



## Editor's Note On

# TIP 35, *Motivation for Change in Substance Abuse Treatment*

**2017**

Published in 1999, Treatment Improvement Protocol (TIP) 35 offers guidance to addiction treatment providers on using the motivational interviewing (MI) therapeutic approach, along with the stages-of-change model of behavior change, in substance use treatment. The Consensus Panel was not reconvened to review and update the information in TIP 35. However, a literature search on the use of MI in substance use treatment covering 2013 to mid-2017 was conducted, and its results inform the discussion below.

Although the underlying concepts of the stages-of-change model (also known as the *transtheoretical model of change*) remain much the same as described in TIP 35,<sup>1</sup> MI theory and practice have significantly evolved. The TIP relied on the concepts in Miller and Rollnick's 1991 foundational text—*Motivational Interviewing: Preparing People to Change Addictive Behavior*.<sup>2</sup> This book has since been revised twice and has expanded beyond its original focus on addiction treatment. This Editor's Note revisits the MI aspect of TIP 35 with the most current (2013) edition of Miller and Rollnick's text in mind. (The third/current edition, *Motivational Interviewing: Helping People Change*,<sup>3</sup> is referred to as “the Third Edition” when discussed below.) Some recent research on MI in addiction treatment is also discussed.

## Clinical Updates

### *The Processes of MI*

TIP 35 describes five general principles of MI: (1) express empathy through reflective listening, (2) develop discrepancy between clients' goals or values and their current behavior, (3) avoid argument and direct confrontation, (4) adjust to client resistance rather than oppose it directly, and (5) support self-efficacy and optimism.

The Third Edition instead uses four processes as the basis of the MI approach: (1) engaging, (2) focusing, (3) evoking, and (4) planning.<sup>3</sup> These processes are discussed below.

**Engaging**, as defined in the Third Edition, is “the process of establishing a mutually trusting and respectful relationship.”<sup>4</sup> Important elements of engaging include interacting with a new client before beginning an assessment or intake procedures, listening as well as asking questions, and not rushing to identify the primary focus of the counseling sessions.



The Third Edition defines **focusing** as “an ongoing process of seeking and maintaining direction.”<sup>5</sup> Two core strategies are agenda mapping and the elicit–provide–elicit approach to information exchange. In agenda mapping, the counselor and the client pause their conversation to select which of several possible topics to explore. In the elicit–provide–elicit approach, the counselor first asks the client questions or seeks permission to convey information, then provides advice or information, and finally elicits the client’s response to the advice or information given.

**Evoking** “involves eliciting the client’s own motivations for change.”<sup>6</sup> At the heart of evoking is increasing the amount of client *change talk* (called *self-motivational statements* in TIP 35) relative to the amount of *sustain talk* (similar to TIP 35’s *countermotivational assertions*), as change talk is considered a precursor to behavior change.

The **planning** process is defined as being with the client “while he or she forms a change plan that will work.”<sup>7</sup> Counselors should avoid starting this process before the client is ready.

## ***Selected Other Changes to MI***

The Third Edition emphasizes incorporating the spirit of MI in clinical practice. The four key elements of the spirit of MI are partnership, acceptance, compassion, and evocation. For an introduction to these elements, see the [Spirit of MI](#) section of the Indiana Prevention Resource Center’s *Introduction to Motivational Interviewing* online course.<sup>8</sup>

In describing the types of reflective listening statements that evoke change talk, the Third Edition distinguishes between *simple* and *complex* reflections. Simple reflections repeat or slightly reword what the client said and help the client feel heard and understood. However, if overused, simple reflections reinforce sustain talk instead of evoking change talk. In a complex reflection, the clinician makes a hypothesis about the client’s unexpressed meaning or feeling and reflects that back to the client. Complex reflections can help clients get in touch with their values, build discrepancy between those values and health risk behaviors, and reinforce behaviors in alignment with what is important to the clients. (See also the 2011 study on the effect of MI fidelity in the Research Updates section below.)

TIP 35 describes *decisional balancing*, in which the client lists and explores the pros and cons of a change goal, as an important element of MI. The Third Edition instead reserves decisional balancing for when a clinician wants to counsel with neutrality instead of influencing the client to move toward a specific change. (See also the 2017 study on decisional balancing in the Research Updates section below.)

In TIP 35, the term *resistance* denotes client statements or behaviors favoring the status quo. The Third Edition discards the concept of resistance, in part because the authors believe it is pathologizing. Instead, the Third Edition recognizes sustain talk as a normal expression of ambivalence about change and introduces the term *discord* to describe tension in the clinician–client relationship.

The Third Edition explicitly warns clinicians against the *righting reflex*, the impulse to “fix” clients by telling them what they should do. Such a directive style is likely to produce sustain talk and discord, according to the authors.

Since TIP 35’s publication, additional tools have been developed to evaluate MI treatment fidelity. The most frequently used is the Motivational Interviewing Treatment Integrity coding system, which has been found helpful in clinical as well as research settings.<sup>9</sup> The Third Edition emphasizes the importance of training and quality assurance in ensuring that MI coding instruments are used accurately.

Since publication of TIP 35, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has been revised twice. The American Psychiatric Association has published several useful [fact sheets](#)<sup>10</sup> that explain changes in the current version, DSM-5.<sup>11</sup>

## Research Updates

MI for substance use has been extensively studied, and while there have been many positive MI trials, there have also been an “impressive number” of negative trials, according to Miller and Rollnick themselves.<sup>12</sup> Studies have looked at the effectiveness of MI for treating different types of substance use disorders<sup>13</sup> or co-occurring mental and substance use disorders. Other studies on MI for substance use have considered MI’s effectiveness with different populations, settings, provider types, or delivery modes as variables.<sup>14</sup> Researchers have also been examining specific processes and elements of MI—and counselors’ adherence to them and skill in deploying them—to understand whether or how these “ingredients” affect outcomes.<sup>15</sup> Below is a sampling of more recent studies (some studies used MI interventions based on the second edition of Miller and Rollnick’s work).

A 2011 study of the **effect of MI fidelity on cannabis cessation** among adolescents with at least weekly cannabis use found that counselors’ adherence to the spirit of MI and the proportion of complex to simple reflections were each statistically significant predictors of whether participants reported cannabis cessation 3 months after a one-session intervention.<sup>16</sup>

In a small 2013 study comparing the effects of a **culturally adapted version of MI** (CAMI) with standard MI for Latino heavy drinkers, participants in both groups at follow-up reported fewer days of heavy drinking and fewer negative consequences of impulsive drinking, such as driving under the influence of alcohol.<sup>17</sup> However, the CAMI participants showed greater reductions at 2-month follow-up and continuing reductions at 6-month follow-up compared with the standard MI participants.

The authors of a 2014 meta-analysis of **MI’s key causal model** (“that proficient use of the techniques of MI will increase clients’ in-session change talk and decrease their sustain talk, which in turn will predict behavior change”<sup>18</sup>) found a small but significant positive effect for change talk when one outlier study was disregarded.<sup>19</sup> The authors also found that more in-session sustain talk was associated with worse outcomes, leading them to ask whether sustain talk should be avoided or whether MI research has not yet clarified the difference between explored and resolved client ambivalence toward change. Most of the primary studies included in this meta-analysis looked at MI for alcohol or drug use.

A 2015 meta-analysis of MI for **smoking cessation** found that MI interventions compared with brief advice or usual care produced a modest but significant increase in quitting.<sup>20</sup> Interventions carried out by general practitioners appeared to be more effective than those carried out by counselors or nurses.

In a 2015 study of MI to reduce substance use among **adolescents with a substance use disorder in inpatient psychiatric treatment**, versus treatment as usual, participants who received two MI sessions waited longer before using any substance following discharge than did the treatment as usual group.<sup>21</sup> The MI group also reported fewer days of any substance use during the first 6 months postdischarge, largely because of decreased marijuana use. However, this effect did not last beyond 6 months postdischarge, leading the study authors to suggest research into booster sessions, greater family involvement, or use of technology such as text messaging.

A paper from 2015 reported that a 2014 study of a manualized intensive nine-session version of MI (IMI) for people with **methamphetamine dependence** had the unexpected finding that women with **co-occurring alcohol problems** in the IMI group reported reduced alcohol use at 4- and 6-month follow-up, but men in the IMI group with co-occurring alcohol problems did not.<sup>22</sup> This effect was also not found with women and men in the other study arm, who received a single session of standard MI. The authors attributed the gender difference in the IMI outcomes to the stronger therapeutic alliances formed by the female IMI participants. The paper noted that both treatment groups showed reduced methamphetamine use during treatment and at 6-month follow-up, with no differences in use between the IMI and standard MI groups.

One finding of a 2016 study involving a single brief MI session for **hazardous drinking** among nontreatment-seeking Swiss young men was that the intervention was counterproductive when conducted with participants with lower alcohol severity and by therapists with less MI experience.<sup>23</sup> This result led the authors to conclude that “attention should be paid to therapist selection and/or training and supervision until they reach a certain level of MI competency.”<sup>24</sup>

A 2016 study looked at the efficacy of three MI sessions versus receipt of educational literature in reducing **hazardous drinking and drug use among adults in outpatient depression treatment**.<sup>25</sup> The study found MI more effective than the literature intervention in reducing marijuana and alcohol use (the two substances most commonly used by participants) at 6-month follow-up, although the effect was small. Depression improved for both groups.

A 2017 study on the use of **decisional balancing** as the only component of an MI session with college tobacco smokers not intending to quit, versus health education on smoking, found that MI participants reported more pros of smoking posttreatment, while the health education participants reported fewer pros posttreatment.<sup>26</sup> The authors concluded that “the decisional balance exercise as formulated by earlier versions of MI may be counter-productive.”<sup>27</sup>

## Resources

Some tools and resources recommended in TIP 35 have been updated with newer content, replaced by other resources, or moved to new web addresses. Several of the most pertinent changes are listed below.

TIP 35 Resource	Current Resource(s)
Alcohol Use Disorders Identification Test (AUDIT)	AUDIT (US) in <a href="#">Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use</a>
Brief Situational Confidence Questionnaire (BSCQ)	The BSCQ and related materials are available on Nova Southeastern University’s <a href="#">Guided Self-Change forms webpage</a>
Readiness To Change Questionnaire (Treatment Version)	<a href="#">Revised Readiness To Change Questionnaire [Treatment Version]</a>
University of Rhode Island Change Assessment Scale (URICA)	<a href="#">URICA: Psychotherapy Version</a> (alcohol and drug versions of the URICA are available on the <a href="#">HABITS Lab</a> website at the University of Maryland, Baltimore County)

## Additional Resources

Potentially useful resources not listed in TIP 35 or mentioned above include the following:

CASAA (Center on Alcoholism, Substance Abuse, and Addictions)—[Coding Instruments](#) (webpage with downloadable coding instruments for assessing counselor proficiency in MI)

<https://casaa.unm.edu/codinginst.html>

CASAA—[Motivational Interviewing and Therapist Manuals](#) (webpage with downloadable manuals)

<https://casaa.unm.edu/mimanuals.html>

[Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency \(MIA-STEP\)](#)

[www.motivationalinterviewing.org/sites/default/files/mia-step.pdf](http://www.motivationalinterviewing.org/sites/default/files/mia-step.pdf)

[Motivational Interviewing Network of Trainers](#) (webpage that includes links to publications, MI assessment and coding resources, and training resources and events)

[www.motivationalinterviewing.org](http://www.motivationalinterviewing.org)

## Notes

- 1 Connors, G. J., DiClemente, C. C., Velasquez, M. M., & Donovan, D. M. (2013). *Substance abuse treatment and the stages of change: Selecting and planning interventions* (2nd ed.). New York, NY: Guilford Press.
- 2 Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
- 3 Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.
- 4 Ibid., 40.
- 5 Ibid., 94.
- 6 Ibid., 28.
- 7 Ibid., 268.
- 8 Indiana Prevention Resource Center. (n.d.). Spirit of MI [Section of online course]. Retrieved August 21, 2017, from [http://iprc.iu.edu/training/courses/intro-to-MI/a\\_02\\_01\\_01.html](http://iprc.iu.edu/training/courses/intro-to-MI/a_02_01_01.html)
- 9 Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The Motivational Interviewing Treatment Integrity Code (MITI 4): Rationale, preliminary reliability, and validity. *Journal of Substance Abuse Treatment*, 65, 36–42.
- 10 American Psychiatric Association. (2013). DSM-5 fact sheets [Webpage]. Retrieved August 18, 2017, from [www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets](http://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets)
- 11 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- 12 Miller, W. R., & Rollnick, S. (2012). Meeting in the middle: Motivational interviewing and self-determination theory. *International Journal of Behavioral Nutrition and Physical Activity*, 9, 1–2. doi:10.1186/1479-5868-9-25
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- 15 Magill, M., Stout, R. L., & Apodaca, T. R. (2013). Therapist focus on ambivalence and commitment: A longitudinal analysis of Motivational Interviewing treatment ingredients. *Psychology of Addictive Behaviors*, 27(3), 754–762.
- 16 McCambridge, J., Day, M., Thomas, B. A., & Strang, J. (2011). Fidelity to Motivational Interviewing and subsequent cannabis cessation among adolescents. *Addictive Behaviors*, 36, 749–754.
- 17 Lee, C. S., López, S. R., Colby, S. M., Rohsenow, D., Hernández, L., Borrelli, B., & Caetano R. (2013). Culturally adapted motivational interviewing for Latino heavy drinkers: Results from a randomized clinical trial. *Journal of Ethnicity in Substance Abuse*, 12(4), 356–373.
- 18 Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing (p. 529). *American Psychologist*, 64, 527–537.

- 19 Magill, M., Gaume, J., Apodaca, T. R., Walthers, J., Mastroleo, N. R., Borsari, B., & Longabugh, R. (2014). The technical hypothesis of motivational interviewing: A meta-analysis of MI's key causal model. *Journal of Consulting and Clinical Psychology, 82*(6), 973–983.
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- 24 Ibid., 216.
- 25 Satre, D. D., Leibowitz, A., Sterling, S. A., Lu, Y., Travis, A., & Weisner, C. (2016). A randomized clinical trial of Motivational Interviewing to reduce alcohol and drug use among patients with depression. *Journal of Consulting and Clinical Psychology, 84*(7), 571–579.
- 26 Krigel, S. W., Grobe, J. E., Goggin, K., Harris, K. J., Moreno, J. L., & Catley, D. (2017). Motivational interviewing and the decisional balance procedure for cessation induction in smokers not intending to quit. *Addictive Behaviors, 64*, 171–178.
- 27 Ibid., 172.

This publication lists nonfederal resources to provide additional information to consumers. The content and views in these resources have not been formally approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). Listing of these resources does not constitute an endorsement by SAMHSA or HHS.