IFIOC The Institute for Individual And Organizational Change

What it Really Takes to Learn the Foundational Best-Practice for Motivation & Change: Myth-Busting the Motivational Interviewing Learning Process

Version 3.1

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Intention:

The intention of the information below is to provide evidence-based clarity in achieving the outcomes found with the best-practice foundation in motivation and behavior change—Motivational Interviewing (MI). Much confusion, misperception and strong opinion exist regarding MI, at least in part to its fast and wide spread popularity and perceived prevalence of fidelity. Below is an attempt at capturing as much of the research and relevant quotes from such studies that this author could find in the allotted time of its creation. If you think it would benefit from further information, amendments, etc…, then your feedback would gratefully be considered if you send it to john.gilbert@ifioc.com. With the information below, you can make a more evidence-informed choice for you and/or your organization depending on whether you want to:

A. **Be able to do and provide MI** with likely outcome improvements seen in fidelity studies

   OR

B. **Know about MI** with concepts/acronyms and likely without skill transfer to achieve associated outcomes and return on investment (be it time, money, effort, or otherwise)

This document is focused on informing you on the prior (A.), with the answer to the latter (B.), being much more basic given it's virtually any training in MI that you receive that does not include the components below. The content below is relevant to all working environments for which MI has been studied (many as you will see), with a special emphasis within the health care field for the initial intended audience of Functional and Lifestyle Medicine professionals.

Special thanks for compilation aid by Dr. Susan Butterworth, with Qconsult LLC, found here http://qconsulthealthcare.com/

Quick Navigation Tip: If you are looking for a specific topic, or get lost, you can press down "Ctrl" + "F" on a PC, or "Command" + "F" on a Macintosh to then enter your topic in the search box that appears.

Executive Summary/FAQs:

(clicking on the text directly below will take you to its expanded counterpart)

FAQs hereafter:

B. How much training do I need to get the clinically significant and consistent outcomes shown in MI research?

C. How is it a "best-practice?"
   - "Motivational Interviewing is the **ONLY health coaching approach to** be fully **described and consistently demonstrated** as **causally and independently associated** with positive behavioral outcomes."
     - Within MI… "Reflection of Change Talk directly correlated to positive clinical outcomes"

D. What about other health coaching I've heard about?

E. Don't I do MI already? I've read multiple books, seen webinars, and have been trained on it (I could even tell you all the acronyms!)…

F. Isn't it just a basic counseling "technique?"

   i. Why would there be so much confusion if there are so many studies saying it takes personalized feedback & coaching?

G. If I'm being nice & kind to my patients and really keeping in mind what's in their best-interest, does this level of quality assurance really matter?

   i. SPOILER ALERT: By taking a nice, kind, and/or well-meaning approach that is still measurably not patient-centered, nor MI, the practitioner can be DOING HARM to the patients in their well-intentioned approach to help.

H. How does it fit with what we do already?

   i. Similarly, will hinder or help with my job satisfaction, stress, or burnout?

   ii. Since MI is patient-centered, can I provide them with information, advice, or opinions?

I. I heard some studies haven't been consistent, what's that about?

J. Why does it take so much training when it seems so basic and overhyped?

K. Is it worth it for you, or your organization, or your patients, and where can I get more guidance on what to do next?

Expansions of Letters Directly Above

A. Health Coaching Conundrum & Need for Fidelity as a Whole

(clicker here to return to where you just came from **above**)

- "The Treatment Fidelity Workgroup of the **NIH Behavior Change Consortium** **recommends fidelity monitoring strategies to ensure that counselors meet criteria for skill proficiency,** monitoring be conducted throughout the intervention **to prevent "drift"** in adherence to manual protocol, and training be adapted to meet the needs of diverse trainees (Bellg et al., 2004)." (Koken et al., 2012)

- "Yet a recent review of more than **400 publications describing behavioral interventions** found that **only 12% of publications could be said to have followed a "gold standard" for measuring and maintaining treatment fidelity** by reporting the use of a treatment manual, measures of protocol adherence, or strategies to improve the competence of treatment providers (Borrelli et al., 2005)." (Koken et al., 2012)

- "And many healthcare professionals and lay persons are using **health coaching** to support healthy behavior. Yet, while health coaching is a popular and appealing approach, it remains **poorly defined**. Further, popular life coaching-based health coaching training programs and approaches—**while often incorporating psychological terms and concepts—do not generally reflect the body of research or the consensus of experts** in health-related behavior change from the fields of health psychology and behavioral medicine.1 Most popular approaches have been adapted to healthcare from business or personal coaching settings." (Butterworth & Andersen, 2011)

- **"Today, health care organizations lack an evidence-based approach** to address treatment adherence, disease self-management and lifestyle management issues with patients [8,9]." (Butterworth & Andersen, 2011)

- "Moreover, since behavior change is often the goal of case management, **optimal case management outcomes require the systematic and routine application of the best practices of the behavioral sciences**. These approaches also **ensure that "whole person" or "patient-centered" are not just aspirations but deliverables**." (Andersen 2010)

- **"Few health care organizations use any validated tool to assess the fidelity** of their health coaching services to evidence-based health coaching best practices [13, 29]." (Butterworth & Andersen, 2011)

- "When health coaching training is provided, there is generally a lack of a comprehensive curriculum and appropriate follow-up activities to ensure that there is a significant change in skill set." (Butterworth & Andersen, 2011)

- Further demonstration of this **rarity in fidelity training** are illustrated by Damschroder et al., 2016
    - "Despite the clear need, exceedingly few studies explicitly report assessment of treatment delivery fidelity [5, 6, 9]. One review found only **30 % of 287** published studies over a 10-year span included a mechanism by which to assess treatment delivery and **only 6 % assessed the presence of non-treatment specific effects (e.g., empathy**) in delivery [9]."

- "**Evaluating clinician adherence and competence will** not only help **ensure** that clinicians are following the tenets of an **intervention appropriately but also have the potential to facilitate skill development**. Although these evaluations have traditionally relied on clinical judgment, the increasing complexity of interventions combined with the **call for accountability suggests that evaluators will be helped by the guidance of empirically sound evaluation tools**." (Madson M.B., Campbell T.C., 2006)

- "**Motivational interviewing (MI)**, for example, which is a complex behavioral intervention often used with substance use disorders [and many other health related conditions], **would benefit from empirically based evaluation tools.**" (Madson M.B., Campbell T.C., 2006)

- "Practice doesn't make perfect, practice makes consistent. Practice plus feedback makes perfect. Feedback narrows the gap between performance and aspiration." (Undrill 2014)

B. How much training do I need to get the clinical significant outcomes with MI and why?

(clicker here to return to where you just came from **above**)

- There is no minimum or sufficient "dose" of training to guarantee competence in MI. The only way to document MI skillfulness is through observed practice [video, audio, or live]…Establish a criterion performance level of proficiency for MI providers in a clinical and provide training, feedback, and coaching until each provider reaches it." (Miller & Rollnick, 2013)

- "This indicated that trainees need more than a one-time workshop to improve skillfulness in this complex method. Two common learning aids seemed good candidates for improving training: progressive individual feedback on performance, and personal follow-up coaching." (Miller & Rose, 2009)

- "…well-intentioned efforts to train all staff can fail to have the intended impact. **The glue** that often binds the learning process is **ongoing coaching and peer support**." (Miller & Rollnick, 2013)

- "Record all sessions and **use a reliable coding instrument to monitor quality of delivery**…Fidelity monitoring should be immediate and ongoing." (Miller & Rollnick, 2013)

- "Lastly, the coding process should include **random health coaching encounters coded systematically over time** to ensure continuous quality." (Butterworth & Andersen, 2011)

- "**On average**, **three to four feedback/coaching sessions** **over a 6-month period sustain skills among trainees for motivational interviewing,** mainly for substance use disorder treatment. However, high rates of attrition from feedback/coaching contributes to post-workshop skill erosion." (Schwalbe et al., 2014)

    - "The results of this study suggest that the level of **post-training expert supervision needed** to sustain MI skills is somewhat modest—approximately **three to four contacts totaling at least 5 hours** of contact time over a 6-month period was sufficient for the average study to sustain training effects over a 6-month window." (Schwalbe et al., 2014)

- "Previous research indicates that motivational interviewing **(MI) skills decline over time** among participants in training workshops **when post-workshop feedback and coaching are not provided**." (Schwalbe et al., 2014)

- "Training workshop effects were sustained when trainees had **more contact with their trainers and expert supervisors**." (Schwalbe et al., 2014)

- "Most MI scholars and trainers recognize that reading the MI literature (e.g. manuals) and participating in training workshops are not sufficient to sustain training gains for most human service professionals. Rather, evidence from practitioner training in evidence-based behavioral interventions [1], along with experimental studies from the MI training literature [2], support a multi-modal training approach." (Schwalbe et al., 2014)

- "Several studies have demonstrated this empirically, showing diminished skills among workshop participants at follow-up times as short as 2 months [2,6,7]…Usually, training workshops include a mix of didactic presentation, demonstrations and practice delivered over 1–3 days [4]. To sustain skills over time, **a training workshop needs to influence mediating processes that provide ongoing support to counselor skillfulness, such as organizational support and counselor acceptance** [8–10]." (Schwalbe et al., 2014)

- "It is **unlikely that 75% of clinicians can achieve beginning proficiency** in MI spirit after training **unless competency is benchmarked and monitored** and training is ongoing." (Hall et al., 2016)
    - More clarity on this idea of the expectations we may have of our skill set, based off the fact that we have actually been trained in MI or read and practiced it, are within Section E of "Don't I do MI already?"

Why does this matter?

- "**Unless** MI proficiency can be developed, **measured** and sustained, it will simply **not be possible** for organizations to achieve the types of improvements in patient-level **outcomes demonstrated in MI clinical research trials."** (Butterworth& Andersen, 2011)

- "Although many studies have found MI to be effective for improving health behaviors, **delivery of the treatment often varies among therapists and across samples** (Carroll et al., 2006; Madson & Campbell, 2006; McCambridge, Day, Thomas, & Strang, 2011). This is especially critical as **therapist fidelity to MI techniques and style has been found to predict client behavioral outcomes** (Cox et al., 2011; McCambridge et al., 2011; Moyers, Martin, Houck, Christopher, & Tonigan, 2009)." (Koken et al., 2012)

- "And to this counsel of "try it" we add the reminder that developing skill in MI takes time. Hasty efforts with minimal training often fail to produce good results. **Low-quality MI practice** might be likened to half doses of a vaccine or antibiotic: **the right idea but insufficient strength**." (Miller & Rollnick, 2013)

- "Failure to establish treatment fidelity can result in unanticipated, non-significant findings that are **erroneously attributed to problems with the intervention itself as opposed to its poor delivery** (Resnicow et al., 2006)." (Robbins et al., 2012)

C. How is it a best-practice and foundation for motivation and behavior change?

(clicker here to return to where you just came from **above**)

a. "[MI] is the **ONLY health coaching approach** to be fully described and consistently demonstrated as **causally and independently associated with positive behavioral outcomes."** (Butterworth, et al., 2007; Noordman, et al. 2012; Olsen & Nesbitt 2010; Wolever, et al. 2013)

i. "Reflection of Change Talk **directly correlated to positive clinical outcomes**" (Barnett et al., 2013)

1. Increased change talk **increases likelihood for target behavior change**. (Moyers, et al., 2009)

a. "MI does roughly **doubles the rate of change talk and halves the rate of resistance**, relative to action-focused counseling or confrontation" (Miller et al., 1993)

b. Complimentarily…

i. **MI outperforms traditional advice-giving**-based approaches in treating a broad range of behavioral problems and diseases (Ruback et al., 2005)

ii. "MI is a well-articulated and learnable skill [57–59] and appears to be a useful intervention for a range of health-behaviour-change targets, such as diet and exercise, weight management, smoking cessation, medication adherence, and alcohol consumption. All of these behaviours are relevant to people living with multimorbidity." (McKenzie et al., 2015)

D. MI Plays Well with Others

(clicker here to return to where you just came from **above**)

a. What about **other health coaching I've heard about?**

i. It's NOT about it being MI "OR" something else; rather, **MI "AND" something** for less motivated/less ready/less successful patients

1. **MI has been shown to be complimentary** in many evidence based interventions such as CBT, DBT, ACT, IHC, BST, Mindfulness, etc…

a. Research supports outcomes improving beyond additive and complimentary **to SYNERGISTIC (E.g. 1+1 = 4)** when utilizing other evidence-based interventions (e.g. Cognitive Behavioral Therapy [CBT] that is another best-practice in adult weight management).

i. Click on the text here for research article quotations and studies supporting all this

E. Self-Perception Deception

(clicker here to return to where you just came from **above**)

Don't I do MI already? I've read multiple books, seen webinars, and been trained on it (I could even tell you all the acronyms!)…

iii. Yes, it's possible, just not likely for most people. Most people's **self-perception** of their MI skillset is **inaccurate**

1. Counterintuitively, **self-perception of practicing MI does not align with actual skill-set/practice**.

iv. "This MI method is nothing new. I do this every day." **This is a common reaction** among practitioners who are presented with a description of MI for the first time. You may have recognized explanations and even recalled recent consultations characterized by some of the principles described…" (Rollnick Miller, & Butler, 2008)

v. From GP's to Nurses to other healthcare practitioners, **many think they provide MI, with them being surprised that there's much more** to it than they originally thought
1. For research study quotes and citations for these claims, click here

F. Mistaken as Basic & Easy: Confusion from Diffusion

(clicker here to return to where you just came from **above**)

Isn't it just a basic counseling "technique?"

ii. The strongest research on MI says no in that **counseling approach that cannot be performed naturally** by most people without fidelity training that includes feedback of them practicing MI, particularly in "real-world" settings with actual clients/patients

iii. If there's no measurement of skill, particularly with a validated MI fidelity tool, it's unlikely the intervention of MI, and its subsequent outcome enhancement, is not actually occurring in the interaction

1. See citations and quotations of more detail on this by clicking this text here

i. **Why would there be so much confusion** if there are so many studies saying it takes personalized feedback & coaching?
1. Click here to see why there's confusion from diffusion

G. Well-meaning Harm & Frustration Possible

(clicker here to return to where you just came from **above**)

If I'm being nice & kind to my patients, and really keeping in mind what's in their best-interest, **does this level of quality assurance really matter?**

i. **IF you want to** align with the essence of the Hippocratic Oath of "**First Do No Harm**," then it matters much.
ii. Click here for reasons why, and the supporting research

H. Fits Within Busy Working Environments—Long or Short Interactions

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How does it fit with what we do already?

- "How do you take MI, developed by psychologists for counseling, and use it in your everyday practice? Your time is often short, and we are asking you to absorb not just technical matters but also a different way of thinking about promoting change in others. MI can seem both comfortingly familiar and difficult to integrate. Is it **something completely different** from what you do normally? Our answer is **no**." (Rollnick, Miller, & Butler, 2008).

- **Yes, MI fits into many types of work settings** from clinical to public health and many more. More importantly to the connotation of this question, it also has been **shown to improve outcomes while being integrated** into that setting.

- "**MI is a useful communication method for healthcare providers** to incorporate into routine clinical care **because there is a limited amount of time** to help move patients toward behavior change." (Simmons & Wolever, 2013)

    i. What about it helping with **stress, burnout**, and **job satisfaction** improvements?

        - "It might help to train staff in **MI to improve clinician satisfaction, team cohesion, perceived skills, and patient satisfaction**."

        - "Clinicians in the intervention clinics reported **improvements in burnout scores, self-rated MI skills, and perceived cohesion** whereas clinicians in the **control clinic reported worse scores**. **Patient satisfaction improved in the intervention clinics** more than in the control clinics."

            - Paul Nagy, John Bigger, Alicia Bilheimer, Pauline Lyna, Xiaomei Gao, Michael Lancaster, R. Chip Watkins, Fred Johnson, Sanjay Batish, Joseph A. Skelton, Sarah Armstrong. (2016). Effect of teaching motivational interviewing via communication coaching on clinician and patient satisfaction in primary care and pediatric obesity-focused offices *Patient Education and Counseling*, 99 (2) , pp. 300-303

        - "If the results can be replicated, this would further support MI-based health coaching as an effective health promotion intervention, and health status could serve well as a proxy in the absence of other clinical or cost indices. Perhaps **of greatest interest is the mechanism by which MI influences mental health status and should be the emphasis in future studies."**

            - Butterworth, Susan; Linden, Ariel; McClay, Wende; Leo, Michael C. Effect of motivational interviewing-based health coaching on employees' physical and mental health status. Journal of Occupational Health Psychology, Vol 11(4), Oct 2006, 358-365. http://dx.doi.org/10.1037/1076-8998.11.4.358

        - **Improved job satisfaction and less burn out** (Liv-Ran & Nitzan, 2011; Rollnick, Miller & Butler 2008)

            - Liv-Ran S, Nitzan U. Motivational Interviewing in Health Care. Harefuah. 2011 Sep;150(9):733-6, 749.

- Rollnick S, Miller WR, Butler C. Motivational Interviewing in Health Care: Helping Patients Change Behavior. New York: Guilford Press;. 2008

- For references and quotes from research to further clarify this, as well as limitations found in neutral outcome studies with MI, and practitioner stress/burnout/job satisfaction outcomes with MI, click here

- Since MI is patient-centered, **can I give the patient information, advice, or my opinion?**
  - Yes, with informed choice/awareness that the helpfulness of this information differs depending on when & how the information is conveyed, along with the mindset/intention you are coming from
    - For example:
      - **Fixing & "getting them to…" vs. discovering** their thoughts/knowledge/experience, and/or **guiding their efforts to be more effective** in getting them what they want when they appear they would be interested in it (**commonly asking permission/if it would be helpful**)—awareness of being a dictator vs. a consultant, respectively
    - Doing it to "fix" or "correct" someone tends to result in "yeah, but…" or other such responses that make the case against change, which can be predictive of no improvement in outcomes with such MI-inconsistent behavior, and could lead to worse outcomes than if the patient didn't talk about the potential change at all (see how in Section G of Well-meaning Harm & Frustration)

      1. "…the more a client verbalizes arguments against change (sustain talk), the less likely change is to occur (Miller, Benefield and Tonigan, 1993; Moyers et al., 2009)." (Miller & Rose 2015)

      ii. Doing it from a place of highlighting their motives/values/change talk, with the **when** (timing)
        1. e.g. after engagement, after strong change talk and high importance or confidence of the issue, or emphasis of their choice/control…

      iii. **and how**
        1. e.g. based on strong change talk, values, priorities in patient's life, etc…

      iv. can result in improving outcomes/helpfulness
        a. "Evidence for the causal role of change talk includes the **association between the amount and trajectory of client change talk expressed within session and subsequent behavioral outcomes** (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Gaume et al., 2013; Gaume, McCambridge, Bertholet, & Daeppen, 2014; Magill et al., 2014; Vader, Walters, Prabhu, Houck, & Field, 2010) as well as studies demonstrating that specific therapist behaviors (and training activities) can facilitate expression of CT (Barnett et al., 2014;

Carcone et al., 2013; Gaume et al., 2014; Glynn & Moyers, 2010; Magill et al., 2014; Moyers et al., 2009)."

- Resnicow & Mcmaster explain a succinct yet significant contrast below that could be utilized for sharing all kinds of information (including something as intensive as a Lifestyle Medicine program)
    - "In standard medical and health counseling practice, practitioners often provide information about the risks of continuing a behavior or the benefits of change with the intent of persuading the client. A traditional counseling statement might be, "It is very important that you change." In this style of highly directive counseling or unsolicited advice, the practitioner often attempts to instill motivation by increasing the client's perceived risk. This type of communication can elicit reactance, or push back from the client[56,57]…
    - In contrast, in MI information is presented using an ELICIT-PROIVDE-ELICIT framework. The counselor first elicits the person's understanding and need for information, then provides new information in a neutral manner, followed by eliciting what this information might mean for client, using a question such as, "What does this mean to you" or "How do you make sense of all this?" MI practitioners avoid trying to persuade clients with "pre-digested" health messages and instead allow clients to process information and find what is personally relevant for them. Autonomy is supported by also asking how much information the client might desire." (Resnicow & McMaster, 2012)

I. MI is Not a Panacea. Simultaneously the Majority of Studies Do Not Implement Quality Assurance with Fidelity Measurement/Feedback

(clicker here to return to where you just came from **above**)

I heard some studies haven't been consistent, what's that about?

- **Question of the intervention ACTUALLY being MI** is a widespread issue

i. McKenzie et al., 2015 clearly illustrates how this is a widespread issue in their Table 5…(click here to view this table)

1. **The Majority** (66% (2/3) out of the 12) **of systematic reviews of MI in health care**, which included meta-analyses…
    a. …**have the Minority** (less than 50%) **of their studies providing treatment fidelity** information.
    b. **Only 4 of the 12 studies (33%) have the majority of studies reporting fidelity**, and, of those studies that have at least 50%, the percentage of studies don't go far beyond 50% (55-64%), except for one study that had 71% reporting fidelity. (McKenzie et al., 2015)
2. "Further research may benefit from a **greater focus on clinician proficiency**, and a greater emphasis on the effectiveness of MI when

delivered by a range of clinicians. **Future research also needs to include treatment fidelity measures** [37] to ensure the intervention being studied is indeed MI." (McKenzie et al., 2015)

3. If you have heard that studies on MI have been inconsistent, then you have likely come across one of these many reviews or studies that does not take into account the fidelity implementation of MI

    a. However, there are of course a multitude of other factors that could exist, including MI not being effective in that study—even with a fidelity measure. Further clarity on this and other aspects of limitations within MI research & practice can be found by clicking here

J. Fidelity MI Training Aligns with Best-Practices in Adult Training

(clicker here to return to where you just came from **above**)

Why does it take so much training when it seems so basic and overhyped?

- It can most definitely feel this way given the relatively small percentage of training (12% according to a 2012 NIH study) that implements evidence-based interventions with fidelity, in hopes that these trainings will clinically improve outcomes like those found in the research, even though a lack of fidelity makes it unlikely—sufficing rather maximizing potential of the evidence-based intervention.
- Similarly, your **sense or relativity from going through other trainings could amplify the sense of how much training it takes** to learn MI, as evidenced by the lack training with fidelity in the majority of training (see "Health Coaching Conundrum & Need for Fidelity as a Whole" in section A.)
- "The MI research is well-aligned with the research and best practices in the field of learning and organization development, including the **American Society of Training and Development (ASTD)**, that emphasize the limitations of legacy stand-alone training programs that do not provide sufficient attention to competency development and assessment, transfer of new learning to the job, and **return on investment (ROI) of training costs**[8]."(Butterworth & Andersen, 2011)

K. Is it worth it for you, your organization, or your patients to:

- Be truly patient-centered—not facilitating patient self-harm via your communication intervention
- Improve job satisfaction & decrease burnout
- Have integrity in providing the best-practice intervention in the world for facilitating sustainable behavior?

(clicker here to return to where you just came from **above**)

- If yes, then you can feel free to let me know how best I can serve you in guiding you to where you want to be with patient-centered care and/or MI by emailing me at john.gilbert@ifioc.com
- If not at this time, then know that you can still feel free to be in touch with me whenever you come across MI again and/or would like some clarity or guidance with MI/patient-centered care in any way.

The Opportunity From Here!...

- To **operationalize and embody patient-centered** care that:
  - Engages,
  - Empowers, &
  - Activates patients
    - in aligning their behaviors with their values (who, why, and how they want to be), while **everyone benefits in the outcomes of this fidelity enacted intention** by:
      - improving provider & patient satisfaction (less stress & burnout),
      - sustainability of the planet from increased healthy eating & efficiency,
      - & decreased financial and human suffering.

If you are interested or would find it helpful, I look forward to serving you to achieve this shared vision together!

Sincerely,

John Gilbert, MS, RD, RHC-III, ACSM-CEP®

IFIOC The Institute for Individual And Organizational Change

Research Citations

A. Health Coaching Conundrum

(clicker here to return to where you just came from above)

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B: **(click here to return to section that brought you here from above)**

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C: (clicker here to return to where you just came from **above**)

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- Olsen JM, Nesbitt BJ. Health Coaching to Improve Healthy Lifestyle Behaviors: An Integrative Review. American Journal of Health Promotion 2010;25(1):e1-e12.
- Wolever RQ, Simmons LA, Sforzo GA, et al. A Systematic Review of the Literature on Health and Wellness Coaching: Defining a Key Behavioral intervention in Healthcare. Globl Adv Health Med 2013;2(4):38-57.
- Barnett, E., Moyers, T. B., Sussman, S., Smith, C., Rohrbach, L. A., Sun, P., & Spruijt-Metz, D. (2014). From counselor skill to decreased marijuana use: Does change talk matter? *Journal of Substance Abuse Treatment, 46*(4), 498-505. doi:10.1016/j.jsat.2013.11.004
- Moyers TB, Martin T, Houck J, Christopher P, Tonigan J. From in-session behaviors to drinking outcomes: a causal chain for motivational interviewing. J Consult Clin Psychol 77:1113–1124, 2009
- Miller, W. R., Benefield, R. G. & Tonigan, J. S. (1993) Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. Journal of Consulting and Clinical Psychology, 61, 455–461.
- Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. Br J Gen Pract 2005;55(513):305-12.

- MCKENZIE, Kylie J.; PIERCE, David; GUNN, Jane M.. A systematic review of motivational interviewing in healthcare: the potential of motivational interviewing to address the lifestyle factors relevant to multimorbidity. Journal of Comorbidity, [S.l.], v. 5, n. 1, p. 162-174, dec. 2015. ISSN 2235-042X. Available at: <http://jcomorbidity.com/index.php/test/article/view/55>. Date accessed: 16 oct. 2016. doi:http://dx.doi.org/10.15256/joc.2015.5.55.

D: (click here to return to section that brought you here from above)

"Motivational Interviewing is **complementary to and may even be synergistic with other treatment approaches**."

- Hettema, J., Steele, J., & Miller, W. R.. (2005). Motivational interviewing. Annual Review of Clinical Psychology, 1, 91-111.

"**Clinicians can use MI before, after or during other treatments** (Anstiss 2009, Bien & Miller 1993, Noonan & Moyers 1997)."

- Giada Pietrabissa, Angela Sorgente, Gianluca Castelnuovo, Integrating Motivational Interviewing with Brief Strategic Therapy for Heart Patients, Procedia - Social and Behavioral Sciences, Volume 165, 2015, Pages 136-143, ISSN 1877-0428, http://dx.doi.org/10.1016/j.sbspro.2014.12.615.
    - Anstiss, T. Motivational interviewing in primary care. Journal of clinical psychology in medical settings, 16 (2009), pp. 87–93
    - T.H. Bien, W.R. Miller, J.S. Tonigan Brief interventions for alcohol problems: a review Addiction, 88 (1993), pp. 315–335
    - W.C. Noonan, T.B. Moyers. Motivational interviewing. Journal of Substance Misuse, 2 (1997), pp. 8–16

"Unexpectedly, the specific effect size was larger (Burke et al., 2003) and more enduring (Hettema et al., 2005) when **MI was added to another active treatment**, a somewhat counterintuitive finding in that one might expect larger effects when the competition is no treatment at all. This suggests a **synergistic effect of MI with other treatment methods**."

- Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *The American psychologist*. 2009;64(6):527-537. doi:10.1037/a0016830.
    - Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. Journal of Consulting and Clinical Psychology. 2003;71:843–861.
    - Hettema, J., Steele, J., & Miller, W. R.. (2005). Motivational interviewing. Annual Review of Clinical Psychology, 1, 91-111.

"While we concur with Miller and Rollnick **[MI co-founders]** that importance and confidence are critical to behavior change, we have found that:

1. the interaction between building rapport and addressing the patient's judgments of importance and confidence is more than additive16; it is **synergistic**, and

2. **this synergy literally "energizes" the possibility of change."**

    - Berger BA, Villaume WA. A New Conceptualization and Approach to Learning and Teaching Motivational Interviewing. Inov Pharm. 2016;7(1): Article 3.http://pubs.lib.umn.edu/innovations/vol7/iss1/3
        - 16. Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *The American psychologist*. 2009;64(6):527-537. doi:10.1037/a0016830.

"For substance abuse and health behaviors, reviews have supported the **use of MI in combination with other treatments for enhanced engagement and outcomes** (e.g., Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010)."

- Henny A. Westra, Michael J. Constantino, Martin M. Antony. Integrating Motivational Interviewing With Cognitive-Behavioral Therapy for Severe Generalized Anxiety Disorder: An Allegiance-Controlled Randomized Clinical Trial.. *Journal of Consulting and Clinical Psychology*, 2016; DOI: 10.1037/ccp0000098
  - Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. Research on Social Work Practice, 20,137–160. http://dx.doi.org/10.1177/1049731509347850

"Although the articles included in the series as well as other research (Westra et al., 2009) support the idea that **MI and CBT provide a synergistic effect on client outcomes."**

- Westra, H. A. (2004). Managing resistance in cognitive behavioural therapy: The application of motivational interviewing in mixed anxiety and depression. Cognitive Behaviour Therapy, 33 (4), 161–175

"The findings of the current study and that of Kertes et al. offer preliminary process research consistent with the theoretical notion of **a synergistic effect when practicing with MI and CBT.** "

- Melanie M. Iarussi and Cynthia J. Osborn. Counselors' Experiences Using Motivational Interviewing and Cognitive Behavior Therapy. Journal of Counselor Leadership and Advocacy Vol. 1 , Iss. 1,2014

The **integration of MI and CBST provides maximum flexibility to meet the individualized needs** of clients[38] and has been shown to be effective in previous substance use interventions.[39,40]

- Parsons JT, Golub SA, Rosof E, Holder C. Motivational Interviewing and Cognitive-Behavioral Intervention to Improve HIV Medication Adherence Among Hazardous Drinkers: A Randomized Controlled Trial. *Journal of acquired immune deficiency syndromes (1999)*. 2007;46(4):443-450.

"…**MI pretreatment results in increased active engagement in subsequent therapy**."

- Angela Kertes, Henny A. Westra, Lynne Angus, Madalyn Marcus, The Impact of Motivational Interviewing on Client Experiences of Cognitive Behavioral Therapy for Generalized Anxiety Disorder, Cognitive and Behavioral Practice, Volume 18, Issue 1, February 2011, Pages 55-69, ISSN 1077-7229, http://dx.doi.org/10.1016/j.cbpra.2009.06.005.

"…our main hypotheses were generally supported through findings that **adding MI to CBT, compared to no pretreatment prior to CBT, was associated with significantly greater worry reduction and improved engagement in CBT in terms of increased therapist-rated homework compliance** over the course of CBT."

- Westra HA, Arkowitz H, Dozois DJA. Adding a Motivational Interviewing Pretreatment to Cognitive Behavioral Therapy for Generalized Anxiety Disorder: A Preliminary Randomized Controlled Trial. *Journal of anxiety disorders*. 2009;23(8):1106-1117. doi:10.1016/j.janxdis.2009.07.014.

Others research articles supporting the synergy and/or complimentary nature of MI with another evidence-based practice—all being different from those listed/quoted above:

1. Westra HA, Dozois DJA. Preparing clients for cognitive behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. Cognitive Therapy and Research. 2006;30:481–498.
2. Simmons LA, Wolever RQ. Integrative Health Coaching and Motivational Interviewing: Synergistic Approaches to Behavior Change in Healthcare. Global Advances in Health and Medicine. 2013;2(4):28-35. doi:10.7453/gahmj.2013.037
3. Angela Kertes, Henny A. Westra, Lynne Angus, Madalyn Marcus, The Impact of Motivational Interviewing on Client Experiences of Cognitive Behavioral Therapy for Generalized Anxiety Disorder, Cognitive and Behavioral Practice, Volume 18, Issue 1, February 2011, Pages 55-69, ISSN 1077-7229, http://dx.doi.org/10.1016/j.cbpra.2009.06.005.
4. Bricker, J. and Tollison, S. (2011) 'Comparison of Motivational Interviewing with Acceptance and Commitment Therapy: A Conceptual and Clinical Review', *Behavioural and Cognitive Psychotherapy*, 39(5), pp. 541–559. doi: 10.1017/S1352465810000901.
5. Osborn, C.J. Bilingual Therapeutics: Integrating the Complementary Perspectives and Practices of Motivational Interviewing and Dialectical Behavior Therapy. J Contemp Psychother (2011) 41: 81. doi:10.1007/s10879-010-9162-0
6. Stephanie Jean Sohl, Gurjeet Birdee, & Roy Elam. Complementary Tools to Empower and Sustain Behavior Change: Motivational Interviewing and Mindfulness *American Journal of Lifestyle Medicine 1559827615571524, first published on February 18, 2015 doi:10.1177/1559827615571524*
7. Spahn, Joanne M. et al. State of the Evidence Regarding Behavior Change Theories and Strategies in Nutrition Counseling to Facilitate Health and Food Behavior Change. Journal of the American Dietetic Association , Volume 110 , Issue 6 , 879 – 891

E: (click here to return to section that brought you here from above)

- Rollnick, S., Miller, W. R., & Butler, C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York: Guilford Press.

- "A **single workshop** or training by webinar, video or books is **insufficient to change one's skill set**."[1,2]

- "Instead, proficiency [in MI] typically requires an immersion experience, such as a two-day worship first, followed by regular practice **with feedback coaching over time"**[3]

- "Self-assessed proficiency in MI is **statistically unrelated to actual proficiency in MI** as measured via a standardized, validated tools"[3]

- "In short, the **workshop convinced clinicians that they had acquired MI skillfulness, but their actual practice did not change enough to make any difference to their clients** (Miller & Mount, 2000)." [4]

- "A practical challenge in training clinicians in MI, then, is to help them persist in behavior change past an initial **workshop exposure that may erroneously convince them that they have already learned the method…"**[4]

- "Clinicians' **self-reported proficiency in delivering MI has been found to be unrelated to actual practice proficiency ratings** by skilled coders (Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez & Pirritano, 2004), and it is the latter ratings that predict treatment outcome."[4]
- "**GP ratings of performance did not predict these outcomes**.[5] This suggests that simulations can help predict professionals' motivational interviewing skills, but **practitioner self-report methods may not be the best measure of success**."[6]

1. Miller WR, Yahne CE, Moyers TB, Martinez J, Pirritano M. A Randomized Trial of Methods to Help Clinicians Learn Motivational Interviewing. J Consult Clin Psych 2004;72(6):1050-1062.
2. Madson MB, Loignon AC, Lane C. Training in motivational interviewing: A systematic review. J Subst Abuse Treat 2009;36:101-109.
3. Butterworth S, Anderson B. Health Coaching Performance Assessment: A New Tool for Benchmarking & Improving Effectiveness. HealthSciences Institute Publication. 2011.
4. William WR, Rose GS. Towards a Theory of Motivational Interviewing. Am Psychol. 2009 Sep; 64(6): 527–537. doi:10.1037/a0016830
5. Gerner B, Sanci L, Cahill H, Ukoumunne OC, Gold L, Rogers L, McCallum Z, Wake M. Using simulated patients to develop doctors' skills in facilitating behaviour change: addressing childhood obesity. Med Educ 2010;44(7):706-15.
6. Research Scan: Training Professionals in Motivational Interviewing. Nov. 2011. The Health Foundation. P. 1-37.

- "In evaluating a motivational conversation, it is clearly insufficient to wait outside the dance hall and ask Partner 2 how well they danced together. **For a host or reasons, people are not particularly reliable reports of their own skillfulness in MI**. There are things they miss in the busyness of the process. For people who are not depressed, there is a natural human tendency to overestimate their own performance. **Whether to judge the quality of the dance, to offer some helpful pointers, or just enjoy the dance itself, it is necessary to observe. There is no substitute for seeing (or at least hearing) what actually transpired in a conversation**. Such observation is also the only way to tell others (as in a clinical or scientific report) what actually transpired."

  - Miller, W. M., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press. P. 389, ISBN 978-1609182274

- "Although all participating **health professionals attended four-hour training sessions, differences were seen in implementation of the MI sessions."**

- "Although health professionals take an interest in having a motivational conversation, the "fix the disease" model persists."

- "Our analysis suggests that when a health professional encounters individuals with low motivation for change, this increases the complexity of the intervention and several interactional dilemmas may occur that make it difficult to follow basic MI principles."

- "Although health professionals take an active interest in having a collaborative relationship, they resolve the dilemmas of interaction from a biomedical perspective."

- "…two very different types of practice: patient-centered vs. problem-centered (i.e., the professional uses resources oriented toward resolving the problem, a familiar clinical interaction for the person with a health concern)."
  - Codern-Bové N, Pujol-Ribera E, Pla M, et al. Motivational interviewing interactions and the primary health care challenges presented by smokers with low motivation to stop smoking: a conversation analysis. BMC Public Health. 2014;14:1225. doi:10.1186/1471-2458-14-1225.

F: (click here to return to section that brought you here from above)

- "…**MI is not a trick or a technique that is easily learned and mastered**. It involves the conscious and disciplined use of specific communication principles and strategies to evoke the person's own motivations for change." (Miller & Rollnick, 2009)
  - Miller, W.R. & Rollnick, S. (2009) Ten things that Motivational Interviewing is Not Behavioural and Cognitive Psychotherapy, 2009, 37, 129-140.

- "An unfortunate consequence of such rapid dissemination is that misunderstanding of this method easily arise, and the quality of service delivery can suffer. **In some ways MI is simple, but mastering it is neither quick nor easy.** We have likened the process to that of learning to play a musical instrument or a skillful sport. Reading and lectures can take you a certain distance, but **ultimately it is practice that shapes and improves skill in MI. As in music or sport, it helps to receive good feedback and coaching** along the way."
  - Rosengren, D. B. (2009). *Building motivational interviewing skills: A practitioner workbook*. New York: Guilford Press. P. ix.

- "Apodaca and Longabaugh (2009) concluded that **MI is reliably differentiated from** minimal/placebo control conditions, **treatment-as-usual**, and other active treatment conditions such as cognitive-behavior therapy, in rates of both MI-consistent and MI-inconsistent therapist responses." (William & Rose, 2009)
  - William WR, Rose GS. Towards a Theory of Motivational Interviewing. Am Psychol. 2009 Sep; 64(6): 527–537. doi:10.1037/a0016830

Nutritionist is to Dietitian as Self-assessed MI is to Actually Competent MI (& associated outcomes)

- "…**anyone can claim to be practicing or teaching MI without accountability**."
  - Miller, W. M., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press. P. 389, ISBN 978-1609182274

Why would there be so much confusion if there are so many studies saying it takes personalized feedback & coaching?
Confusion from Diffusion
(click here to go back to section that brought you here from above)

> "When a complex method disseminates as widely and rapidly as has happened with MI, it is **not surprising that its boundaries become unclear**. With the diffusion of any complex innovation (Rogers, 2003) there is a natural process of "reinvention" whereby **practitioners adapt the innovation to their own understanding and style**. Some such modifications may improve the innovation or render it more accessible for a particular population (Miller, Villanueva, Tonigan and Cuzmar, 2007). It is also possible that reinvention removes some critical elements of the innovation, "active

ingredients" in its efficacy. It is therefore **important to understand what the essential elements are, and what components can be altered without disrupting the defining nature of a method.** Good progress is being made in understanding what makes MI work (Amrhein, Miller, Yahne, Palmer and Fulcher, 2003; Moyers, Miller and Hendrickson, 2005), but clearly there is still a long way to go.

It also sometimes happens that an innovation is altered so fundamentally that it no longer resembles, or is even contradictory to its pristine form."

- Miller, W.R. & Rollnick, S. (2009) Ten things that Motivational Interviewing is Not Behavioural and Cognitive Psychotherapy, 2009, 37, 129-140.

G: **…does this level of quality assurance really matter?**
(click here to return to section that brought you here from above)

- By taking a nice, kind, and/or well-meaning approach that is still **measurably not patient-centered, nor MI, the practitioner can be DOING HARM to the patients they are trying to help**.
    - As Dr. Susan Butterworth **POWERFULLY** points out,
        1. Practitioner can evoke discord [e.g. blame, irritation with you, very passive or disengaged, etc…] or counter-change talk from the patient [e.g. **Yeah but…, complain, excuse, reasons against change**] (Moyers & Martin, 2006)
        2. Higher patient discord increases confrontational behaviors in practitioner (Francis, Rollnick, McCmbridge et al., 2005)…[**including well-intentioned fixing, unsolicited advice, "yeah, but**…" convincing tactics, etc…]
        3. Practitioner pushes against perceived resistance, [**even in well-meaning approach]**, amplifying resistance/discord (Hetman, Steele & Miller, 2005)
        4. Discord predicts poor clinical outcome (Miller & Rollnick, 2002)

Moyers TB, Martin T. Therapist influence on client language during motivational interviewing sessions: Support for a potential causal mechanism. J Subst Abuse Treat 2006:30:245-251.

Francis, N., Rollnick, S., McCambridge, J., Butler, C., Lane, C. & Hood, K. (2005) When smokers are resistant to change: experimental analysis of the effect of patient resistance on practitioner behaviour. *Addiction*, 100 (8), 1175–1182.

Hettema J, Steele J, Miller WR. Motivational interviewing. Annu Rev Clin Psychol 2005;1:91-111.

W. R. Miller & S. Rollnick (2002). Motivational interviewing and the stages of change. *Motivational interviewing: Preparing people to change* (2nd ed., pp. 201–216). New York, NY: Guilford Press.
Resnicow, K., Gobat, N., Naar, S. Intensifying and igniting change talk in motivational interviewing: A theoretical and practical framework. The European Health Psychologist. 2015;17:102–110.

The more conscientious reason:

- Resnicow and others (2010) show that
  - "In standard medical and health counseling practice, practitioners often provide information about the risks of continuing a behavior or the benefits of change with the intent of persuading the client. A traditional counseling statement might be, "It is very important that you change." In **this style of** highly directive counseling or **unsolicited advice, the practitioner often attempts to instill motivation** by increasing the client's perceived risk. **This type of communication can elicit reactance, or push back from the client**[56, 57]."

5. Resnicow K, McMaster F. Motivational Interviewing: moving from why to how with autonomy support. *The International Journal of Behavioral Nutrition and Physical Activity*. 2012;9:19. doi:10.1186/1479-5868-9-19.

- Fruit and Vegetable consumption is affected by this (Pirlott et al., 2012)
  - "**MI-consistent counselor behaviors predicted an increase** in total positive client **change talk**, and in turn, total positive client **change talk increased fruit and vegetable consumption**."
    - Pirlott AG, Kisbu-Sakarya Y, DeFrancesco CA, Elliot DL, MacKinnon DP. Mechanisms of motivational interviewing in health promotion: a Bayesian mediation analysis. *The International Journal of Behavioral Nutrition and Physical Activity*. 2012;9:69. doi:10.1186/1479-5868-9-69.

- "The role of change talk is consistent with self-perception theory [36], which suggests that individuals more strongly endorse and may act on attitudes they hear themselves say rather than what others are advising them."
  - Pirlott AG, Kisbu-Sakarya Y, DeFrancesco CA, Elliot DL, MacKinnon DP. Mechanisms of motivational interviewing in health promotion: a Bayesian mediation analysis. *The International Journal of Behavioral Nutrition and Physical Activity*. 2012;9:69. doi:10.1186/1479-5868-9-69.

- We as humans become more convinced of what we hear ourselves commit to out load (Bem, 1967) and, as evidenced by the research showing if we make the case against change (sustain talk), **we will likely continue these (potentially unhealthy and damaging—albeit slowly in chronic illness) behaviors**, whereas if we hear ourselves make the case for change (change talk), we have a higher likelihood of changing.
  - Bem DJ. 1967. Self-perception: an alternative interpretation of cognitive dissonance phenomena. Psychol. Rev. 74:183–200
  - Bem, D. J., Self-Perception Theory. In L. Berkowitz (ed). Advances in Experimental Social Psychology, Vol 6, 1972.

- "Evidence for the causal role of change talk includes the association between the **amount and trajectory of client change talk expressed within session and subsequent behavioral outcomes** (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Gaume et al., 2013; Gaume, McCambridge, Bertholet, & Daeppen, 2014; Magill et al., 2014; Vader, Walters, Prabhu, Houck, & Field, 2010) as well as **studies demonstrating that specific therapist behaviors (and training activities) can**

facilitate expression of CT (Barnett et al., 2014; Carcone et al., 2013; Gaume et al., 2014; Glynn & Moyers, 2010; Magill et al., 2014; Moyers et al., 2009)."

- Resnicow K, McMaster F. Motivational Interviewing: moving from why to how with autonomy support. *Int J Behav Nutr Phys Act*.. 2012; 9: . Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330017/

The more basic reasoning:

- "From the **ethical minimum of "First, do no harm,"** it is reasonable to screen for and teach accurate empathy…regardless of theoretical orientation." (Moyers & Miller, 2013).
    1. Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors, 27,* 878 – 884. doi:10.1037/a0030274

- *"MI-inconsistent behaviors* consisted of summing the following utterance categories: confront, advise without permission, direct, raise concern without permission, and warn [44]."
    - Pirlott AG, Kisbu-Sakarya Y, DeFrancesco CA, Elliot DL, MacKinnon DP. Mechanisms of motivational interviewing in health promotion: a Bayesian mediation analysis. *The International Journal of Behavioral Nutrition and Physical Activity*. 2012;9:69. doi:10.1186/1479-5868-9-69.

- "**Confronting clients** can evoke reactance and shut them down[2]."
    1. Resnicow K, McMaster F. Motivational Interviewing: moving from why to how with autonomy support. *Int J Behav Nutr Phys Act*.. 2012; 9: . Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330017/
        - 2. Miller W: Motivational interviewing with problem drinkers. Behavioural Psychotherapy. 1983, 11: 147-172. 10.1017/S0141347300006583.

H: How does MI fit with what we do already?
(click here to return to section that brought you here from above)

- Rollnick, S., Miller, W. R., & Butler, C. (2008). Motivational interviewing in health care: Helping patients change behavior. New York: Guilford Press.
- Simmons, L. A., & Wolever, R. Q. (2013). Integrative Health Coaching and Motivational interviewing: Synergistic Approaches to Behavior Change in Healthcare. *Global Advances in Health and Medicine*, *2*(4), 28–35. http://doi.org/10.7453/gahmj.2013.037
- Miller, W.R. and Rose, G.S. (2015) 'Motivational Interviewing and Decisional Balance: Contrasting Responses to Client Ambivalence', Behavioural and Cognitive Psychotherapy, 43(2), pp. 129–141. doi: 10.1017/S1352465813000878.
- Resnicow, K., Gobat, N., Naar, S. Intensifying and igniting change talk in motivational interviewing: A theoretical and practical framework. The European Health Psychologist. 2015;17:102–110.
- Resnicow K, McMaster F. Motivational Interviewing: moving from why to how with autonomy support. *Int J Behav Nutr Phys Act.*. 2012; 9: . Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330017/

- "Large effects from brief motivational counseling have **held up across a wide variety of real-life clinical settings**." (Center for Substance Abuse Treatment, 1991)

- "…we can implement motivational interviewing interventions that are tailored to specific patient needs, and **can be adapted to accommodate time limitations in different clinic settings**." (Apodaca et al., 2014)

    - Apodaca TR, Tsai SL, Miller MK, Maddux MH, Kennedy D, Trowbridge K. Implementing Motivational Interviewing in a Pediatric Hospital. *Missouri medicine*. 2014;111(3):212-216.

- "Motivational interviewing is a highly effective technique for **gathering accurate and comprehensive information** that is supportive of and additive to the assessment phase of the case management process. Using motivational interviewing, **case managers can more readily uncover health and lifestyle needs of their clients**." (Tahan et al., 2012)

    - Tahan HA, Sminkey PV. Motivational Interviewing: Building Rapport With Clients to Encourage Desirable Behavioral and Lifestyle Changes. Professional case management. 2012;17(4):164-172.Sdf

- "The central implication of our findings is that **MI can profitably be delivered by a range of professionals** with a minimum investment of time in medical care settings in a variety of formats and time frames **for patients of different ages, genders, and ethnicities**. (Lundahl et al., 2013)"

    - Lundahl B, Moleni T, Burke BL, Butters R, Tollefson D, Butler C, Rollnick S. Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. Patient Education and Counseling 2013; 93(2): 157-168.

- "[MI's] efficacy has been demonstrated in numerous **randomized trials across a range of conditions and settings** [5, 6, 7, 8]. Over the past 15 years, there have been

considerable efforts to adapt and test MI across various chronic disease behaviors [7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21].

  - Resnicow, K., & McMaster, F. (2012). Motivational Interviewing: moving from why to how with autonomy support. *The International Journal of Behavioral Nutrition and Physical Activity*, *9*, 19. http://doi.org/10.1186/1479-5868-9-19

- "…individuals from many professional disciplines including, but not limited to, nurses, dieticians, physicans, councelors, social workers, psychologists, additction professionals, probation officers, clergy, battered women's advocates, and laypeaple have saught to learn MI so they can be instrumental in helping others make positive changes in their lives (Madson, Loignon, & Lane, 2009; Soderlund, Madson, Rubak, & Nilsen, 2011). The good news is that although individuals from different professional backgrounds may encounter unique challenges in trying to learn MI (Schumacher, Madson, & Nilsen, 2014) there is evidence that individuals from a variety of backgrounds and professions can achieve equal outcomes when delivering MI (Barwick, Bennett, Johnson, McGowan, 7 Moore, 2012; Lundahl et al., 2010)."
  - Schumacher, J. A., & Madson, M. B. (2015). Fundamentals of motivational interviewing: Tips and strategies for addressing common clinical challenges. P. 5
- For those of you who have come across studies that **don't show** a change in stress, burnout, or patient or practitioner satisfaction, many (if not the majority), have many limitations such those listed directly below that are typically listed in the discussion section of such studies:
  - "This study has several limitations. First, **a control group was not used**…
  - short follow-up period **does not allow us to determine whether any training gains will be maintained over time** or whether such gains have an effect on patient outcomes such as satisfaction, use of care, and/or treatment…
  - unable to collect data on providers' actual behavior over the course of the training. Thus, we are **unable establish the validity** of the written vignettes as an indicator of actual behavior change. This step is critical to determine if such a strategy is to be used as a proxy for measuring actual behavior change adherence…
  - Additionally, and **similar to the limitations of studies listed throughout this guide, here are more common limitations** of such studies…
    - There are several reasons for not observing significant differences after the training. First of all, it is **possible that professionals could overestimate their empathy**…
    - "…this has not been proved in our study, possibly due to the satisfactory baseline scores on such features. There are several studies that point out that basic workshops do not produce sufficient competence in MI and that **it takes much more practice in real-life situations (rather than role-playing).** This implies that trainees may need longer-term continuing supervision and support than previously recognized [31]."
    - …we have not included specific measures to assess the professionals' real performance when facing patients and how they integrate the MI skills into their daily practice…

- Coaching and reviewing sessions were not demanded for all professionals and, as some research has demonstrated, postworkshop inputs such as feedback and coaching assessing performance after training are usually needed to sustain training gains over time [32]."
    1. Pilar Lusilla-Palacios and Carmina Castellano-Tejedor, "Training a Spinal Cord Injury Rehabilitation Team in Motivational Interviewing," Rehabilitation Research and Practice, vol. 2015, Article ID 358151, 7 pages, 2015. doi:10.1155/2015/358151

I. I've heard **some studies haven't been consistent, what's that about?** (click here to return to section that brought you here from above)

- McKenzie, Kylie J.; Pierce, David; Gunn, Jane M.. A systematic review of motivational interviewing in healthcare: the potential of motivational interviewing to address the lifestyle factors relevant to multimorbidity. Journal of Comorbidity, [S.l.], v. 5, n. 1, p. 162-174, dec. 2015. ISSN 2235-042X. Available at: <http://jcomorbidity.com/index.php/test/article/view/55>. Date accessed: 16 oct. 2016. doi:http://dx.doi.org/10.15256/joc.2015.5.55.

- "**What could be causing such variability in both the outcome of the treatment itself** and the way it is offered? We argue that this variability is **best explained by the presence of one or more unknown active ingredients within MI**, which are employed inconsistently by therapists and researchers." (Moyers et al., 2009)
    - Moyers, T. B., Martin, T., Houck, J. M., Christopher, P. J., & Tonigan, J. S. (2009). From in-session behaviors to drinking outcomes: A causal chain for motivational interviewing. Journal of Consulting and Clinical Psychology, 77(6), 1113–1124. http://doi.org/10.1037/a0017189

- "As discussed earlier, there have been a number of published trials finding no effect of MI. In some of these there was **no measurement of fidelity** in treatment delivery. In others, the published **quality assurance measures indicated a low level** of clinician skill (or at least conscientiousness) in delivering MI. Often the **pretrial training of MI providers has been too brief to expect proficiency.** It is unsurprising that "MI" would be ineffective when delivered with low fidelity.
- There have also been trials, **however, where training and fidelity monitoring were done very well, and yet no effect of MI was found**. As discussed in Chapter 19, such a study conducted by Miller et al. (2003) yielded no trace of efficacy, and we concluded from retrospective process analyses (see Box 19.1) that **we had been too restrictive in the therapist manual that was used**, preventing the therapist from responding appropriately to client reluctance."
    - Miller, W. M., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press. P. 382, ISBN 978-1609182274

- Another potential source of variation in the efficacy of MI is the **nature of the treated sample**…Clients who enter treatment ready for change might not be expected to benefit from MI (or at least from the evoking process) since their ambivalence appears already to have been resolved."

- “Did the efficacy of MI thus somehow disappear? There is indeed an old medical aphorism to “use new treatments while they still work,” reflecting the nonspecific effect of enthusiasm when any novel treatment is introduced. One would then discontinue use of the no-longer-effective treatment and move on to a new “flavor of the month.” While there is a kernel of truth in this aphorism, science progress in a more cumulative way. MI has been found to be effective in many randomized clinical trials conducted by enough different investigators working various nations and with very different problems to indicate that **something significant is happening**. The variability in its efficacy across therapists, sites, and studies tells us that **we do not yet sufficiently understand what is happening to produce this change when it occurs**.”
    - Miller, W. M., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press. P. 383, ISBN 978-1609182274