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Abstract

Objectives. To explore clients' experience of the therapy process in Motivational Interviewing (MI) for alcohol abuse.

Design. A qualitative study using Grounded Theory.

Methods. Interviews with nine clients were conducted using Interpersonal Process Recall (IPR), a methodology which utlises a video recording as a cue to aid memory recall. Clients watched a videotape of their MI session and were asked to identify and describe important moments in the therapy session. The transcribed interviews were then analysed using Grounded Theory.

Results. A single session of MI is seen by the clients in this study as a complex interpersonal interaction between client and therapist, which impacts on the client's cognitive and affective intrapersonal processes.

Conclusions. The themes which emerged partly confirm processes of motivational interviewing previously hypothesised to be important, but also highlight the importance of factors common to all therapeutic approaches.

Practitioner points

- The aspects of therapy which clients in this study felt were important are similar to those hypothesised to underlie the effectiveness of MI, including a non-confrontational approach, affirmation, and developing discrepancies between beliefs and behaviour.

- These were embedded in aspects common to all therapies, including the qualities of the therapist and the therapeutic relationship
- Client perspectives on therapeutic processes is an important area of research, and IPR is a particularly suitable method.

There is a large evidence base for the effectiveness of Motivational Interviewing (MI) in treating alcohol abuse (Hettema, Steele & Miller, 2005, UK Alcohol Treatment Trial (UKATT), 2005). As in psychotherapy, how and why change occurs in MI is less clear (Buhringer & Pfeifer-Gerschel, 2008) and identifying the process of change in therapy is a priority for the further development of psychological treatments (Longabaugh, 2007, Orford, 2008). This may be especially true for MI where the initial impetus came from insights into clinical practice, and hypotheses about possible theoretical underpinnings followed (Miller, 1999; Miller & Rollnick, 2002).

MI is characterised by an empathic relationship between therapist and client and an avoidance of confrontation and persuasion. The therapist uses active listening skills to elicit motivation to change from the client, including discrepancies between belief, values and behaviour, whilst also being mindful of the importance of self-efficacy if change is to be successful. The therapist is directive in helping the client to examine and resolve ambivalence, but the client is seen as having responsibility for the decision to change. MI shares many characteristics with other therapies, but places greater emphasis on balancing directiveness of the therapist within an empathic therapeutic relationship.

Several proposed mechanisms of change in MI have been investigated in empirical studies including therapist interpersonal style (Moyers, Miller & Hendrickson, 2005, Miller & Baca,

1983) and reductions in client resistance (Miller, Benefield & Tonigan, 1993). Change talk - a client's verbalisation of the need or desire to change - is also thought important (Moyers et al, 2007). Subdividing this into 'preparatory' talk (expressing desire to change) and 'commitment' talk (committing to change), Amrhein, Miller, Yahne, Palmer & Fulcher (2003) have shown that strength of commitment talk is related to change in substance use, though others have found preparatory talk linked to drinking outcomes (Martin et al, 2011).

Though such research has linked some characteristics of MI with client outcome, current process models have been criticised as too simplistic (Buhringer & Pfeifer-Gerschel, 2008, Longabaugh, 2007). Longabaugh argues that different people change for different reasons at different times, and that focussing on one mechanism will necessarily be restrictive. In a meta-analysis of process research in MI, Apodaca and Longabaugh (2009) identified 19 quantitative studies that measured the relationship between at least one process variable and outcome. Analysis suggested a link between therapist behaviours such as open questions and client change talk, though the methodology could not explore the inter-related nature of the various mechanisms (Finney, 2009).

The majority of process studies in MI have coded client and therapist utterances and used quantitative methods to explore relationships. This allows the role of constructs such as commitment talk to be measured, but only allows investigation of overt behaviour and language previously identified as important and cannot explore underlying cognitive or affective processes.

There has also been a general focus on therapist behaviours such as treatment fidelity (McKay, 2007). This paints a picture of the client as a passive recipient, and tells us little about client responses to different aspects of MI (Morgenstern, 2007). An alternative approach, which compliments efficacy studies, is to use designs that allow the development

of a greater understanding of the interaction between client, therapist and therapeutic rationale (Orford et al., 2006). Qualitative research offers one way to do this, though few studies have been conducted in MI. Orford et al (2006) found that clients being treated for alcohol abuse linked treatment to changes in thinking and behaviour, and highlighted the importance of context - increased support from family and friends. This conveys some of the complexity of treatment processes, though participants were asked to reflect on their overall experience of treatment rather than specific within-session events.

Three qualitative papers have explored the experience of clients who received combined MI and cognitive behaviour therapy (CBT) for Generalised Anxiety Disorder in a Canadian trial. Angus and Kagan (2009) reported on one client who identified several themes including facilitated disclosure of painful memories and increased self-efficacy, which was related to the therapist's empathic attunement. The authors linked this to the concept of the 'spirit of MI', used by Miller and Rollnick (2009) to describe the key qualities of the approach. Kertes, Westra, Angus, & Marcus (2011) explored the difference that adding MI to CBT made to client perceptions of their therapist, finding therapists appeared less directive, and clients felt more engaged. Finally, Marcus, Westra, Angus, & Kertes (2011) analysed the experiences of eight clients of four sessions of MI. Clients experienced the therapist as empathic and creating a safe place to explore feelings, and themselves as engaged in seeking change. The authors concluded that these experiences are consistent with MI principles and processes.

The limited qualitative research in MI offers support for the central role of therapist empathy and client commitment, offering insights into the processes that may underlie the findings of the coding studies described above. All were reliant on the participants' ability to recall events, however, a criticism made more generally of qualitative research on client perspectives in therapy (Elliott, 1986). This may be confounded in the three Canadian studies

by the interviews being conducted after therapy completion, meaning processes in the earlier sessions may be under-represented.

In summary, MI has been shown to be effective, but a more complex model of the underlying process of change is needed. Process research using qualitative methods to explore client perspectives has been useful, but is limited by recall. Clients with addictions are underrepresented. The current study built upon previous work by qualitatively exploring the experiences of clients with addictions who were receiving MI, using interpersonal process recall (IPR). The study therefore aimed to gain a detailed account of the client's views on the processes within a single clinical session of MI.

Method

Participants

The nine participants were aged between 24 – 55 (M = 41.2 SD = 10.1) Six were male; all were white British and English speaking. Three were employed, one retired and five unemployed. All had a primary problem of alcohol misuse, as assessed by the therapy staff. In common with the majority being treated in this setting, there were no secondary mental health problems or dual diagnosis, such as psychosis, mood disorder, personality disorder or cognitive impairment. None had acute or high risk status. Recruitment was through the service therapists, who were simply asked to refer clients with whom they had been using MI. MI is the standard, first line treatment for alcohol abuse used in this service.

All participants were told that the content of their interviews would contribute to the main analysis and would not be fed back to their individual therapist.

The Service Context

A city wide alcohol and substance misuse community outpatient service in the UK. It uses a standardised programme of stepped care following an initial protocol of three sessions of MI.

Study Therapists and MI Adherence

The participants were the clients of five therapists, two male and three female. All therapists had Higher Education Graduate Diplomas in MI and one lectured on this course. Number of years practicing MI ranged between 6 – 25 years (M= 12.8 SD = 7.6). All received weekly clinical supervision.

The sessions used in the study were rated for treatment integrity using the Motivational Interviewing Treatment Integrity coding system, version 3.1.1 (MITI 3.1.1, Moyers, Martin, Manuel, Miller & Ernst, 2010) by a psychology graduate with 12 months experience using the MITI 3.1.1. The coding for each session, together with the recommended competency threshold, is shown in Table 1. All sessions comfortably met the competency level for global clinician ratings, percentage of open questions and complex reflections. Average ratio of reflections to open questions (1.5) does not meet the recommended threshold of 2, though this may be because they were taken from a very brief three session intervention which were of necessity less exploratory. The percentage MI adherent score was 100% for all but two sessions (one contained one utterance of advice giving, and one an utterance of slight warning-giving). On balance, it was felt that these sessions met the requirements for treatment integrity and represented good examples of MI for addictions in practice.

TABLE 1

Researcher's stance

The IPR interviews and coding was carried out by SJ, a Clinical Psychology trainee. Her therapeutic orientation was primarily CBT; she had some previous experience of MI. The research team have interests in psychotherapy process and MI. One supervisor is affiliated with the service in which the research was based.

Procedure

Clients were referred to the service via their GP. All therapy sessions are routinely video recorded in the service. Therapists were asked to refer any client being seen for alcohol problems to the study after session two or three if the client was interested in taking part and could be interviewed within one week of the session. Session one is an assessment and was not chosen as it was felt that this gave less opportunity for the full range of MI skills. Clinicians were asked only that they select sessions in which they felt they had used MI. As recruitment continued, theoretical sampling was used to widen the sample characteristics and challenge theories emerging from the data: Client 6 and Client 7 were theoretically sampled as they were continuing to use alcohol and Client 9 was selected as she was female.

SJ subsequently met with all clients to provide information and to gain consent. Research interviews were conducted as soon as possible after the MI session to preserve recall. Six took place on the same day as the MI session, and the others one, two and five days after.

The IPR interview took place whilst SJ and participant watched a video of the clinical session that was the focus (Elliott, 1986). Participants were given standardised instructions to 'pause the tape at points you thought were important or interesting, and talk me through what was going through your mind at the time'. These could be 'both helpful or unhelpful moments in the session'. The aim was to explore participants' internal experience during therapy, and they were asked 'to focus on what you were thinking at that moment in time, there and then, rather than how you think about the session now'. When the tape was paused, SJ facilitated the account of the thoughts and perceptions of the client during that moment using an eliciting style (e.g. 'can you tell me more about that?'), as recommended by Elliott. The rationale for using the IPR interview is that the use of tape playback provides powerful retrieval cues which make the descriptions of process in therapy far more detailed than free recall (Elliot, 1986).

Grounded Theory analysis

All IPR interviews were digitally audio recorded and transcribed by SJ. They were then analysed using a version of Grounded Theory (GT) (Glaser & Strauss, 1967; Charmaz, 2006; Straus and Corbin, 1990), a qualitative approach ideally suited for the discovery of theory from data.

SJ coded each interview line by line, labelling all words and phrases considered to have a single meaning (open coding). The next stage (axial coding) involved consideration of each open code, looking for similarity in meaning and grouping them into subcategories. Conceptual links were made between sub categories, and a hierarchy with core categories and

subcategories distinguished. Finally, core categories and sub categories were arranged into a theoretical formulation providing a model of the experiences of MI of the participants.

Quality control

A number of steps were taken to ensure the credibility of the analysis. Constant comparison - repeatedly moving between emerging codes and categories and transcripts to re-check interpretation and clarify meaning – was used consistently and two coding credibility checks were carried out to examine accuracy. Two independent coders (a Psychology post-graduate student and a non-Psychology graduate student) were given a list of the subcategories together with a list of participant quotations representative of each, and asked to match the quote with the relevant subcategory. None had any knowledge of MI. The Kappa coefficient of agreement was $k = 0.88$ for both coders, with each coder incorrectly matching four statements out of 34. This is considered a high coefficient suggesting that the process of coding used in this study was robust. At the final stage of analysis one of the participants was asked to comment on how accurately the final theoretical formulation reflected their own experience. They agreed it was a 'fair representation' of their experience and suggested no changes.

Results

Analysis resulted in 569 open codes; initial axial coding produced 155 categories, refined in a second axial coding stage to produce six core categories and 33 sub categories. The overall conceptual model is illustrated in Figure 1, and is grouped around the therapist, the client, the

interaction between them and the context of the session. To illustrate the process of coding, Figure 2 shows the different levels of open and axial coding in detail for one Core Category, 'Therapist Qualities'.

FIGURE 1

FIGURE 2

Table 2 presents a taxonomy of the core categories and subcategories together with the number of clients and open codes contributing to each. They are described and illustrated with quotations below.

TABLE 2

Core category 1: Therapist Actions

This core category consists of the actions of the therapist that clients felt were important in the session. All nine described at least one helpful thing that their therapist had done; most described several. The data are organised into five subcategories. First, 'Autonomy left with client' refers to the way therapists gave the clients responsibility for actions and decisions and emphasised client autonomy, whilst also influencing the direction of the conversation:

"She's driving the conversation, very very subtly, that's the trick. If you listen to her carefully it's just little key words, little key notes. She's allowing me to take the reins of the conversation, but she's steering it very gently."(client 3)

Second, 'active listening' referred to the therapist listening, reflecting and summarising. All participants referred to how important it was to feel listened to; one noted whilst watching the video that the therapist used the same words that they had:

"He actually recaps using words you've actually used. Which shows that he's actually paying attention. Again it's not something you're conscious of when he's doing it." (client 8)

Third, 'eliciting from the client', is similar to the second sub-category, and refers to the therapist drawing the content of the session from the client, encouraging their own reflections rather than making assumptions. The fourth subcategory was the therapists 'positive regard' for the client, leaving them feeling valued, validated and understood:

"I think she's got faith in me. I think she's got more faith in me than I have." (client 4)

The final subcategory was 'raises awareness', which referred to the ways in which the therapist brought issues into the client's awareness, and sometimes helped them view issues in a new way:

"She's just, I don't know, she's made us think about stuff I didn't even know I was thinking."(Client 9)

Core category 2: Therapist qualities

This core category includes comments on the personal qualities of the therapists. All participants reported this as important. It contained four subcategories. First, 'Positive personal qualities' was mentioned by all participants and refers to the interpersonal style of the therapist, that they were friendly, natural and relaxed; 'nice' was often used:

"I don't know, it's just that way about her. She's a nice person, she's friendly." (client 6)

Six participants made an explicit link between this and the way it 'enables you to talk', and this formed the second core category, 'Therapist qualities led to talking':

"The good thing about X is, and I think actually truthfully speaking, this is how counsellors must work, and I fell right into the trap and I swore to myself that I wouldn't, they sit back and let you talk, and before you know it you're 'Blah Blah Blah'. She's a sneaky sod!" (Client 3)

The third subcategory was 'Therapist is competent', referring to the therapist being active in the session, using their skills in a competent and professional manner to help. The fourth subcategory, 'Therapist is non-judgmental', refers to the non-judgmental stance of the therapist and the importance of this in feeling able to talk:

"The way she responded was very, not blasé, but 'Don't be ashamed of it', you know." (Client 2)

Core category 3: Therapeutic Alliance

This core category, contributed to by all participants, refers to the experience of a positive therapeutic alliance. It has two subcategories, 'Relationship' refers to the importance of having a good relationship with the therapist, particularly that they trusted them and found them supportive. 'Alliance', describes a collaborative partnership with the therapist. This

included having a shared understanding, shared hope, a shared plan, and a shared commitment:

"So, and because we've worked together, and that's the only way to describe it, 'working together', because its team work, she is supporting me, and I'm working through this" (client 3)

Core category 4: Awareness

The fourth core category consists of posited internal processes of the client, referred to by them at several points when watching their session and grouped generally around the theme of increasing awareness of problem drinking. These processes were facilitated by therapist actions and qualities described earlier. There were several subcategories, grouped into four clusters, reflecting the complexity of the processes being described.

(A) Talking.

All clients referred to the way in which they were able to talk honestly in the session, facilitated by the therapist's interpersonal style and questioning technique. Some said it was the first time they had talked openly about their alcohol use:

" you just find that your letting it go, letting it off, letting it off your chest, 'I want to tell someone this', I want to say what it's really really like. How I feel, what I want to do, how scared I am." (Client 3)

Honesty was also mentioned as being important - talking honestly with the therapist allowed them to be honest with themselves. Finally some (4/9) highlighted the importance of hearing themselves say things about their drinking and their desire to change.

(B) Becoming aware.

Seven participants referred to the way the MI session made them more aware and think about issues around their drinking, particularly the negative consequences for themselves and others but also the progress they were making, which they felt was important in maintaining morale.

"This is the first time in my life that I've owned up that it was the drink." (Client 2)

(C) Discrepancy and core values.

This category, contributed to by five participants, is linked with increased awareness but is focussed on how this triggers a discrepancy with core values and preferred self-image (e.g. being a good parent). This was described as part of a process by which the session produces an emotional reaction.

"It doesn't feel nice. As a mother and a grandmother and a wife, that you're alcohol dependent." (Client 4)

(D) Feelings Activated.

All participants reported emotional reactions during the session. Negative emotions were commented upon more often. Sometimes this was unhelpful, such as feelings of guilt or shame; more often negative emotions were seen as being difficult but helpful in the process of change:

"she actually brought tears to my eyes, when she mentioned it, because it gets me here (touches heart)… She notices. She mentions it and my eyes start….It is helpful…It made me think ….I know I'm doing wrong, I'm here to get it sorted'." (Client 7)

Most also described experiencing positive emotions in the session, feeling up-beat and positive about the future. These were all described as helpful.

Core category 5: Motivation

The fifth core category similarly describes posited internal process of the client, all connected to motivation and the likelihood of behaviour change. It consists of three sub-categories. Autonomy was described in terms of three different stages of treatment: the decision to seek help, the decision-making within the session around whether or not to attempt behaviour change, and (once the decision had been made) ownership of a plan to change and responsibility for carrying it out. Making a decision was recognized as being difficult ('denial is easier') but was held to be important because it acknowledged the reality of ultimately being the one that has to make the changes 'on your own':

"They can run around till the cows come home saying 'I want you to do this, I want you to do that', but at the end of the day, it's down to that individual person…She lets you do the talking. She lets you … face your own demons, find your own solutions for it." (Client 3)

Self-efficacy, the second sub-category, reflects the belief that feeling able to make a change was crucial to whether it succeeds, and that the therapist was important in increasing confidence:

"It was just, 'Right, I can actually do this'"(Client 9)

The third sub-category, self-esteem, is linked to self-efficacy but focussed more generally on feelings of self-worth which increased during the session, with therapists conveying a sense that the client was valued and clients leaving the session feeling 'better about themselves':

"I come away with a renewed sense of purpose. It's like re-shining your armour. Giving it a new coat of polish." (Client 3)

Core category 6: Service context

The final category reflects the perceptions of the clients of the factors outside of the clinic room that affect their experience of therapy: the wider experience of the service and what happens outside of the session. It is made up of two subcategories. 'Overall service experience' refers to the comments of participants on their positive experience of all aspects of the service and this appeared to mirror descriptions of the MI session, in that all staff were described as being non-judgemental.

'Outside the session' reflects the references three participants made to how the 'real-world' outside the session had an impact on how successful the intervention was. Two reported that it was difficult to maintain motivation outside the session and felt that their thinking inside the session was different to when they were outside it:

"I have great intentions, but when I leave here. First thing I think of, and I know it sounds absolutely ridiculous, but the first thing I think of is, how I'll have one pint." (Client 4)

Discussion

MI Processes

The views of the participants in this study generally mirror what MI theory suggests is important - they felt their therapists emphasised their autonomy, made them feel listened to, elicited content rather than imposing their own views, helped them talk about their drinking, all whilst avoiding confrontation. They noticed some more subtle aspects of their therapist's behaviour whilst watching the videos, such as using their own words, which may have helped to avoid conflict. These therapeutic actions were founded on the relationship. They referred to the therapist's personal qualities, which made them easy to talk to, particularly their non-judgemental attitude. They trusted their therapist and felt that they were in a collaborative relationship, working together on the problem.

The clients, then, experienced their therapist as active and strategic in the session, and alongside the MI skills there is a sense that the therapists created an atmosphere in which the client felt comfortable to talk about difficult material. Miller and Rollnick (2009) have cautioned that MI is not a set of techniques but rather involves an underlying spirit and communication style. This resonates with the accounts of clients in the current study.

Do the therapist behaviours described translate into helpful therapeutic events? In terms of the internal processes referred to by the participants, increasing awareness of problematic aspects of drinking through open and honest conversation was a key element. For almost all this entailed new realisations and for most there was explicit acknowledgment that this had

led to an uncomfortable discrepancy with core values. This awareness also activated an emotional response which was in most cases seen as uncomfortable but helpful, though some emotions such as guilt and shame were felt to have a negative impact on motivation. When the session did not connect with core values or activate an emotional response, it was described as less helpful. The other key process was variation in motivation to change. Participants recognised three elements that they felt were associated with increased motivation: feeling autonomy for making the decision, greater confidence in ability to succeed and a greater sense of self-worth. These processes again concur with those hypothesised to be important in MI – that an impetus for change is brought about by raising awareness and increasing discrepancy, with a commitment to take action influenced by self-efficacy.

The concept of awareness of discrepancy with core values in MI is consistent with Self Determination Theory (Deci & Ryan, 2004) which suggests that the most sustainable autonomous behaviour change occurs when it is in line with core values. The clients in the current study found moments in the session that touched upon core values to be more significant. Interestingly, emotions were discussed as much as cognitive processes. Emotion activation is recognised as an important aspect in other psychotherapeutic approaches (Greenberg & Pavio, 2003) and those in the current study reported finding negative emotions helpful. This is consistent with Cognitive Dissonance Theory (Festinger, 1957), in which negative or unpleasant emotions associated with discrepancies are conceptualised as producing a desire for resolution, a theory cited initially by Miller and Rollnick as underlying MI. Wagner and Ingersoll (2008) discuss the neglected role of emotions in MI, arguing that both negative and positive emotions are important: the former as negative reinforcement which motivates change, and the latter in reducing the 'fight or flight' threat response and increasing problem solving abilities. This is consistent with increased interest in the role of

arousal and threat response in cognitive approaches such as Compassionate Mind (Gilbert, 2009) and the Interacting Cognitive Subsystems (ICS) model (Teasdale & Barnard, 1993)

Clients in the current study saw autonomy as an important feature of their session. Miller and Rollnick (2002) argue that externally controlled behaviour change is less enduring than internally regulated autonomous behaviour change (Markland, Ryan, Tobin & Rollnick, 2005). The results of the Apodaca and Longabaugh (2009) meta-analysis offers support for this, finding that the therapist behaviour of 'giving responsibility' was related to both MI practice and client outcome.

Self-efficacy and self-esteem were seen as important to clients in the current study. Self-esteem was mentioned in Miller's (1983) original paper on MI, but he suggests that, on its own, it is not often causally related to outcome because it involves interaction. Miller (1983, p4) describes it as a mediating factor: if a person sees the need to change, feels able to change, but doesn't feel they are worth changing for, this may impact on outcome. Raistrick (2007) comments that although self-esteem is an imprecise concept, it continues to have meaning for clients and practitioners, and this receives some support from this study.

In summary, several processes hypothesised to be related to change in MI were cited by clients in the current study, including developing discrepancy, increasing self-, and maintaining autonomy. Many of the categories that emerged overlap with those of Marcus et al (2011). That study highlighted the importance to the client of the safe, nonthreatening atmosphere created by the empathic behaviour of the therapist which allowed them to 'open up, express themselves, and explore their feelings' (p456), leading to increased awareness and motivation to change. Similarly, clients in the current study spoke of the empathic and non-judgemental nature of the therapist, which enabled honest conversations to take place. The consequences reported in both studies are similar – increased problem awareness and

motivation to change, though emotions were a particular feature of the current study, and may reflect the nature of the client's addiction problems. Taken together, both studies suggest that the principles of MI – an empathic, non-judgemental approach and collaboration with the client in which their views are elicited and their autonomy respected - are reflected in the experiences of clients, who at least perceive them to be important and helpful.

The emphasis on collaboration with the therapist echoes the literature on therapeutic alliance, long argued as an important mechanism of change in all psychotherapies (Patterson, 1984; Elvins & Green, 2008). This raises the question of how many of the observations made by clients in this study might also apply to other models of therapy. The picture which emerges in the current study of therapists adapting their intervention in response to the client's state and edging them to greater self-awareness certainly resonates with the concept of the 'therapeutic zone of proximal development' (TZPD) (Leiman and Styles, 2001; Ribeiro, Ribeiro, Gonçalves, Horvath and Stiles, 2013). The TZPD is described as the space between the client's current and potential capacity for insight. As shared reflections become internalised over time, the therapist equips the client with tools that foster self-reflection and understanding. This model seems particularly apt for application to therapy in addictions. In fact, if people abusing alcohol have problems naming and expressing emotions (alexithymia), as recently noted in substance abuse (Lysaker, Olesek, Buck, Leonhardt, Vohs, Dimaggio, Popolo, and Outcalt, 2014), the role of the therapist in helping clients develop awareness of their own mental states is particularly important. As noted above, sessions which triggered an emotional response were often noted as being particularly helpful by the participants in the current study.

Studies of process in psychotherapy using IPR

The current study follows a tradition in psychotherapy research of exploring clients' reflections on significant events in therapy, of which IPR was an early research tool (Timulak, 2010).

Rennie (1994) used IPR in interviews with 14 clients about their experiences of a psychotherapy session. The major category in a GT analysis was deference to the therapist, with secondary themes that included meeting therapists' expectations and indebtedness to the therapist. This contrasts with the way clients in the current study referred to their therapists enhancing rather than undermining their own autonomy. This was also highlighted by Timulak and Lietaer (2001), who used IPR to identify moments in brief person centred counselling that six clients identified as positive, and found feelings of empowerment were present in half of the episodes, and feeling safe in a quarter. Their model emphasised the importance of the therapeutic relationship and the clients' own search for meaning in therapy, which they argued was facilitated by the alliance. Similarly, Levitt, Butler and Hill (2006) used IPR to interview 26 therapy clients two months after treatment and found that the therapeutic alliance was more important than any other factor.

The findings of the current study resonate with process research conducted within a variety of psychotherapeutic models (Elliot & James, 1989), though there are also differences, with central categories in the current study relating to awareness raising, discrepancy and change, for example. This should not be surprising - clients report different types of significant events in therapy depending upon the model of therapy received (e.g. Llewelyn et al, 1988).

Methodological strengths and weaknesses

The check for treatment integrity was thorough and met for almost all aspects. It might be argued that this could be improved, particularly if the sessions had been taken from a clinical trial where a treatment fidelity measure was in use, but this was not available. We acknowledge, too, the limitation in not having multiple coders rate the sessions so that an inter-rater reliability check could be performed. We had access to only one rater with enough experience of using the MITI. On balance, however, we feel that the scores were sufficient to allow confidence that these were recognisably MI sessions, conducted as part of routine care in a specialised addiction service.

Asking for the clients' perspective in process research has been questioned as it relies on the client's ability to recognise and report internal processes (Humphreys & Wilbourne, 2006), and is clearly restricted to conscious processes (Elliot, 1986). These perspectives are in turn interpreted and structured in Grounded Theory introducing the possibility of investigator bias. In the current study, the researchers had prior experience of MI. This is reflected in the language available when labelling units of meaning and core categories in Grounded Theory. In an attempt to counter this, steps were taken to reduce bias at every stage of the research. Interpretation was grounded in the data and several credibility checks used. The clients, rather than the researcher, selected the important moments in therapy in the IPR interview.

This study explored client perspectives on the process of change in MI, and it is of course possible that these perspectives may also be subject to bias. The use of IPR acted as a retrieval cue and minimised recall problems, but does not rule out the possibility that clients' beliefs about what was important in therapy were erroneous, i.e. aspects of therapy may have felt significant to the client, but not be related to outcome. It is also possible that clients were reflecting the rationale for therapy presented to them by their therapists, perhaps using the language that they had heard their therapists using.

This is a qualitative study with a small number of participants. Though it is argued that qualitative research is a powerful tool for identifying topics for further research and can complement quantitative approaches, caution is clearly needed in generalising from this study, particularly to psychotherapy with other clients groups.

Finally, the majority of previous research into the process of MI has been by observer-ratings and researcher selected measures, and the main strength of the current study – notwithstanding the possibility of bias described above - is arguably that client's views on the process of change were sought. The spirit of MI recognises the expertise of the client, and this research is consistent with this view.

Further research

The range of factors identified by clients in the current study supports Apodaca and Longabaugh's (2009) view that too little is known about possible processes of change in MI. Further process studies from the client's perspective would add to the generalisability of these findings. It would also be interesting to gain the perspective of therapists. For these findings to be translated into improved practice however an important objective for future research would be to explore links between processes hypothesised by clients to be important, and outcome. In terms of the therapeutic outcome of the clients who took part in this study, no long term follow up data were available, but two were still alcohol dependent at the time of the interview. The categories that they contributed to were not noticeably different from the group as a whole, but it would be useful for future research to include larger numbers with good and poorer outcomes to enable further exploration. A combined approach of RCT

methodology with qualitative and quantitative process research will go a long way to opening the 'black box' of therapy (Buhringer & Pfeifer-Gerschel, 2008).

Conclusion

MI is an effective and acceptable treatment for addictions but mechanisms of change remain uncertain. Meta-analysis of MI process studies suggests research is prematurely narrow in its focus on one or two hypothesised mechanisms of change. The current study offered a different perspective, exploring the client's own perceptions of a session. It supports Longabaugh's (2007) view that current models of the change processes underlying MI may be overly simplistic, and that factors other than 'change talk' (Moyers et. al., 2007) are perceived by clients as being important to the process of change in MI.

The clients in the current study described a complex interaction between therapeutic factors, many of which are consistent with theoretical accounts of MI. Further work is necessary to explore the processes of change in MI and the interactional nature of the active ingredients. Russell, Jones and Miller (2007) likened therapy to a rich tapestry woven from several interrelated threads, each of which has different salience at different points in the therapy. The challenge for future MI process research is to identify the different threads and understand their interactions, without unravelling the tapestry and losing the overall spirit and meaning of this approach.

References

Amrhein, P.C., Miller, W.R., Yahne, C.E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology*, 71, 862-878.

Angus, L., & Kagan, F. (2009). Therapist empathy and client anxiety reduction in motivational interviewing: ‘‘She carries with me, the experience’’. *Journal of Clinical Psychology*, 65, 1156-1167.

Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction*, 104, 705-715.

Buhringer, G., & Pfeifer-Gerschel, T. (2008). COMBINE and MATCH: The final blow for large scale black box randomised controlled trials. *Addiction*, 103, 708-709.

Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis.* London: Sage.

Deci, E.L., & Ryan, R.M. (2004). Overview of self-determination theory: An organismic dialectical perspective. In Deci, E.L., Ryan, R.M. (Eds.) *Handbook of Self-determination Research*. Rochester, NY: Boydell and Brewer.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology*, 32, 307–322.

Elliot, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443-467.

Elliott, R. (1986). Interpersonal process recall (IPR) as a process research method. In Greenberg, L., Pinsof, W. (Eds.), *The Psychotherapeutic Process: A Research Handbook*. (pp 503-527). New York: Guilford.

Elvins, R., & Green, J. (2008). The conceptualisation and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, 28, 1167–1187.

Festinger, L. (1957). A theory of cognitive dissonance. Evanston, IL: Peterson. Cited in: Aronson, E., (1997). A theory of cognitive dissonance. *American Journal of Psychology*, 110, 127-137.

Finney J. (2009). Meta-analyses and the search for specific and common mediators of substance misuse intervention effects. *Addiction*, 104, 716-717.

Gilbert, P. (2009). *The Compassionate Mind*. London: Constable.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.

Greenberg, L.S. & Paivio, S.C. (2003). *Working With Emotions In Psychotherapy*. New York: Guilford Press

Hettema, J., Steele, J., & Miller, W.R. (2005). A meta-analysis of research on motivational interviewing treatment effectiveness (MARMITE). *Annual Review of Clinical Psychology*, 1, 91-111.

Humphreys, K. & Wilbourne, P. (2006). Knitting together some ripping yarns. *Addiction*, 101, 4-5.

Kertes, A., Westra, H., Angus, L., & Marcus, M. (2011). The impact of motivational interviewing on client experiences of cognitive behavioral therapy for generalized anxiety disorder. *Cognitive and Behavioral Practice*, 18, 55-69.

Leiman, M. and Stiles, W.B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: the case of Jan revisited. *Psychotherapy Research*, 11: 311-330.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, 53, 314–324.

Llewelyn, S. P., Elliott, R., Shapiro, D. A., Hardy, G., & Firth-Cozens, J. (1988). Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology*, 27, 105–114.

Longabaugh, R. (2007). The search for mechanisms of change in behavioural treatments for alcohol use disorders: A commentary. *Alcoholism: Clinical and Experimental Research*, 31, 21-32.

Lysaker, P.H., Olesek, K., Buck, K., Leonhardt, B., Vohs, J., Dimaggio, G. , Popolo, R. & Outcalt, J. (2014). Metacognitive mastery moderates the relationship of alexithymia with cluster C personality disorder traits in adults with substance use disorders. *Addictive Behaviors*, 39, 558-561.

Marcus, M., Westra, H.A., Angus, L., & Kertes, A. (2011) Client Experiences of Motivational Interviewing for Generalized Anxiety Disorder: A Qualitative Analysis. *Psychotherapy Research,* 21, 447-461.

Martin, T., Christopher, P. J., Houck, J.M., & Moyers, T. B. (2011). The structure of client language and drinking outcomes in Project MATCH. *Psychology of Addictive Behaviours*, 25, 439-445.

Markland, D., Ryan, R.M., Tobin, J.V., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. *Journal of Social and Clinical Psychology*, 24, 811-831.

Marshall, M.N. (1996). Sampling for qualitative research. *Family Practice*, 13, 522-525.

McKay, J.R. (2007). Lessons learned from psychotherapy research. *Alcoholism: Clinical and Experimental Research,* 3, 48–54.

Miller, W.R. (1983). Motivational interviewing with problem drinkers. In Miller, W.R. (2008). From the desert: The first description of motivational interviewing. *Motivational Interviewing Network of Trainers (MINT) Bulletin*, 14, 3-38.

Miller, W.R. (1999). Toward a theory of Motivational Interviewing. *Motivational Interviewing newsletter: updates, education and training*, 6, 2-4.

Miller, W.R. & Baca, L.M. (1983). Two-year follow up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers. *Behavior Therapy*, 14, 441-448.

Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People to Change (2nd ed.)*. New York: Guilford Press.

Miller, W.R. & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy*, 37, 129-140.

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.

Morgenstern, J. (2007) Perspectives and future directions. *Alcoholism: Clinical and Experimental Research*, 31, 87-90.

Moyers, T.B., Martin, T., Christopher, P.J., Houck, J.M., Tonigan, J.S., & Amrhein, P.C. (2007). Client language as a mediator of motivational interviewing efficacy: Where is the evidence? *Alcoholism: Clinical and Experimental Research*, 31, 40-47.

Moyers, T.B., Martin, T., Manuel, J.K., Miller, W.R. & Ernst, D. (2010). *Revised Global Scales: Motivational Interviewing Treatment Integrity 3.1.1 (MITI 3.1.1).* Retrieved 23rd April 2012 from http://motivationalinterviewing.org/sites/default/files/MITI%203.1.pdf

Moyers, T.B., Miller, W.R., & Hendrickson, S.M.L. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology*, 73, 590-598.

Orford, J. (2008). Asking the right questions in the right way: The need for a shift in research on psychological treatments for addiction. *Addiction*, 103,1-11.

Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., Fryer, K., Handforth, L., Alwyn, T., Kerr, C., Thistlethwaite, G., & Slegg, G. (2006). The clients' perspective on change during treatment for an alcohol problem: qualitative analysis of follow-up interviews in the UK Alcohol Treatment Trial. *Addiction*, 101, 60–68.

Patterson, C.H. (1984). Empathy, warmth, and genuineness in psychotherapy: A review of reviews. *Psychotherapy: Theory, Research, Practice, Training*, 21, 431-438.

Raistrick, D. (2007). Motivation and barriers to change. In Tober, G., Raistrick, D. (Eds.) *Motivational Dialogue: Preparing addiction professionals for motivational interviewing practice, (pp16-33),* London: Routledge.

Rennie, D.L. (1994). Client's deference in psychotherapy. *Journal of Counselling Psychology*, 41, 427-437.

Ribeiro, E., Ribeiro, A.P., Gonçalves, M. H., Horvath, A.O. and Stiles, W.B. (2013). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory, Research and Practice*, 86, 294–314.

Russell, R.L., Jones, M.E., & Miller, S.A., (2007). Core process components in psychotherapy: A synthetic review of P-technique studies. *Psychotherapy Research*, 17, 273-291.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research*. London: Sage.

Teasdale, J.D. and Barnard, P.J. (1993). *Affect, Cognition and Change: Remodelling Depressive Thought.* Hove, UK, Lawrence Erlbaum Associates.

Timulak, L., Significant events in psychotherapy: An update of research findings. (2010). *Psychology and Psychotherapy: Theory, Research & Practice*, 83: 421-447.

Timulak, L., & Lietaer, G. (2001). Moments of empowerment: A qualitative analysis of positively experienced episodes in brief person-centred counselling. *Counselling and Psychotherapy Research*, 1, 62–73.

UKATT Research Team (2005). Effectiveness of treatment for alcohol problems: Findings of the randomised UK alcohol treatment trial (UKATT). *British Medical Journal*, 331 (7516), 541-544.

Wagner, C.C., Ingersoll, K.S. (2008). Beyond cognition: Broadening the emotional base of motivational interviewing. *Journal of Psychotherapy Integration*, 18, 191–206.

Table 1: Treatment integrity coding using MITI 3.1.1.

Aspect (competency threshold)	MI session								
	1	2	3	4	5	6	7	8	9
Global Clinician Rating (4)	4.3	4.7	5	4.3	4.3	4.7	5	5	4.3
Reflection to Open Question Ratio (2)	1.6	2.9	2.9	0.6	0.8	1.1	1.0	1.0	1.8
% Open Questions (70%)	100%	86%	86%	94%	93%	79%	100%	100%	81%
% Complex Reflections (50%)	71%	70%	75%	70%	73%	65%	63%	78%	76%
MI adherent (100%)	100%	94%	100%	100%	94%	100%	100%	100%	100%

Figure1. Overall Conceptual Model

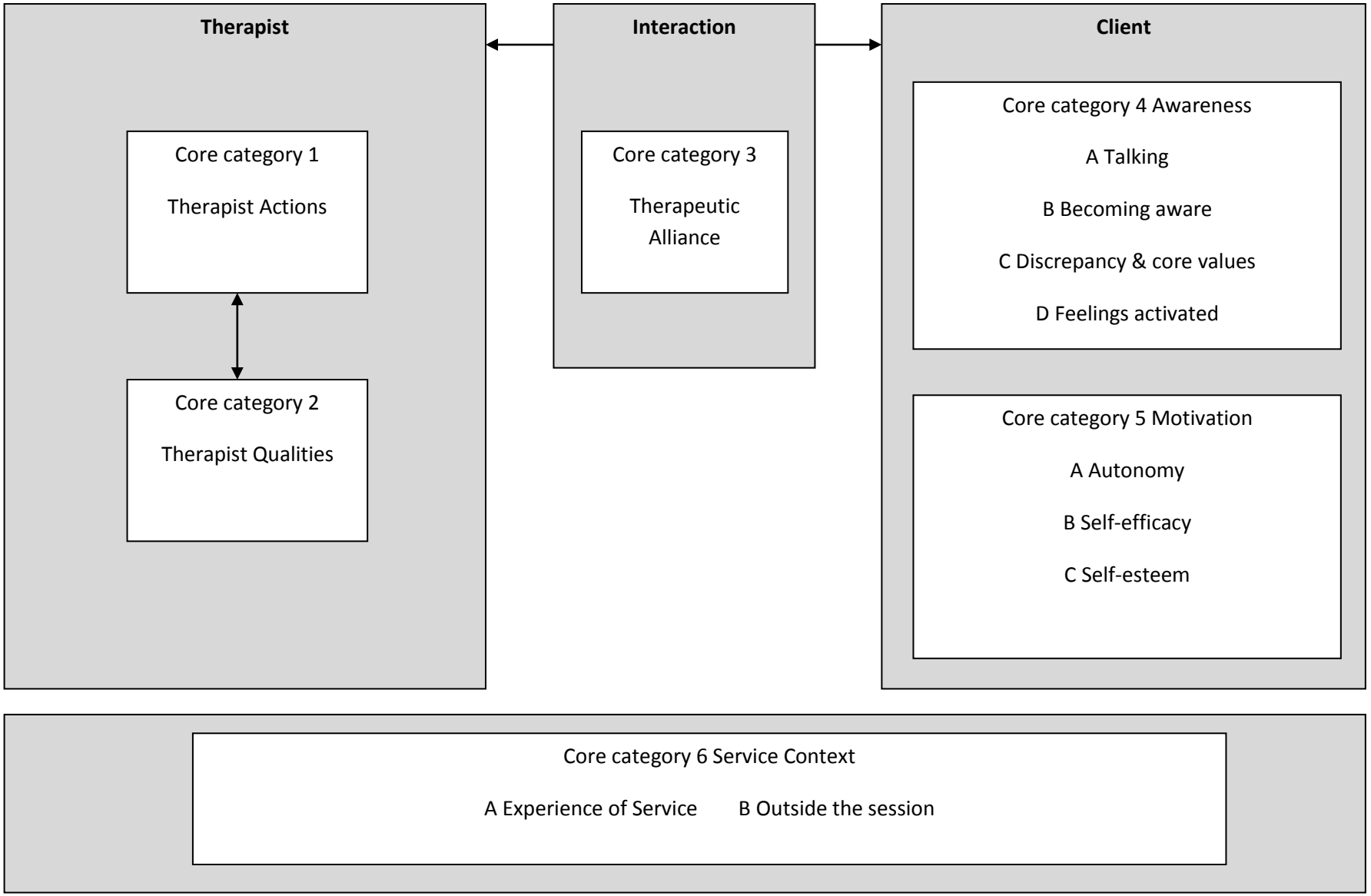

Figure 2: Example of coding hierarchy ‘Therapist Qualities’; Number in brackets shows number of participants out of 9 that contributed to code.

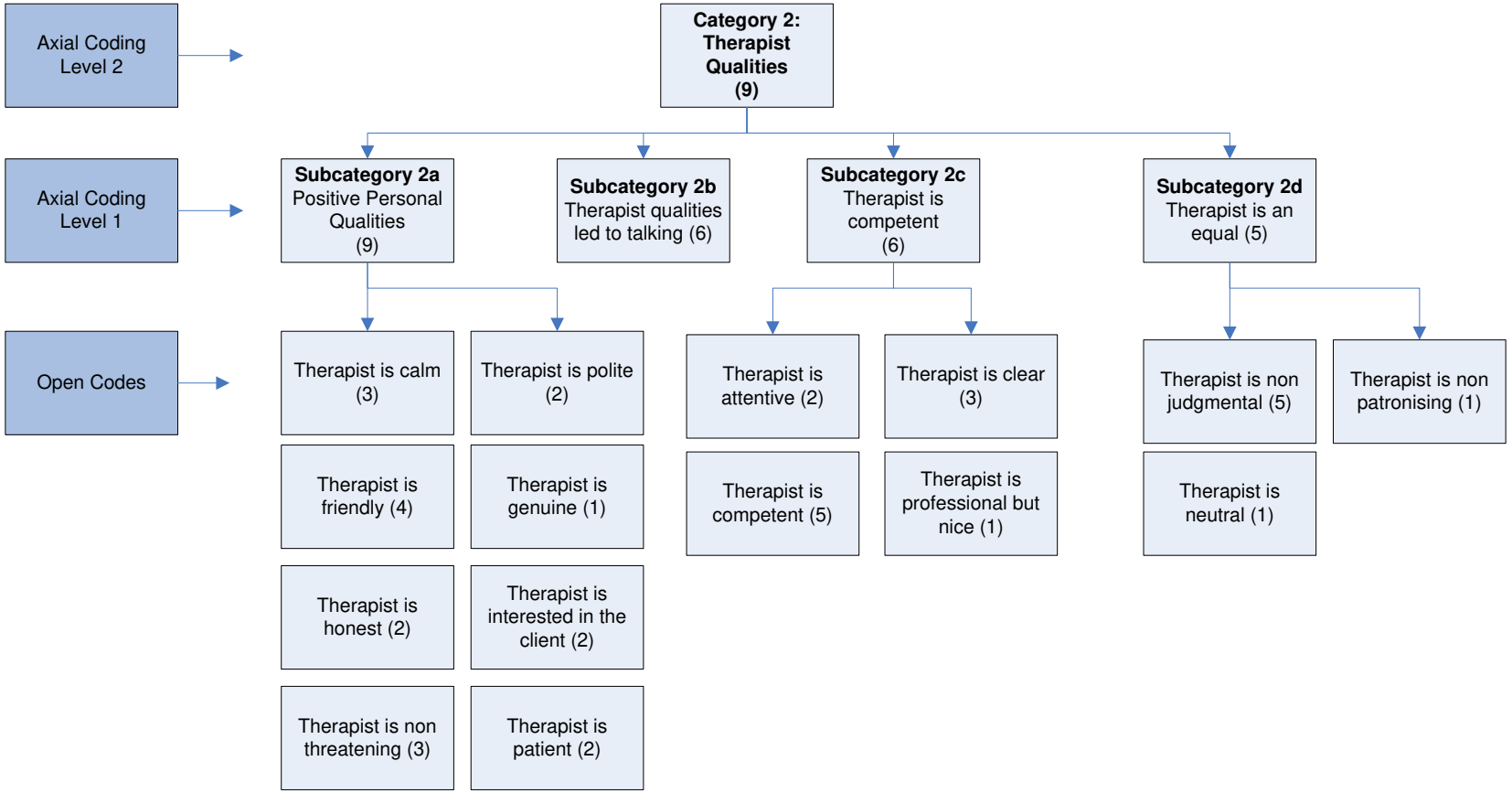

Table 2: Taxonomy of core categories and subcategories

Category	No. participants contributing
Core Category 1: Therapist Actions	9
Autonomy left with client	4
Active listening	7
Therapist elicits from client	5
Positive regard	8
Raises awareness	6
Core Category 2: Therapist Qualities	9
Positive personal qualities	9
Therapist qualities led to talking	6
Therapist is competent	6
Therapist is an equal	5
Core Category 3: Therapeutic Alliance	9
Alliance	7
Relationship	6

Core Category 4: Awareness	
(A) Talking	9
Talking is an important process	6
Talking and honesty	9
Hearing self say it	3
(B) Becoming aware	7
Pros and cons	6
Level of drinking	2
Self awareness	6
Cause of drinking	3
Aware of progress	5
(C) Discrepancy and core values	5
(D) Feelings activated	9
Negative – unhelpful	4
Negative – helpful	8
Positive emotions	6
Session content did not activate emotions	1
Core Category 5: Motivation	
(A) Autonomy	8
Autonomous help seeking	7
Autonomous decision making	6
Autonomous action	5
(B) Self-efficacy	8

(C) Self esteem	6

Core Category 6: Service Context

(A) Overall service experience	6
Positive service experience	6
Favourable comparison to other services	6
(B) Outside of the session	3
Motivation decreases outside of the session	2
Involvement from other services	1