Review Paper

Motivational Interviewing and Clinical Psychiatry

Florence Chanut, MD, FRCPC[1], Thomas G Brown, PhD[2], Maurice Dongier, MD, FRCPC[3]

Objectives: Our objectives were as follows: 1) to survey the literature on motivational interviewing (MI), "a client-centered yet directive method for enhancing intrinsic motivation to change by exploring and resolving client ambivalence" and a well-established method of brief intervention, especially in the field of addictions treatment; 2) to review hypotheses about its mode of action; and 3) to discuss its possible impact on clinical psychiatry, in particular, on teaching communications skills.

Method: Literature reviews and metaanalyses of numerous clinical trials of MI for addictions treatment have already been published and are briefly summarized. So far, no literature survey exists for MI applied to psychiatric patients. This review is limited to a synthesis of the articles relevant to psychiatry and to comments based on our team's experiences with MI.

Results: There is no evidence that MI achieves better results than other established techniques for treating addictions; it may simply work faster. The explanation for the method's rapid effectiveness remains speculative. Outcomes concerning the application of MI to psychiatric patients, although preliminary, are promising. Methods of assessing the integrity of MI treatment are more developed than in most psychotherapies, which permits the learning progress of trainees to be measured.

Conclusions: MI offers a complement to usual psychiatric procedures. It may be worthwhile to teach it, not only for addictions but also for other broad treatment issues, such as enhancing patients' medication compliance and professionals' communication skills. Questions remain concerning MI's feasibility in psychiatry settings.

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Clinical Implications

- MI adaptations can improve treatment adherence and dual disorder outcomes among psychiatric patients.
- MI implies the systematic practice of empathic communication skills. These skills could be improved during psychotherapy training. Existing objective measures can contribute to this improvement.
- As a brief intervention, MI could probably be more easily embedded into psychiatric care than comprehensive integrated treatment for dual disorders, although it cannot yet claim to replace more elaborate programs.

Limitations

- The literature on MI adapted to psychiatric care is relatively sparse and heterogeneous, which limits our recommendations.
- Objective data explaining the specific MI mechanisms and speed of action are currently lacking, which constrains us to hypothetical explanations.
- Rigorous training in MI techniques requires time and follow-up coaching, which could limit its dissemination.

Key Words: *motivation, motivational interviewing, brief intervention, psychotherapy, communication skills, dual disorder, addiction treatment, phenomenology*

Worldwide, motivational interviewing (MI) is a well-established approach to treating addictions. It has been defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving client ambivalence" (1). Ambivalence may prevent some patients from achieving desired changes, even after they seek or are referred to professional treatment. Motivational interviewers make a fundamental effort to match their patients' levels of problem recognition and motivation to change with specific strategies and goals.

Two decades ago, the high dropout rates commonly seen in addictions treatment stimulated William R Miller and Stephen Rollnick to experiment with a brief (up to 4 sessions) preparatory intervention aimed at improving motivation for regular treatment (1). Subsequently, it was shown that brief MI, when provided as a stand-alone treatment, could lead to improvements in drinking outcomes that compared well with those seen in 12-step programs (that is, facilitation of adherence to AA principles and attendance) and in cognitive-behavioural treatment—interventions that are more intensive and longer (2,3). With these results, interest in MI has expanded to include not only treatment of other psychoactive substance use disorders, such as cannabis and cocaine abuse, but also treatment of other health behaviour problems. Of these, medication compliance, diet and exercise, reduction of HIV-risk behaviours, smoking cessation, and eating disorders have to date been the most studied. Notably, preliminary data suggest that dual diagnosis patients show significant improvement when successfully engaged in a treatment program and that MI may improve engagement in this population (4). Given that substance abuse, compliance to medication regimens, and treatment engagement are interrelated and crucial to the management of patients with severe mental illnesses (5), MI may have wide-ranging beneficial effects.

Consideration of MI's role in psychiatry settings seems particularly relevant at this time. Interest in improving communication skills in medicine and psychiatry—an area on which MI places heavy emphasis—is growing, even as the current environment of cost containment makes the feasibility of introducing any new psychotherapeutic approach uncertain. Resolution of this problem is complex, yet many mental health professionals see their patients facing daily substance abuse, motivation, and compliance issues—especially those suffering from mental illnesses, such as schizophrenia, that require long-term treatment adherence. Does MI have a role to play in the overall success of psychiatric treatment?

Abbreviations used in this article

CBT	cognitive-behavioural therapy
MI	motivational interviewing
MISC	Motivational Interviewing Skill Code
MITI	Motivational Interviewing Treatment Integrity
RCT	randomized controlled trial

What is MI?

Four basic principles guide the conduct of MI: 1) expressing empathy, 2) developing discrepancy, 3) supporting self-efficacy, and 4) rolling with resistance (2–4,6). First, empathy, although essential to all psychotherapies, is more specifically defined in MI. In addition to verbal and nonverbal listening skills, it takes the highly valued form of reflective listening, also described by Carl Rogers as accurate empathy (7). Through successive reflections, the therapist attempts to maximize the patient's perception that all efforts are being made to fully understand him or her.

This basic reflective listening skill is also instrumental to developing discrepancy, the second principle of MI. A key hypothesis—that the patient's perspective on the importance of change is fundamental to the patient's readiness to change—concerns this principle and directs therapists during interviews. To develop discrepancy, the therapist makes a concerted effort to increase perceived cognitive dissonance, or discrepancy, between the patient's present behaviour and his or her core values. Reflective listening combined with the aforementioned empathic communication style creates an environment amenable to a full exploration and articulation of these values, which can be then juxtaposed with the patient's current behaviour. Motivational interviewers actively formulate reflections to subtly lead the session toward resolving patient ambivalence and initiating change.

It is also hypothesized that patients' confidence in their ability to achieve the desired change is a key issue. This is the basis of the third principle of MI practice: supporting self-efficacy. Perception of self-efficacy is a reliable predictor of positive outcome from psychotherapy, and here, the directive component of MI significantly departs from pure Rogerian therapy: In addition to supporting the patient's self-efficacy, the therapist shows unwavering optimism regarding the patient's capacity for meaningful change.

According to the last principle, rolling with resistance, the therapist takes care not to directly confront the patient's perception of his or her own problems. Again, reflective listening is used to deal with client resistance and to avoid argument. Unlike many therapeutic approaches, MI views resistance not as a patient characteristic but as a gauge of the health of the collaborative relationship and therapeutic rapport between therapist and patient. Resistance arises when the level of

intervention offered by the therapist is incompatible with the patient's level of problem recognition or stage of change (8,9). A common example of this occurs when the therapist encourages concrete solutions while the patient is still not fully convinced that he or she has a problem or needs to take action. In this case, patient resistance to the suggested change is a signal for the therapist to adjust strategies and perhaps reconsider the patient's degree of problem recognition, prior to providing a solution. In another major strategy for reducing resistance, the clinician avoids explicitly advocating for change and attempts instead to encourage the patient to do this. An individual's verbalization of his or her intent to change is significantly more predictive of change than therapist exhortations alone (6). A repertoire of MI tactics can help patients deepen their exploration of the advantages (and inconveniences) of change in an environment of security, objectivity, and patient–clinician collaboration.

The MI concept of resistance proceeds directly from the MI concept of motivation. MI posits that motivation, in addition to being a modifiable and fluctuating state rather than a permanent trait, depends on the behaviour being considered. For instance, a patient may be highly motivated to take his or her medication but not motivated to quit smoking. Consequently, an indispensable first step is for the therapist to jointly negotiate with the patient a specific behavioural target, among multiple possible targets, that will be the focus of the interview.

The major technical strategies for conducting MI sessions are summarized by the acronym OARS:

- O open questions that lead to active elaboration by patients, rather than closed questions
- A affirmation of patients' self-efficacy and support
- R reflections ranging from simple rephrasing of patients' thoughts to more complex bouquets of patients' desires, abilities, reasons, needs, and commitments
- S summaries, a specific form of complex reflection used intermittently to organize patients' narratives to resolve ambivalence and promote consideration of change

Literature Survey

MI Efficacy Studies

Compelling evidence exists for MI's effectiveness in treating addiction as well as other problem behaviours. In the last 10 years, 3 methodologically exemplary studies (2,10,11) have demonstrated MI's efficacy in the alcohol and drug addiction field. For smoking and HIV-risk behaviours, the 4 available studies (12–15) failed to discern significant effects for MI. A recent metaanalysis investigated MI delivered individually to treat several behavioural problems (16). From a selection of 30 well-controlled clinical trials and conservative data analyses, the authors concluded that MI produced significant beneficial effects in the moderate range (effect size = 0.25 to 0.57) in 3 problem areas: alcohol and drug abuse, diet, and exercise. Moreover, these effects were superior to those observed with either no treatment or placebo and were equivalent to those obtained with other bona fide treatments (16). The same investigators also examined whether MI's therapeutic effects were sustained over time and at what minimum dosages. They found that MI's impact (effect size = 0.13; n = 1519) on outcomes at about 20 weeks posttreatment persisted up to 67 weeks (effect size = 0.11, n = 1479). In certain cases, these effects were observed at 4-year follow-up. The medium effect sizes seen in studies of MI are comparable to those seen with psychotherapies in general, according to the metaanalytic data available (17), but at far smaller dosages (that is, under 100 minutes) than are used in typical psychosocial interventions. Thus, if we can conclude from the above that MI works and works rapidly with addiction clients, what can be said about MI's impact on psychiatric patients with or without substance use disorders?

Studies Involving Psychiatric Patients

No metaanalyses or review articles have been published so far on MI applied to psychiatric patients. In March 2004, we conducted a literature survey wherein we searched the term motivational interviewing in the PubMed and Medline databases, as well as in relevant bibliographies, and then manually selected all English articles related to psychiatric patients. Of the 161 articles retrieved in this way, 30 specifically examined MI efficacy in this population, with all reports published after 1996.

Overall, the literature is sparse and suffers from several methodological shortcomings. The dual diagnosis populations investigated are diverse, comprising inpatients and outpatients, variable therapeutic and organizational environments, substance use disorders involving either abuse or dependence, and case mixes that involve different diagnostic categories. The most common Axis I diagnoses are either schizophrenia or mood disorder. Methodologies also vary greatly among studies, although samples are generally small and follow-up periods limited.

Notwithstanding these limitations, the findings are so far promising. To date, research inquiry can be broken down into 3 specific outcome categories: engagement in inpatient or outpatient treatment, reduction in alcohol or substance misuse, and medication compliance.

Engagement in Treatment

Several trials have found that one session of MI produced increased attendance at psychiatric outpatient care if applied just prior to hospital discharge (18,19). When applied shortly after inpatient admission, MI did not significantly affect

engagement (20). One session of MI before or early in a course of psychotherapy, however, did have a positive impact (21).

Reduction in Alcohol or Drug Misuse

At baseline, most adults with schizophrenia and substance abuse have little motivation to quit (22). Some evidence is emerging that MI may in fact be more effective with patients having the lowest levels of motivation pretreatment but less effective with those in a higher motivational state (15). Compared with simple referral by the medical team to a nonpsychiatric specialized addiction unit, MI in addition to active postdischarge community follow-up could increase the number of patients actually accepting specialist care (23).

Apart from one recent study that found treatment effects with MI in a dual diagnosis population comparable to those found in nonpsychiatric populations (24), all other studies produced positive, but more modest, results (25–27). This finding has led several investigators (25,28,29) to conclude that a longer or more intensive MI format may be necessary to achieve maximum benefits with dual diagnosis patients.

Medication Adherence

Common features of successful interventions to improve medication adherence have been identified through a systematic literature review (30). These include the use of motivational or concrete problem solving techniques that directly target problems of nonadherence. Other authors have advocated for the use of MI to improve medication compliance among patients suffering from psychosis (31–33). One group of investigators has created an adaptation of MI for patients with psychosis, named "compliance therapy," that focuses on treatment adherence (34). Their RCT supported the finding that compliance therapy offered significant advantages in regard to improved functioning and social stability over an 18-month period (35).

Other Research

Combined Approaches for Dual Disorders

Two studies investigated the impact of MI combined with other treatment modalities for dual diagnosis patients. An RCT of routine care for patients with comorbid schizophrenia, alone or combined with MI, CBT, and family intervention, demonstrated the superior effectiveness of combined approaches (36); however, the relative efficacy of the different treatment components was unclear. Another combined treatment protocol targeting the same population achieved similar results (37).

Mechanisms of Action and Delivery Modality

That MI acts to increase readiness to change has been supported in research with schizophrenia patients (38). It has also proved feasible to clinically implement MI in either group or individual format in both inpatient and outpatient psychiatric services for dually diagnosed individuals, although the evidence for the effectiveness of group-delivered MI is so far tentative (39).

Adaptations of MI

Specific modifications have been proposed to adapt MI to a population of substance-abusing patients with psychotic disorders (18,30,33,40–42). In particular, treatment components related to psychiatric care may be necessary additions to the formal MI approach. Moreover, the cognitive deficits and disordered thinking that often accompany psychosis may necessitate adapted strategies, including simplified reflections, repetition, and increased MI duration. At the same time, it has been argued that the nonconfrontational style of MI is more suitable for schizophrenia patients than the confrontational methods favoured in many traditional substance abuse treatments (39).

Summary

The research on MI applied to psychiatric patients has important methodological shortcomings. Nevertheless, it has generally shown positive results, especially increased treatment engagement and adherence, although modifications of MI for this population may be necessary. One remarkable aspect of this literature survey is that it reveals how rapidly significant change can occur, especially in addiction-treatment populations. The rapidity of its apparent action is probably the main reason why MI has garnered so much attention (and, in some circles, scepticism) worldwide. Our focus in the next section turns to a consideration of this distinctive aspect.

Significant and Lasting Changes in a 2-Session Intervention? A Hypothesis

MI includes many of the nonspecific factors common to most psychotherapies (43); however, its rapid action requires explanation. MI attempts to reduce the obstacles to rapid change that are hypothesized to originate from clinician behaviour (6). In part, MI is thought to help suppress what its proponents call the "righting reflex," that is, the tendency to offer a solution based on the therapist's knowledge. Overly eager provision of advice or a prescription for change can increase resistance under certain conditions, especially when clients have poor problem recognition or find the proposed prescription poorly adapted to their needs.

Emphasis on diagnosis can also undermine motivation. Although instrumental to the selection of appropriate treatment or referral, insistence that patients accept a diagnosis (like the insistence on accepting the label "alcoholic" in traditional substance abuse milieus) can sometimes lead to dissension in the therapeutic relationship. Stigma associated with a

psychiatric label and role is a common and important obstacle to a patient's readiness to comply, as is the tacit acceptance of a psychiatric diagnosis implied by active engagement in treatment. Therapists' temporary suspension of diagnostic judgment or differentiation between "normal" and "abnormal" can help circumvent these pitfalls—especially, early in the therapeutic process. In short, during MI, 2 common attitudes of the mental health professional are briefly suspended or bracketed: the expert stance and the diagnostic preoccupation.

There are similarities between Miller's descriptions of MI (44,45) and those of phenomenological and existential psychotherapists (46–49). The competent expert's natural attitude is suspended during the clinical encounter in favour of an intersubjective endeavour to jointly examine a lived experience. Miller has described this as an essential feature of MI; namely, it involves replacing the therapist's attitude of "doing to" with an attitude of "being with." Thus it seems that MI is consistent with Kafka's comment "Prescribing is so easy, understanding people so hard" (50, p 24).

Assessment Methods

Unique to MI are quantitative methods to assess treatment adherence and reliability (see http://casaa.unm.edu/tandc.html). The 2 methods presently available provide global measures to assess adherence to the spirit of MI (for example empathy) as well as specific behaviour counts for such features as open questions and simple reflections. The MISC (51,52) requires transcripts and at least 3 passes of the audiotape reviews by trained coders. Both patient and therapist utterances are coded. A recent study has found its reliability to be acceptable (53).

Moyers and colleagues (54) have derived a simpler coding method from the MISC. The MITI, available in preliminary form, provides structured and formal feedback to improve practice in nonresearch settings and measure the treatment integrity of clinical trials that use MI. Its exclusive focus is therapist utterances. Normally, the MITI requires a single, 20-minute review of audiotapes and no transcripts. Its ease of use, relative to the MISC, promises to enhance its feasible application in nonresearch clinical settings.

Our results from a preliminary investigation of the MITI's interrater reliability suggest that the MITI could provide a viable alternative to the more demanding MISC (55). Moreover, following an introductory workshop in MI techniques, MITI training and MI coaching appeared complementary in terms of trainees' achieving greater autonomy and greater mastery of MI. The direct supervision carried out with taped interviews of real sessions and with attention paid to every therapist utterance may hasten trainees' progress and deepen their mastery of MI's humanistic spirit and communication style. This may be critical to the feasibility of MI. In a rare empirical study on MI training using the MISC as the outcome measure of adherence to MI (56), researchers found that, without continual supervision in MI, no significant effect of initial training persisted beyond 4 months for most trainees.

Possible Impact on Clinical Psychiatry

The MI approach has developed mostly outside the field of psychiatry. However, several pragmatic incentives could make it attractive to mental health professionals, even to those who have little interest in the field of addictions. These include

- an integrated, although contrived, approach to dual diagnoses (whereas complex, expensive programs are likely to remain scarce in spite of their demonstrated superiority) (57)
- a tool to improve treatment adherence when compliance may be problematic
- a rigorous method to improve therapists' communications skills, often taken for granted in psychiatric training (58).

At the organizational level, brief therapies such as MI might help psychiatric teams follow the present health care trend for ambulatory care. The obligation for motivational interviewers to focus on a restricted number of topics during a time-limited sequence of interviews may usefully and efficiently concentrate patient and clinician efforts. Also, the MI interpersonal view of resistance and the therapist's effort to adapt quickly to this view may contribute to a more respectful and collaborative environment within mental health settings.

Given the evidence for MI's effectiveness and suitability in psychiatric settings, it might be tempting to argue that widespread training of psychiatrists in MI is warranted. However, important obstacles may impede the dissemination of MI. In-depth training and a long-term commitment to ensure MI fidelity and quality are time-intensive and require significant resources. Moreover, MI practice implies a paradigm shift that in many ways contradicts the psychiatrist's role as expert, which could impede its ready adoption. Related research underscores the difficulty of transferring other brief intervention techniques for substance misuse into primary care settings outside a research protocol (59–66). The feasibility of specialists' adoption of MI practice is also uncertain. It may be more feasible to coach students or residents-in-training (67–71). Another strategy could be to designate specific members of a mental health team (specialized or not) as MI practitioners. These professionals might be better placed than psychiatrists to suspend the diagnostic approach to psychiatric treatment and expose a larger proportion of psychiatric patients to MI. Strong leadership and modelling by psychiatrists, as well as the organizational will to adopt this treatment technology, are paramount to the success and longevity of any implementation strategy.

Conclusion

Motivation and treatment adherence are key issues in daily psychiatry practice. They are often the cornerstones of patient outcomes, because even the most powerful treatments are ineffectual if patients are not prepared to comply. In treating a population typically grappling with multiple problems, adopting a structured, flexible, stepwise approach that accommodates patient priorities may also be beneficial. MI seems well

suited to address these needs. However, a significant allocation of resources for proper training and a profound paradigm shift in the patient–professional interaction are required for its successful incorporation into practice. Determining MI's ultimate role in psychiatry awaits more research into how it must be adapted to the specific needs of psychiatric patients, together with innovative approaches to its effective dissemination in mental health settings.

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References

1. Miller WR, Rollnick S. Facilitating change. In: Miller WR, Rollnick S. Motivational interviewing: preparing people for change. 2nd ed. New York: Guilford Press; 2002: p 20 –9.
2. Project MATCH Research Group. Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. J Stud Alcohol 1997;58:7–29.
3. Project MATCH Research Group. Matching alcoholism treatment to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research 1998;23:1300 –11.
4. Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, Bond GR. Review of integrated mental health and substance abuse treatment for patients with dual disorders. Schizophr Bull 1998;24:589– 608.
5. RachBeisel J, Scott J, Dixon L. Co-occurring severe mental illness and substance use disorders: a review of recent research. Psychiatr Serv 1999;50:1427–34.
6. Miller WR, Rollnick S. Motivational interviewing: preparing people for change. 2nd ed. New York: Guilford Press; 2002.
7. Rogers CR. Client-centered therapy: its current practice, implications, and theory. Boston (MA): Houghton Mifflin; 1951.
8. Prochaska JO, Diclemente CC. Stages of change in the modification of problem behaviors. Prog Behav Modif 1992;28:183–218.
9. Prochaska JO, Diclemente CC, Norcross JC. In search of how people change. Applications to addictive behaviors. Am Psychol 1992;47:1102–14.
10. Miller WR, Benefield RG, Tonigan JS. Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. J Consult Clin Psychol 1993;61:455–61.
11. Stephens RS, Roffman RA, Curtin L. Comparison of extended versus brief treatments for marijuana use. J Consult Clin Psychol 2000;68:898–908.
12. Baker A, Heather N, Wodak A, Dixon J, Holt P. Evaluation of a cognitive-behavioural intervention for HIV prevention among injecting drug users. AIDS 1993;72:247–56.
13. Baker A, Kochan N, Dixon J, Heather N, Wodak A. Controlled evaluation of a brief intervention for HIV prevention among injecting drug users not in treatment. AIDS Care 1994;6:559–70.
14. Butler CC, Rollnick S, Cohen D, Russel I, Bachmann MSN. Motivational consulting versus brief advice for smokers in general practice: a randomised trial. Br J Gen Pract 1999;49:611–6.
15. Colby SM, Monti PM, Barnett NP, Rohsenow DJ, Weissman K, Spirito A, and others. Brief motivational interviewing in a hospital setting for adolescent smoking: a preliminary study. J Consult Clin Psychol 1998;66:574–8.
16. Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. J Consult Clin Psychol 2003;71:843–61.
17. Lipsey MW, Wilson DB. The efficacy of psychological, educational, and behavioral treatment. Confirmation from meta-analysis. Am Psychol 1993;48:1181–209.
18. Corrigan PW, McCracken SG, Holmes EP. Motivational interviews as goal assessment for persons with psychiatric disability. Community Ment Health J 2001;37:113–22.
19. Swanson AJ, Pantalon MV, Cohen KR. Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. J Nerv Ment Dis 1999;187:630–5.
20. Baker A, Lewin T, Reichler H, Clancy R, Carr V, Garrett R, and others. Motivational interviewing among psychiatric in-patients with substance use disorders. Acta Psychiatr Scand 2002;106:233–40.
21. Walitzer KS, Dermen KH, Connors GJ. Strategies for preparing clients for treatment. A review. Behav Modif 1999;23:129–51.
22. Ziedonis DM, Trudeau K. Motivation to quit using substances among individuals with schizophrenia: implications for a motivation-based treatment model. Schizophr Bull 1997;23:229–38.
23. Wylie K, House A, Storer D, Raistrick D, Henderson M. Deliberate self-harm and substance dependence: the management of patients seen in the general hospital. J Ment Health Adm 1996;23:246–52.
24. Graeber DA, Moyers TB, Griffith G, Guajardo E, Tonigan S. A pilot study comparing motivational interviewing and an educational intervention in patients with schizophrenia and alcohol use disorders. Community Ment Health J 2003;39:189–202.
25. Baker A, Lewin T, Reichler H, Clancy R, Carr V, Garrett R, and others. Evaluation of a motivational interview for substance use within psychiatric in-patient services. Addiction 2002;97:1329–37.
26. Brown RA, Ramsey SE, Strong DR, Myers MG, Kahler CW, Lejuez CW, and others. Effects of motivational interviewing on smoking cessation in adolescents with psychiatric disorders. Tob Control 2003;12 (Suppl 4):IV3–IV10.
27. Hulse GK, Tait RJ. Five-year outcomes of a brief alcohol intervention for adult in-patients with psychiatric disorders. Addiction 2003;98:1061–8.
28. Carey KB, Purnine DM, Maisto SA, Carey MP. Enhancing readiness-to-change substance abuse in persons with schizophrenia. A four-session motivation-based intervention. Behav Modif 2001;25:331–84.
29. Carey KB, Carey MP, Maisto SA, Purnine DM. The feasibility of enhancing psychiatric outpatients' readiness to change their substance use. Psychiatr Serv 2002;53:602–8.
30. Zygmunt A, Olfson M, Boyer CA, Mechanic D. Interventions to improve medication adherence in schizophrenia. Am J Psychiatry 2002;159:1653–64.
31. Coffey M. Psychosis and medication: strategies for improving adherence. Br J Nurs 1999;8:225–30.
32. Gray R, Robson D, Bressington D. Medication management for people with a diagnosis of schizophrenia. Nurs Times 2002;98:38–40.
33. Corrigan PW, Liberman RP, Engel JD. From noncompliance to collaboration in the treatment of schizophrenia. Hosp Community Psychiatry 1990;41:1203–11.
34. Kemp R, Hayward P, Applewhaite G, Everitt B, David A. Compliance therapy in psychotic patients: randomised controlled trial. BMJ 1996;312:345–9.
35. Kemp R, Kirov G, Everitt B, Hayward P, David A. Randomised controlled trial of compliance therapy. 18-month follow-up. Br J Psychiatry 1998;172:413–9.
36. Barrowclough C, Haddock G, Tarrier N, Lewis SW, Moring J, O'Brien R, and others. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. Am J Psychiatry 2001;158:1706–13.
37. Bellack AS, Diclemente CC. Treating substance abuse among patients with schizophrenia. Psychiatr Serv 1999;50:75–80.
38. Pantalon MV, Swanson AJ. Use of the University of Rhode Island Change Assessment to measure motivational readiness to change in psychiatric and dually diagnosed individuals. Psychol Addict Behav 2003;17:91–7.
39. Van Horn DH, Bux DA. A pilot test of motivational interviewing groups for dually diagnosed inpatients. J Subst Abuse Treat 2001;20:191–5.
40. Martino S, Carroll KM, O'Malley SS, Rounsaville BJ. Motivational interviewing with psychiatrically ill substance abusing patients. Am J Addict 2000;9:88–91.
41. Martino S, Carroll K, Kostas D, Perkins J, Rounsaville B. Dual diagnosis motivational interviewing: a modification of motivational interviewing for substance-abusing patients with psychotic disorders. J Subst Abuse Treat 2002;23:297–308.
42. Rusch N, Corrigan PW. Motivational interviewing to improve insight and treatment adherence in schizophrenia. Psychiatr Rehabil J 2002;26(1):23–32.
43. Frank J. Persuasion and healing: a comparative study of psychotherapy. Baltimore (MD): Johns Hopkins University Press; 1961.
44. Miller WR. Toward a theory of motivational interviewing. Motivational Interviewing Newsletter: Updates, Education and Training (MINUET) 1999;6(3),2–4. Available: http://motivationalinterview.org/mint/Mint6_3.PDF. Accessed 2005 June 17.
45. Miller WR. Transcendent moments. Motivational Interviewing Newsletter: Updates, Education and Training (MINUET) 2004;11(1):1–2. Available: http://motivationalinterview.org/mint/MINT11_1.pdf. Accessed 2005 17 June.
46. Binswanger L. Being-in-the-world; selected papers of Ludwig Binswanger. New-York: Basic Books; 1963.
47. Ey H. Consciousness: A phenomenological study on being conscious and becoming conscious. Flodstrom JH, translator. Bloomington (IN): Indiana Univ Press; 1978.
48. Jaspers K. General psychopathology. Chicago (IL): University of Chicago Press; 1963. Republished Baltimore (MD): Johns Hopkins University; 1997.
49. Naudin J, Gros-Azorin C, Mishara A, Wiggins OP, Schwartz MA, Azorin JM. The use of the husserlian reduction as a method of investigation in psychiatry. Journal of Consciousness Studies 1999;6:155–71.
50. Kafka F. A country doctor. The penal colony. Stories and short pieces. New York: Shocker Books; 1917.
51. Miller WR, Moyers T, Ernst D, Amrhein P. Manual for the Motivational Interviewing Skill Code. Version 2.0. Center on Alcoholism, Substance Abuse, And Addictions 2003. Available: http://casaa.unm.edu/download/misc.pdf. Accessed 2005 June 27.
52. Miller WR, Mount KA. A small study of training in motivational interviewing. Does one workshop change clinician and client behavior? Behavioural and Cognitive Psychotherapy 2004;29:457–71.
53. Moyers T, Martin T, Catley D, Harris KJ, Ahluwalia JS. Assessing the integrity of motivational interviewing interventions: reliability of the Motivational

Interviewing Skills Code. Behavioural and Cognitive Psychotherapy 2003;31:177–84.
54. Moyers T, Martin T, Manuel JK, Miller WR. Motivational Interviewing Treatment Integrity (MITI) Code: Version 2.0. Center on Alcoholism, Substance Abuse, And Addictions 2003. Available: http://casaa.unm.edu/download/miti.pdf. Accessed 2005 June 27.
55. Chanut F, Brown TG, Dongier M. A simple tool for the evaluation of the quality of motivational interviewing. Paper presented at the Canadian Psychiatric Association Annual Meeting; 2004 October 14–17; Montreal (QC).
56. Miller WR, Yahne CE, Moyers TB, Martinez J, Pirritano M. A randomized trial of methods to help clinicians learn motivational interviewing. J Consult Clin Psychol.2004;6:1050–62.
57. Mueser KT, Noordsy DL, Drake RE, Fox L. Integrated treatment for dual disorders: a guide to effective practice. New York, London (UK): Guilford Press; 2003.
58. Martin L, Saperson K, Maddigan B. Residency training: challenges and opportunities in preparing trainees for the 21st century. Can J Psychiatry 2003;48:225–31.
59. McCambridge J, Platts S, Whooley D, Strang J. Encouraging GP alcohol intervention: pilot study of change-orientated reflective listening (CORL). Alcohol Alcohol 2004;39:146–9.
60. Rollnick S, Butler CC, Stott N. Helping smokers make decisions: the enhancement of brief intervention for general medical practice. Patient Educ Couns 1997;31:191–203.
61. Strang J, McCambridge J, Platts S, Groves P. Engaging the reluctant GP in care of the opiate misuser: pilot study of change-orientated reflective listening (CORL). Fam Pract 2004;21:150–4.
62. Goodyear-Smith F, Whitehorn M, McCormick R. General practitioners' perceptions of continuing medical education's role in changing behaviour. Educ Health (Abingdon) 2003;16:328–38.
63. Beich A, Gannik D, Malterud K. Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. BMJ 2002;325:870.
64. Kaner EF, Wutzke S, Saunders JB, Powell A, Morawski J, Bouix JC. Impact of alcohol education and training on general practitioners' diagnostic and management skills: findings from a World Health Organization collaborative study. J Stud Alcohol 2001;62:621–7.
65. WHO Brief Intervention Study Group. A cross-national trial of brief interventions with heavy drinkers. Am J Public Health 1996;86:948–55.
66. Ivanets NN, Lukomskaya MI. Evaluation of early intervention strategies used in primary health care: a report on the World Health Organization (WHO) project on Identification and Treatment of Persons with Harmful Alcohol Consumption. Alcohol Alcohol Suppl 1991;1:489–91.
67. Poirier MK, Clark MM, Cerhan JH, Pruthi S, Geda YE, Dale LC. Teaching motivational interviewing to first-year medical students to improve counseling skills in health behavior change. Mayo Clin Proc 2004;79:327–31.
68. Koerber A, Crawford J, O'Connell K. The effects of teaching dental students brief motivational interviewing for smoking-cessation counseling: a pilot study. J Dent Educ 2003;67:439–47.
69. Barsky A, Coleman H. Evaluating skill acquisition in motivational interviewing: the development of an instrument to measure practice skills. J Drug Educ 2001;31(1):69–82.
70. Arthur D. Assessing nursing students' basic communication and interviewing skills: the development and testing of a rating scale. J Adv Nurs 1999;29:658–65.
71. Brown RL, Oriel K. Teaching motivational interviewing to first-year students. Acad Med 1998;73:589–90.

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[1]Fellow in Addiction Psychiatry, Addiction Research Program, Douglas Hospital, McGill University, Montreal, Quebec; Lecturer in Clinical Psychiatry, University of Montreal, Montreal, Quebec.
[2]Director, Addiction Research Program, Douglas Hospital, McGill University, Montreal, Quebec; Assistant Professor, Department of Psychiatry, Douglas Hospital Research Center, McGill University, Montreal, Quebec; Head of Research, Pavillon Foster Addiction Rehabilitation Center, St Philippe de LaPrairie, Quebec.
[3]Professor, Department of Psychiatry, McGill University, Montreal, Quebec.
Address for correspondence: Dr F Chanut, Pavillon Albert-Prévost, Hôpital Sacré-Coeur de Montréal, 6555, Gouin Blvd West, Montreal, QC H4K 1B3
e-mail: f.chanut@videotron.ca

Résumé : La technique d'entrevue motivationnelle et la psychiatrie clinique

Objectifs : Nos objectifs étaient les suivants : 1) recenser la documentation sur l'entrevue motivationnelle (EM), « une méthode axée sur le client tout en étant directive, destinée à stimuler le changement de la motivation intrinsèque en explorant et en résolvant l'ambivalence du client », et une méthode éprouvée d'intervention brève, surtout dans le domaine du traitement des toxicomanies; 2) réviser les hypothèses au sujet de son mode d'action; et 3) discuter de son effet possible sur la psychiatrie clinique, en particulier, sur l'enseignement de l'aptitude à communiquer.

Méthode : Des revues de la documentation et des méta-analyses de nombreux essais cliniques de l'EM pour le traitement des toxicomanies ont déjà été publiées et sont brièvement résumées. Jusqu'ici, il n'existe aucun recensement de la documentation sur l'EM appliquée aux patients psychiatriques. Cette étude se limite à une synthèse des articles pertinents pour la psychiatrie et à des commentaires fondés sur les expériences de notre équipe avec l'EM.

Résultats : Rien ne prouve que l'EM atteint de meilleurs résultats que d'autres techniques établies pour traiter les toxicomanies; elle fonctionne simplement plus rapidement. L'explication de l'efficacité rapide de la méthode demeure spéculative. Les résultats concernant l'application de l'EM aux patients psychiatriques, bien que préliminaires, sont prometteurs. Les méthodes d'évaluation de l'intégrité du traitement par EM sont plus élaborées que dans la plupart des psychothérapies, ce qui permet de mesurer le progrès de la formation des apprenants.

Conclusions : L'EM offre un complément aux procédures psychiatriques habituelles. Il peut valoir la peine de l'enseigner, non seulement pour les toxicomanies, mais aussi pour d'autres enjeux de traitement plus larges, comme améliorer l'observance de la médication par les patients et l'aptitude à communiquer des professionnels. Les questions demeurent sans réponse en ce qui concerne la faisabilité de l'EM en milieu psychiatrique.