Research on MI

What does it tell us?

as of the 4th edition
The facts are always friendly, every bit of evidence one can acquire, in any area, leads one that much closer to what is true.

- Carl Rogers
The size of the literature

- >2,000 controlled trials involving MI
- >200 meta-analyses and systematic research reviews
- >11,000 new citations per year now (Google Search)
- >173,000 total citations (Google Search)
Effectiveness of MI

- With over 2,000 controlled trials, MI is an evidence-based treatment
- Average effect size is in small-to-medium range in meta-analyses
- Wide variability in the efficacy of MI across studies, sites, and therapists
- About ¼ of controlled trials report no significant effect of MI
- Most meta-analyses report a significant average effect of MI
- When measured, the quality of MI that was provided accounts for some of the variability in outcomes
- Adding MI to another evidence-based treatment often improves client outcomes
- When directly compared with other active interventions of greater intensity or duration, MI often yields similar outcomes
For whom does MI work (or not)?

- **Differential indications (particularly helpful for):**
  - Lower motivation for change
  - Higher anger/resistance

- **Contraindications (potentially harmful):**
  - Clients who are already motivated/ready for change
  - This appears to be a mismatch of MI tasks: prolonged *evoking* with high-readiness clients is unnecessary and may deter change
  - Better to proceed more quickly to *planning*
  - Respond to apparent in-session readiness
There are both relational and technical components of MI

Fidelity/quality of MI can be reliably measured

The technical aspects include attending to, evoking, and strengthening change talk while softening sustain talk and discord

Sometimes *sustain talk* predicts worse outcome more than *change talk* predicts better outcome

The *ratio* of change talk to sustain talk is a preferable predictor
Both change talk and sustain talk (and their ratio)
In correlational, sequential, and experimental research
Client change/sustain talk in turn predicts outcome
Process Research: *In-Session* Predictors of Better Client Outcomes

**COUNSELORS WHO HAVE:**
- More MI-consistent responses
- Fewer MI-inconsistent responses
- Higher MI-spirit scores; warm empathic style
- Maintained focus toward clear goal
- >1 MI session or longer sessions

**CLIENTS WHO HAVE:**
- Lower sustain talk and discord
- Higher change talk/sustain talk ratio
- Discrepancy or cognitive dissonance
- Greater self-efficacy for change

*Note that these are in-session, not pretreatment predictors of outcome*
Stronger evidence of efficacy with

- Reducing alcohol and cannabis use and problems
- Smoking cessation (tobacco)
- Chronic disease management:
  - medication adherence, dietary change, weight loss, increased physical activity, promoting health screening
  - improving oral health care in adults and in children via parents
- Promoting treatment adherence and self-care in:
  - asthma, cancer, chronic pain, diabetes, heart disease, hypertension
Psychosocial applications of MI

- Modest evidence for impact of MI in managing:
  - anxiety disorders, depression, severe mental disorders
- In school settings:
  - addressing student behavior problems
  - improving academic performance
- Early applications in:
  - facilitating return to work and occupational performance
  - social work practice and child welfare work
MI Across Cultures

- MI is being taught and practiced in at least 70 languages
- Positive controlled trials reported from nations on six continents
- In U.S. studies, MI has been *at least* as effective with disadvantaged “minority” populations if not moreso*
- Logically, MI is a good approach for working with people different from you because clients are the experts on themselves
- Cultural *humility* is consistent with MI spirit
- People *from* a culture will know best how to adapt MI there

Training Research Summary

- Little or no effect from just reading about MI or watching videos
- MI training normally yields medium to large short-term skill gains
- Practice behavior change often fades quickly without follow-up
- Feedback and coaching based on observed practice significantly increase acquisition and maintenance of MI skill
- False confidence is common: self-report ≠ observed competence
- High variability in time to proficiency: train to criterion
- Pre-training skill in accurate empathy facilitates learning MI
Move beyond:
- “Does MI work?” studies at $p<.05$
- “Horserace” studies of MI vs. other evidence-based treatments

When, why, and for whom is MI beneficial when delivered, how well, and by whom or what?
- Document the fidelity of MI that was provided
- Train providers to criterion proficiency *before* trial begins
Recommendations for future MI research

- Additive studies of potential augmentations
  - e.g., affirmation, assessment feedback, autonomy support, supportive significant others, values exploration
  - Combining MI with other treatments as a “pre-load” preparation or as a therapeutic factors clinical style in delivering other treatments

- Subtractive studies
  - Remove certain “ingredients” of MI
  - Use MI as a “common factors” control for other treatments

- Study processes/outcomes of individual and group MI
- Study “thin slice” and AI coding of MI fidelity