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A randomized controlled trial to influence client language in substance use disorder treatment

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ABSTRACT

Background: Client language is hypothesized to be a mechanism of action in motivational interviewing (MI). Despite the association of change and sustain talk with substance treatment outcomes, it not known whether providers can intentionally influence this language as hypothesized.
Objective: This is a randomized controlled trial to investigate whether substance use providers can be trained to influence client language.
Methods: Treatment providers specializing in substance use disorders ($n = 190$) were randomly assigned to standard training in MI (MI-AU) or training emphasizing an influence of client language (MI-LEAF). Treatment sessions with actual clients were evaluated 3, 6 and 12 months after training by masked raters. Frequencies of client change and sustain talk were the outcome variables.
Results: Sustain talk, but not change talk, was significantly lower in clients whose providers had received the specialized training ($b = -0.175$, $SE = 0.087$, $p=0.046$, CI[-0.348 to 0.002], $d = -0.325$). Mediation analyses supported a causal chain between a) training, b) providers' attempts to minimize sustain talk in treatment sessions via directive reflective listening and c) client sustain talk in the treatment session ($\kappa^2 = 0.0833$, bootstrap $SE = 0.0394$, 95% CI [0.0148, 0.1691]).
Conclusions: With specialized training, providers can reduce the amount of opposition language their clients offer when considering a change in their substance use. Demonstrating that client language is under partial control of the provider supports the feasibility of clinical trials to investigate the impact of shaping client language on treatment outcomes.

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1. Introduction

Motivational Interviewing (MI) is a psychotherapeutic method commonly used for helping clients resolve ambivalence about changing problem behaviors. Although MI now stands upon a substantial evidence base for improving various client outcomes such as smoking, controlling blood sugar levels and hazardous use of substances (Heckman et al., 2010; Lundahl et al., 2013), concerns have been raised about uneven effect sizes and puzzling variability in clinical trials of MI (Miller and Moyers, 2015a). As with other psychosocial interventions, MI lacks definitive experimental support for specific causal mechanisms, leaving open the possibility that the lack of reliability in client outcomes is caused by including extraneous procedures or omitting critical processes entirely.

Hypothesized causal mechanisms have been identified for MI. A seminal paper by Miller and Rose (2009) describes both a relational and a technical component as active ingredients of the method. Although emphasis on the therapeutic relationship is similar to other client-centered approaches, the technical component is unique to MI. It focuses on the counselor's ability to attend contingently to the client's language about a particular behavior change and shape it toward greater strength and frequency during the therapeutic interaction, while fading attention to language supporting the status quo. This attention to client language is commonly referred to as valuing "change talk" (CT) during MI sessions while strategically overlooking "sustain talk" (ST) and is concep-

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tualized as a method to enhance self-persuasion (Aronson, 1999). Put simply, it is hypothesized that clients are more likely to accept and believe arguments for changing problem behaviors when they themselves are offering them, as opposed to hearing them from an external source. A robust body of social psychological literature indicates that verbally advocating for a course of action ("I should change my drinking") that is incompatible with a personal belief ("my drinking is not a problem") generally leads to a change in the belief in the direction of the verbal statements, a phenomenon known as "counterattitudinal advocacy" (Aronson, 1999). Relevant to the area of substance abuse and other behavior problems, self-persuasion is most likely to occur when a person's actions violate their view of themselves as being honorable or having moral integrity (Leippe and Eisenstadt, 2010; Nel et al., 1969). Cultivating change talk within MI, then, can be seen as a way of facilitating self-persuasion in favor of change and would be especially likely to occur when problematic behaviors violate a person's deeply held beliefs about himself.

Apart from theoretical explanations, there is strong empirical support for the association between the language clients offer in sessions and their subsequent likelihood of change (Romano and Peters, 2015). Multiple studies have shown that change talk in MI sessions is predictive of changing problem behaviors and conversely that sustain talk predicts poorer outcomes (Magill et al., 2014). Other analyses have highlighted the relationship between sustain talk and poorer outcomes, particularly in adolescent and conscripted populations (Gaume et al., 2016). Of course, such language could simply be a marker of some other process, such that clients who are already motivated to make a change discuss that possibility during treatment sessions whereas clients who are less motivated do the reverse. In this way, change and sustain talk could be indicators of some underlying process but not contribute to it, in much the same way that smoke indicates a fire, but does not cause it. This is the peril of correlational research, which has characterized the findings for this causal mechanism to date.

The understanding of client language during MI sessions, and particularly whether it might be a causal mechanism of the treatment, cannot advance further at this point without experimental manipulations of client language. In particular, if client language is actually a causal element in MI, then it should be malleable to counselors influence, whereas if it is simply an epiphenomenal indicator of some other client characteristic (such as motivation), it should not necessarily respond to attempts to shape it. Only one published study (Glynn and Moyers, 2010) has attempted to manipulate client language during MI sessions, using an ABAB design in which counselors switched counseling styles every 12 min during treatment sessions. During segments when counselors were intentionally attempting to influence client change talk it reliably increased, only to decrease during segments when the counselors shifted to a more neutral assessment of the client's drinking.

Although experimental manipulation of change and sustain talk represents the next logical step in investigating this causal mechanism, it must first be demonstrated that counselors can learn to do this. This is a complex challenge for many counselors since it requires: 1) knowledge of the importance of client language, 2) recognition of change talk and sustain talk in real time, 3) selectively responding and 4) proactively and strategically evoking change talk and softening sustain talk, in real-time, while also managing other therapeutic tasks (e.g., maintaining rapport). It is not immediately apparent that frontline treatment providers, including substance abuse counselors, can acquire and execute this skill set or how much training would be required to do so. Previous studies investigating the ability of counselors to learn MI indicate that skill acquisition is closely tied to baseline counseling skills and that counselors are highly variable in their response to MI training (de Roten et al., 2013; Hall et al., 2015; Moyers et al., 2008). Caution is warranted since a non-trivial minority of counselors do not seem to improve in their learning of MI even when they are offered intensive training, feedback, and coaching (Miller et al., 2004).

The current study is a randomized controlled trial intended to investigate the impact of specialized training on substance use disorder counselor's ability to recognize, evoke, and selectively respond to client change and sustain language during MI treatment sessions. It compares standard MI training (MI-AU) to Language Enhanced Attention and Focus MI training condition (MI-LEAF) to investigate: 1) if tailored training will allow frontline substance use counselors to acquire these skills and 2) whether the differential use of these skills increases change talk and decreases sustain talk of their clients in subsequent treatment sessions. We hypothesized that counselors who received the specialized training would exhibit increased selectiveness in responding to client language, and that this would result in more change talk and less sustain talk from their clients in subsequent treatment sessions compared to counselors receiving standard MI training.

2. Method

Project ELICIT (Evaluating Language in Clinical Interviewing Training) was a randomized, controlled trial to evaluate the impact of specialized counselor training upon the frequency of client change talk during MI treatment sessions for substance use disorders. Two training conditions were compared: 1) MI As Usual (MI-AU) and 2) MI Language Enhanced Attention and Focus (MI-LEAF). The primary outcome measures were the frequency of client change and sustain utterances in treatment sessions conducted by the participant counselors at 3, 6 and 12 months after training.

2.1. Sample and participant selection

All study procedures were approved by the Main-Campus Institutional Review board at University of New Mexico prior to the start of recruitment. Participants for this study were mental health professionals working in publically-funded or non-profit settings, treating primarily substance misuse clients. Advertising for the study was done via study website, professional journals, the Clinical Trials Network newsletter, substance use disorders listservs, and trade publications for substance treatment. Initial screening occurred when potential participants (n = 1658) submitted a questionnaire via the study website. Eligibility criteria included: current employment treating mainly substance abuse clients in a not-for-profit or public setting, fewer than 8 h of previous MI training, current licensure or certification in a behavioral health field, and willingness to travel to New Mexico for training. To avoid cross contamination of training conditions, only one participant per treatment site was permitted to enroll in the study.

Initial phone/internet screening was completed for 1658 substance use treatment providers and 406 were eligible for randomization. Of those eligible, 372 requested application packets and 200 returned completed applications. Ten individuals were eliminated because they moved or changed jobs, or decided not to travel for the training. This resulted in 190 participants who were randomized into study conditions. Participants completed a baseline packet, including a baseline work sample of themselves conducting substance abuse treatment with a client in their work setting. All 190 participants were randomized into a training condition, completed the MI training and provided data for at least one follow up point. Additional details on the characteristics of recruited participants are presented below in the Results and summarized in Table 2.

Clients in the audiotaped work samples were required to be real patients (not role played or standardized patients) with a primary

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