the method. 111 MI trainers were asked to select content they would include in a hypothetical MI training. Almost half of trainers chose to teach trainees to "always maintain an attitude of equipoise", a strategy that is contradicted by MI theory and empirical data. This finding suggests a theoretical rift within the MI community with implications for substance use counseling.

KEYWORDS

Motivational interviewing; equipoise; training; direction; mint

Motivational Interviewing (MI) is recommended to counselors as an empirically supported, motivation-enhancing treatment that can be used as a standalone approach or an adjunct to other therapies targeting substance use and high-risk behaviors (American Psychological Association, 2020; Substance Abuse and Mental Health Services Administration, 2020). Indeed, meta-analyses suggest MI has positive effects in the treatment of alcohol use problems in a variety of settings (Bertholet, Daeppen, Wietlisbach, Fleming, & Burnand, 2005; Lundahl et al., 2013), and has been found superior to no treatment and at least as effective as comparable treatments for addressing marijuana, tobacco, and other drug use (Lundahl & Burke, 2009). Given this empirical and institutional support, MI has steadily grown in popularity among treatment providers both within and outside the substance use field. Recent data show that 93% of substance use treatment facilities report using MI as one of their clinical approaches, highlighting the demand for quality practitioner training in this method (Substance Abuse and Mental Health Services Administration, 2020). Training has been empirically identified as one of the core components for integrating scientific findings into practice, and an impressive body of evidence indicates optimal strategies for training MI as it is translated into clinical settings (Miller, Yahne, Moyers, Martinez, & Pirratano, 2004; Moyers et al., 2008). Recognizing this, the Motivational Interviewing Network of Trainers (MINT; www.motivationalinterviewing.org) was established to promote excellence in MI training that would facilitate practitioners' learning of the "when, where, how, and with whom" of this empirically based approach (Fixsen, Blase, Naoom, & Wallace, 2009, p. 534). Recent work has found train-the-trainer models to be effective at establishing competency in MI,

CONTACT David P. Forman dpforman@unm.edu Department of Psychology, University of New Mexico, Albuquerque, NM 87131.

though questions remain regarding how skillfully MI material is covered by new trainers as compared to experts (Frank et al., 2020). Given MI's popularity in the substance use field, investigating real-world training practices in this method offers promise in explaining contradictory empirical findings concerning its value in influencing addiction outcomes. As with other therapeutic approaches, null findings for MI do exist, and even in multi-site trials MI has been associated with sustained decreases in drug use at 12-week follow-up at some sites, while not at others (Ball et al., 2007).

From its inception, Motivational Interviewing has been composed of both a client-centered relationship and a clear intention on the part of the practitioner to influence behavior change (Miller & Rollnick, 1991). This marriage of disparate elements has sometimes attracted counselors who place a higher value on one component or the other, leading to natural differences in the way MI is conceptualized and practiced. It is not unusual to find interviewers who view MI primarily as an intervention to humanize interactions in medical, correctional and educational settings, with little apparent attention to the change-directed focus of the method. This is particularly concerning in light of the fact that the directional elements of MI, such as shaping client language (increasing the proportion of change-favoring to change-opposing statements), are among those with the strongest emerging empirical support in the literature (Magill et al., 2018; Moyers, Martin, Houck, Christopher, & Tonigan, 2009; Pace et al., 2017), and are of particular interest in the treatment of addictions where a clear target change is not in question.

The directional component of MI also distinguishes it from sibling interventions such as Shared Decision-Making (SDM). Although Motivational Interviewing and SDM are similar in their person-centered spirit, important distinctions have been drawn between the two approaches when addressing problems related to health. Elwyn et al. (2014) propose that MI is more suitable for situations in which the clinician has clear evidence for a preferred direction of action and SDM may be more useful when several options are deemed equally appropriate. In the area of substance use, for example, the counselor's decision to guide clients toward reducing or eliminating their substance use is generally non-controversial. Clients entering substance use treatment centers do so because their use has had harmful effects on their lives, and with the expectation that professional help will aid them in changing.

Of course, no matter what the theoretical orientation or clinical method of the counselor, there are situations in which direction is unwise or even unethical. For example, clinicians might be reluctant to have an opinion about whether clients should adopt a child, change careers, end troublesome relationships or donate organs to a relative. The specific situations in which clinicians might choose to explicitly avoid influencing their clients' decisions will depend on their personal biases as well as the professional and ethical frameworks in which they practice. When clinicians using Motivational Interviewing encounter such circumstances, they are encouraged to maintain a position of equipoise (Miller & Rollnick, 2013). The concept of equipoise has roots in the medical research field (Freedman, 1987) and is described by Miller and Rollnick as a clinical stance of avoiding influencing a client's decisions in any particular direction. Such a position is most commonly associated with the traditional client-centered therapy described by Rogers (1959) in which the therapist focuses on the concerns and perspectives of the client without making conscious attempts at influencing the client's direction (although see Traux, 1966 for a discussion of Rogers' tendency to reinforce certain topics more than others in therapy). The Rogerian approach is

explicitly distinguished from MI by MI's original authors. As Miller and Rollnick (2002) describe,

> ... motivational interviewing differs from the method described by Rogers as it is consciously directive ... Motivational Interviewing is intentionally addressed to the resolution of ambivalence, often in a particular direction of change. The interviewer elicits and selectively reinforces change talk and then responds to resistance in a way that is intended to diminish it. Motivational interviewing involves selective responding to speech in a way that resolves ambivalence and moves the person towards change. (p.25)

Equipoise, then, is intended as an *alternative* to the clinical approach of MI, and each is important to a therapist's skill set. A problem for the integrity of both methods, however, is when clinicians believe they are practicing MI but are instead adhering to a classic Rogerian approach. This is of particular concern in settings where the clinical direction is inherent in the agency's purpose, as is the case in substance use treatment centers. If counselors who practice MI avoid its directional elements, this may be the result of decisions by those who train the method, and may partly explain MI's loss of effectiveness in the science-to-service pathway (Miller & Moyers, 2014).

Although it is likely that MI therapists will encounter a need for both equipoise and direction in their practice, there are no data to inform the way they decide to use either. This brief report highlights findings from a recent study of MINT members about their attitudes and training practices. Specifically, we explore MINT members' decisions regarding theg directional elements in MI as they instruct others to practice this method.

Method

Participants

Participants in this study were 111 members of the MINT, who were recruited through an advertisement for the study posted on the MINT website (www.motivationalinterviewing.org) and advertised in the MINT listserve. The only criterion for inclusion in the study was MINT membership. There were no exclusion criteria.

Variables

Trainer characteristics. A questionnaire collected information on participants' demographic characteristics, including: education, practice setting, years in practice, years in the MINT, theoretical orientation, and training experience.

Trainer priorities in selecting MI elements (MI-Elements). A primary construct of interest in this study was the value that MINT trainers placed on commonly discussed elements of MI practice, particularly those that are supported by the current empirical literature and those that are not. We used an indirect measure to evaluate this, by asking participants to design an MI training for a large health care system with a diverse group of learners. They were asked to select which MI elements, among a large array, they would include in this hypothetical training. The elements are presented in Table 1. Based on a text review of MI research publications from 2008–2018 we determined a priori that items 1–10 had at least moderate empirical support in MI practice, while items 11, 12, 13, and 15 lacked support

though questions remain regarding how skillfully MI material is covered by new trainers as compared to experts (Frank et al., 2020). Given MI's popularity in the substance use field, investigating real-world training practices in this method offers promise in explaining contradictory empirical findings concerning its value in influencing addiction outcomes. As with other therapeutic approaches, null findings for MI do exist, and even in multi-site trials MI has been associated with sustained decreases in drug use at 12-week follow-up at some sites, while not at others (Ball et al., 2007).

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The directional component of MI also distinguishes it from sibling interventions such as Shared Decision-Making (SDM). Although Motivational Interviewing and SDM are similar in their person-centered spirit, important distinctions have been drawn between the two approaches when addressing problems related to health. Elwyn et al. (2014) propose that MI is more suitable for situations in which the clinician has clear evidence for a preferred direction of action and SDM may be more useful when several options are deemed equally appropriate. In the area of substance use, for example, the counselor's decision to guide clients toward reducing or eliminating their substance use is generally non-controversial. Clients entering substance use treatment centers do so because their use has had harmful effects on their lives, and with the expectation that professional help will aid them in changing.

Of course, no matter what the theoretical orientation or clinical method of the counselor, there are situations in which direction is unwise or even unethical. For example, clinicians might be reluctant to have an opinion about whether clients should adopt a child, change careers, end troublesome relationships or donate organs to a relative. The specific situations in which clinicians might choose to explicitly avoid influencing their clients' decisions will depend on their personal biases as well as the professional and ethical frameworks in which they practice. When clinicians using Motivational Interviewing encounter such circumstances, they are encouraged to maintain a position of equipoise (Miller & Rollnick, 2013). The concept of equipoise has roots in the medical research field (Freedman, 1987) and is described by Miller and Rollnick as a clinical stance of avoiding influencing a client's decisions in any particular direction. Such a position is most commonly associated with the traditional client-centered therapy described by Rogers (1959) in which the therapist focuses on the concerns and perspectives of the client without making conscious attempts at influencing the client's direction (although see Traux, 1966 for a discussion of Rogers' tendency to reinforce certain topics more than others in therapy). The Rogerian approach is

Table 1. Motivational interviewing training components selected.

Training Component	yes	no
	%	%
1. Detecting change talk	99	1
2. Selectively reinforcing change talk	97	3
3. Having a genuine internal experience of MI	96	4
4. Offering complex reflections that go beyond the client's stated content	96	5
5. Communicating a sense of compassion for the client	96	5
6. Flexibly using open-ended questions, affirmations, reflections, and summaries	94	6
7. Avoiding confrontation	92	8
8. Identifying a specific target goal	92	8
9. Detecting sustain talk	87	14
10. Softening sustain talk	85	15
11. Generating an appropriate ratio of reflections to questions	81	19
12. Developing discrepency between the client's values and actions	78	23
13. Always maintaining an attitude of equipoise	49	51
14. The Stages of Change model of behavior change	47	53
15. Using a decisional balance to move clients away from ambivalence	39	61

Note. $N = 111$

or were contradicted by the available scientific evidence. For example, a recent meta-analysis testing the technical hypothesis of MI found that increases in therapists' use of MI-consistent skills such as offering complex reflections, open questions, and affirmations, were positively associated with increases in clients' proportion of change talk, which was in turn, positively associated with better outcomes (Magill et al., 2018). On the other hand, a review of research on the use of the decisional balance to move clients away from ambivalence found that using the tool with ambivalent clients actually decreased goal commitment and future behavior change (Miller & Rose, 2015). Item 14 did not represent a therapist behavior, and was therefore not included in either category. Descriptive data for trainer characteristics and MI-Elements chosen by those trainers were analyzed by exploring bivariate relationships between them using SPSS.

Procedure

An invitation to participate in the study was posted to the Motivational Interviewing Network of Trainers listserv. Members were invited to complete a 20-minute survey about their training practices in exchange for a 10 USD gift certificate and provided with a link to the questionnaire. Those who clicked the link were taken to an electronic survey hosted on the Opinio platform. Consent was obtained with an electronic signature. All procedures were approved by the Main-Campus Institutional Review board at University of New Mexico prior to the start of recruitment.

Results

Sample characteristics

Of the 284 people who followed the link to the survey, 283 provided electronic agreement to the consent form. Of those, 172 did not complete the survey. The final sample was 111,

which constitutes about 7% of the Motivational Interviewing Network of Trainers membership.

Respondents had a mean age of 49.00 (SD = 11.28). Years of MINT membership ranged from 1 to 22 with an average of 7.86 years (SD = 5.94). Most respondents had a master's degree (57%), some had a PhD (25%), and 10% had a bachelor's degree. In terms of work setting, 23% reported working primarily in academia, 19% in private practice, 14% in community health, 10% in hospitals, and the rest in various settings such as probation and schools. Although Motivational Interviewing is most commonly associated with a humanistic theoretical perspective, only 30% chose Humanistic as their theoretical orientation, while 38% chose Cognitive-Behavioral and 19% chose Eclectic. The remainder chose Family Systems (5%), Psychodynamic (2%), or Other (7%). No previous data are available on the characteristics of MINT members, so the representativeness of this sample cannot be determined.

Training activities of MI trainers

The number of trainings conducted in the previous twelve months ranged from 0–100 with an average of 12.54 (SD = 17.91) and trainers expected to conduct about the same number of trainings in the upcoming year (M = 12.43, SD = 17.54). The most common length of MI training was 1–2 days (52%), followed by greater than two days (28%), four hours to one day (14%), and 2–4 hours (5%). The trainers in this sample were accustomed to conducting at least one MI training per month, and at least half of these trainings lasted for two full days.

Which MI elements did MI trainers select?

Of the fifteen training components offered, the average number selected was twelve, and there was general agreement among the sample on which items to include (Table 1).

Several training items had less of a consensus among trainers. Notably, almost half of trainers (49%) chose to teach trainees to "always maintain an attitude of equipoise", and almost 40% of trainers chose to include "use of a decisional balance to move people away from ambivalence" in their training."

Cronbach's alpha for our Training Element Selection measure was.504 suggesting low reliability (George & Mallery, 2003). This is to be expected since this instrument was measuring disparate theoretical elements that were not intended to meet the assumptions of unidimentionality for Cronbach's alpha (Vaske, Beaman, & Sponarski, 2017).

What predicts the selection of MI elements to be included in training activities?

Endorsement of the equipoise item was positively correlated with having a master's degree ($r = .231, p = .015$) and negatively correlated with having a PhD ($r = -.192, p = .044$). Trainers who reported conducting MI trainings that were longer than two days were significantly less likely to include the Decisional Balance in their training content ($r = -.248, p = .009$). No other relationships between trainer characteristics and MI-Elements were found.

Discussion

Despite the fact that the counselor's intention to influence the client's direction is a fundamental feature of MI, half of the trainers in this expert and experienced sample suggested they would train counselors to forego this element. This is particularly concerning for the field of substance use treatment where the choice of a clinical direction is rarely questioned by practioners and often life-saving for clients. If MI trainers are teaching substance use counselors to prioritize equipoise in their clinical encounters, it is possible that well-intentioned acceptance of "where the client is at" is unwittingly undermining "where the client should go". Substance use problems are often accompanied by considerable ambivalence toward change as clients consider the physical, emotional, and social implications of changing their use. MI is likely effective with this population *because* of therapists' investment in diminishing that ambivalence and increasing motivation toward change. If trainers are teaching counselors to remain in equipoise, it is possible that some of the mixed findings for MI in substance abuse treatment settings are the predictable result of ambivalence on the part of the *client* being met with ambivalence on the part of the *therapist*.

This equipoise-favoring finding is particularly surprising given the empirical support for the therapist's use of MI-consistent skills to shape clients' language toward change as well as the well-documented link between change language and behavioral outcomes. Along with the finding that only 21% of MI adherence tools include a measure of the technical processes of MI (Lundahl et al., 2019), our finding suggests a potential theoretical rift within the MI training community with direct implications for the effectiveness of the method, particularly in areas where a clinical direction is clear and undisputed.

The preference for neutrality on the part of some MI trainers may have its roots in client-centered therapy, which forms an important component of MI. Rogers viewed "non-directivity" as a central value of the therapist, and professed himself to have no aspirations for any particular processes (such as the resolution of ambivalence) to occur within his clients (Brodley, 2011). From this client-centered perspective, therapists should aim to provide empathy, genuineness, and unconditional positive regard, which, when approximated, will allow clients to naturally choose directions of growth without outside influence (Rogers, 1961). Yet, to *always* maintain this position would be to put oneself at odds with the directional elements of MI, which conceptualize the therapist's role as that of a "guide" in the direction of change.

The decision by MI trainers to teach trainees to maintain an attitude of equipoise and to selectively shape client language about change presents a double-bind for new MI practitioners. On one hand, trainees are taught not to impose their own desires for specific outcomes on the client, while on the other they are taught to differentially respond to change and sustain talk. Although it has been suggested that equipoise and MI can co-occur (Zuckoff & Dew, 2012), using both elements simultaneously is untenable. This is because in order to intentionally encourage change talk the therapist must first make a decision about which goal to encourage (and which others to pay less attention to). Only when the therapist has decided which outcome to encourage can she identity which language is change talk and which is sustain talk and differentially respond to what she hears. Indeed, experiments that manipulate the therapist's efforts at eliciting change talk demonstrate that client language about change is highly susceptible to influence, and that MI therapists can intentionally

elicit change talk from clients (Glynn & Moyers, 2010). By simultaneously training two contradictory elements and packaging them as one approach, trainers maybe inadvertently confusing trainees and diluting the efficacy of MI.

We view the practice of avoiding the directional element of MI as unfortunate, particularly on the part of expert trainers. As the empirically- supported treatments movement gains momentum, the accountability of therapists, including those being trained in MI, is increasing. Despite these efforts, the integration of research findings into clinical practice remains low (Stewart & Chambless, 2007; Tolin, McKay, Forman, Klonsky, & Thombs, 2015), and our data indicate that the training and practice of MI may not be an exception. The finding that trainers' endorsement of always maintaining an attitude of equipoise was negatively associated with higher levels of education evokes questions regarding the value of education in adopting empirically supported treatments. In our study, practitioners with more education were less likely to endorse a position inconsistent with the substantial empirical evidence supporting the directional element in MI.

In addition to the impact on trainees, these findings have implications for the viability of MI itself. MI is well positioned as a specifiable, trainable, and brief intervention supported by decades of research trials. If MI trainers are skeptical of the directional aspects of MI, it is likely that those aspects are given inadequate attention in the training of the method. This may mean that fundamental elements of MI with strong empirical support are being lost in the science-to-service pathway, and that this, in turn, is contributing to mixed findings for MI's effectiveness, hindering its dissemination.

Our findings are constrained by several limitations. First, we recruited a convenience sample, so it is not possible to generalize the results of our participants to all members of the MINT. For example, increases in the percentage of MINT members who have less formal education might increase the endorsement rate for always remaining in equipoise. Conversely, if the MINT were comprised of more highly educated members than our sample, we would hypothesize the endorsement of that item to be lower. A second limitation was the measurement of adherence to the empirical elements of MI in a novel but indirect fashion. Ideally we would have included converging measures of validity to support our conclusions. Third, some items may have been confusing to our respondents, and we cannot be sure that each trainer understood the equipoise item the same way. Yet, the finding that endorsement of the equipoise item varied systematically with education, as might be expected, suggests that it may not have been confusing to this sample.

Despite the limitations of this study, our findings suggest that additional research on MI trainers' practices regarding the directional elements of MI is warranted. It is reasonable to speculate that if MI is to realize its full potential as a brief, empirically-supported intervention for addressing issues of substance use, the MI community may first need to explore its ambivalence regarding therapists' appropriate role in helping people change. At the very least, clinical directors and those who are tasked with establishing MI training programs for frontline substance use counselors are encouraged to seek out trainers who are committed to teaching the full-spectrum of relational and directional MI skills. MI occurs, by definition, when therapists have aspirations for their clients, and these aspirations are linked to outcomes that are "on the table" (Miller, 2012; Miller & Rollnick, 2013). A non-directional approach, while perfectly appropriate in many clinical encounters, is nevertheless not MI.

Discussion

Despite the fact that the counselor's intention to influence the client's direction is a fundamental feature of MI, half of the trainers in this expert and experienced sample suggested they would train counselors to forego this element. This is particularly concerning for the field of substance use treatment where the choice of a clinical direction is rarely questioned by practioners and often life-saving for clients. If MI trainers are teaching substance use counselors to prioritize equipoise in their clinical encounters, it is possible that well-intentioned acceptance of "where the client is at" is unwittingly undermining "where the client should go". Substance use problems are often accompanied by considerable ambivalence toward change as clients consider the physical, emotional, and social implications of changing their use. MI is likely effective with this population *because* of therapists' investment in diminishing that ambivalence and increasing motivation toward change. If trainers are teaching counselors to remain in equipoise, it is possible that some of the mixed findings for MI in substance abuse treatment settings are the predictable result of ambivalence on the part of the *client* being met with ambivalence on the part of the *therapist*.

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Disclosure statement

Dr. Moyers has a potential conflict of interest in the content of this paper because she makes money teaching motivational interviewing and consulting with others about it..

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ORCID

David P. Forman http://orcid.org/0000-0003-3498-3044
Theresa B. Moyers http://orcid.org/0000-0003-1029-472X

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