Exploring the challenges that prevent practitioners from implementing motivational interviewing in their work with clients

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DECLARATION

I, the undersigned hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part, submitted it to any university for a degree.

Signature: Date: December 2019

ABSTRACT

Motivational Interviewing (MI) is an evidence-based counselling technique used by psychologists, doctors, nurses, midwives and social workers aimed at behavioural change. The purpose of this qualitative study was to explore the barriers that prevented practitioners from using MI. Studying the problem was necessary because only a few studies have examined practitioners' experiences during their MI training and subsequent implementation of MI. I explored practitioner-related factors, client-related factors, training and supervision and workplace related factors that acted as barriers that hindered the implementation of MI. This study was conducted among 15 social and health practitioners living and working in the Western Cape. All participants were trained in MI and found to be competent after the training. Purposive sampling and snowball sampling was used to recruit participants for the study. Thematic analysis was used to analyse the data of the semi-structured interviews. The study drew on a conceptual framework called the Promoting Action on Research Implementation in Health Services (PARiHS) that attempts to explain how to implement evidence-based practice (EBP) effectively. Practitioner-related factors included the difficulty in making a therapeutic paradigm shift, a lack of confidence and negative attitude toward MI. The client-related factors related to the community, lack of family support, cognitive impairment and client resistance. The lack of continued training and supervision was also found as a barrier. Participants with no counselling qualifications reported that they found it challenging to understand the concepts of MI. Another barrier highlighted in this study was that work environments were not conducive to MI as participants reported that they did not have enough time allocated with clients to implement MI and that there was a lack of support from management to implement MI as an intervention. The findings have identified areas in which interventions can take place to support the implementation of MI.

OPSOMMING

Motiverende onderhoudvoering (MO) is 'n bewys-gebaseerde beradings tegniek wat deur sielkundiges, dokters, verpleegsters, vroedvroue en maatskaplike werkers gebruik word gemik op gedragsverandering. Die doel van hierdie kwalitatiewe studie was om die hindernisse te identifiseer wat die praktisyne verhoed om MO te gebruik. Die studie was nodig omdat daar slegs 'n paar studies was wat fokus op die ervaringe van die praktisyne tydens hul MO opleiding en gevolglike implementering van MO. Ek ondersoek die praktisyn verwante faktore, die klient verwante faktore, opleiding en supervisie en die werksplek verwante faktore wat as hindernisse die implementasie van MO verhoed. Hierdie studie is gedoen onder 15 sosiale- en gesondheid praktisyne wat woon en werk in die Wes-Kaap. Alle deelnemers is opgelei in MO en bevoeg bevind met hul opleiding. Doelgerigte steekproeftrekking en sneeubal steekproefneming is gebruik om deelnemers vir die studie te werf. Tematiese analise is gebruik om die data van die semi-gestruktureerde onderhoude te analiseer. Die studie gebruik die konseptuele raamwerk bekend as die Bevordering van Aksie op Navorsing Implementering in Gesondheidsdienste (BANIG) wat poog om te verduidelik hoe om bewysgebaseerde praktyke (BGP) effektief te implementeer. Praktisyne verwante faktore sluit in die uitdaging om ‘n paradiegma skuif te maak en die verandering toe te pas, die gebrek aan self-vertroue en die negatiewe houding van die deelnemers. Die kliënt verwante faktore was die gemeenskap faktore, die gebrek aan familie ondersteuning, kognitiewe uitdagings en kliënt weerstandigheid. Die gebrek aan voortdurende opleiding en toesig was ook as ‘n hindernis geidentifiseer. Deelnemers met geen vorige beradings kwalifikasies het gesukkel met begrip van die konsepte van MO. 'n Gebrek aan ondersteuning van die bestuur om MO te implementeer asook te min tyd om dit toe doen was ook as ‘n hindernis geidentifiseer. Die bevindinge het areas geidentifiseer wat die implementering van MI kan ondersteun in intervensies.

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CHAPTER 1

Introduction, rationale and aim of study

1.1 Introduction

Behaviour change may be necessary to improve healthcare and health outcomes among patients (Cane et al., 2012). Interventions for behaviour change are usually rooted in theory. The most often-used theories in health behaviour research are the Health Belief Model (HBM), the Transtheoretical Model/Stages of Change (TTM), the Social Cognitive Theory (SCT) and the Social Ecological Model (Glanz, 2008). Furthermore, interventions that are evidence-based can play an important role in improving health behaviour and outcomes (Tacia, Biskupski, Pheley, & Lehto, 2015).

Motivational interviewing (MI) is a behaviour change intervention used to improve patient adherence to medication, smoking cessation and increasing physical activity and more (Miller & Rollnick, 2013). MI is an evidence-based counselling approach applied by psychologists, doctors, nurses, midwives and social workers as an effective intervention aimed at behavioural change (Barnes & Ivezaj, 2015; Cascaes et al., 2014; Van Buskirk & Wetherell, 2014). MI is an agreed-upon, goal-directed communication style that enhances the client's reasons and drive to engage in a different, beneficial behaviour (Miller & Rollnick, 2013).

MI is built on the theoretical foundation of Carl Rogers's person-centered counselling approach (Miller, 1983), but incorporates an explicitly directive style (Westra & Aviram, 2013). MI developed from a non-confrontational counselling approach that incorporated motivation as part of the therapeutic process (Söderlund, 2008). The underlying essence of MI is a non-judgmental partnership between client and practitioner. The counsellor shows respect for clients' perspectives and ideas, which fosters collaboration and power-sharing. Practitioners keep the clients' best interest in mind by expressing compassion, cultivating change talk and reducing talk where clients use language that indicate no intention of change. MI consists of four processes, namely (1) engaging with the client, (2) focusing by finding and keeping useful direction (3) evoking change,

and (4) planning and support (Miller & Rollnick, 2013). In MI, therapists employ communication skills to identify key processes such as ambivalence, resistance, and change talk (Miller & Rollnick, 2002). Practitioners employ MI in two ways. The first method of MI consists solely on the application of MI techniques. The second form of MI is a brief intervention, where the principles of MI are applied in 5-10 minute sessions and are integrated with other approaches (Miller & Rollnick, 2009; Satre et al., 2016).

MI was originally developed in the field of addiction in 1982 but has since been employed in several other fields relating to behaviour change including gambling (Yakovenko et al., 2015) and orientations to corporal punishment (Holland & Holden, 2016). MI has also been applied successfully to change behaviour in relation to smoking, alcohol abuse, HIV and diabetes management (De Vries et al., 2012; Mertens et al., 2014; Morojele et al., 2014; Parry et al., 2012). For example, a randomized controlled trial (RCT) that assessed the effectiveness of MI in reducing alcohol and drug use among 307 patients with depression demonstrated that MI significantly reduced alcohol and drug use 6 months following treatment ($p < 0.05$ *t*-test). In the study, participants in the experimental group received three MI sessions of 45 minutes long at 3-months and 6-months after the initial treatment, while the control group received educational brochures. All participants were assessed at baseline and then followed up at three and six months (Satre et al., 2016).

There is a general consensus that MI is an effective counselling approach in achieving behaviour change (Keeley et al., 2016; LLavoie et al., 2014; Lundahl et al., 2013; Steinkopf, Hakala, & Van Hassel, 2015). However, despite the effectiveness of MI, studies have demonstrated that MI is underutilized in behaviour modification (Keeley et al., 2016; LLavoie et al., 2014; Lundahl et al., 2013; Steinkopf, Hakala, & Van Hassel, 2015). Yet, only a few studies have examined practitioners' experience during their MI training and subsequent implementation of MI (Madson, Loignon & Lane, 2009; Malan, Mash & Everett-Murphy, 2015; Van Buskirk & Wetherell, 2014). These studies found an association between the practitioners' credentials and

the outcome of the MI intervention. One of the findings was that practitioners with higher levels of professional training delivered MI more effective (Van Buskirk & Wetherell, 2014). Another finding was that it was difficult to achieve competency of MI in short trainings. Training should be continuous and longer than the usual one week (Malan, Mash & Everett-Murphy, 2015). Another study found that practitioners will be more likely to engage in applying MI if they are confident in their abilities to perform the MI techniques (Madson, Loignon & Lane, 2008).

1.2 Rationale

MI is an effective therapeutic technique aimed at behaviour change (Miller & Rollnick, 2013). MI is gaining popularity with practitioners in South Africa and all over the world (Dufet & Ward, 2015; Evangeli et al., 2009; Lawani et al., 2016; Serfontein & Mash, 2013; Rendall-Mkosi et al., 2012). It is a cost-effective intervention because it can be integrated into existing practices such as a primary health setting or a private practice. It can also be implemented as a short brief intervention and therefore contribute to cost effectiveness (Barnes & Ivezaj, 2015). In under-resourced contexts, such as South Africa, MI may be an especially valuable tool. Research demonstrates that MI is effective and being a brief intervention can be beneficial in resource-limited settings. In the Western Cape, training for MI is offered and these courses are well attended but there is very little information about implementation of MI (B. Mash, personal communication, August 25, 2017). Information regarding the factors that influence the implementation of MI within the local context is needed. Understanding the factors that impact the implementation of MI as an intervention may improve implementation of MI (Midboe et al., 2011).

MI as a counselling tool has advantages for the patient as well as the practitioner. It can lead to sustained behaviour change for clients (Prochaska, et al., 2008), while the practitioner has a motivated patient to work with. For the client to benefit from this intervention, the practitioner needs to skilfully apply the skills and techniques they've have been trained in. However, in the systematic review, only the impact on the clients were assessed and not the competence or impact of the training on the trainer (Barnes & Ivezaj, 2015). Therefore, the outcome of an

assessment after their training can impact whether they are confident and have the ability to apply this new skills.

It is important to examine factors what hinder the application of MI. However, limited research has explored the challenges that practitioners experienced preventing them from practicing MI with their clients (Barnes & Ivezaj, 2015). This study therefore, explore barriers that prevent practitioners from using MI in their work with clients.

1.3 Research question, aim and objectives

1.3.1 Research question

What are the challenges that practitioners experience that prevent them from applying MI in their work with clients?

1.3.2 Research Aim

The aim of this study was to explore the barriers that practitioners experienced when implementing MI.

1.3.3 Research Objectives

1. To explore practitioner-related factors that influenced the implementation of MI
2. To explore client-related factors that influenced the implementation of MI
3. To explore the role of continuous training and support in the application of MI.
4. To explore workplace related factors that impeded the implementation of MI

1.4 Organization of the dissertation

Chapter 1 In the chapter I introduced the research topic by briefly defining MI and describing its efficacy as a therapeutic intervention for behaviour change. The chapter contains the rationale of the study, aims and objectives of the study. I also provide the organisation of the dissertation.

Chapter 2 contains the literature review and theoretical framework utilized in the study.

Chapter 3 consists of the methodology which I used in doing this research in my attempt to answer the research question. It includes the research design, participant recruitment, data collection process, data analysis and ethical considerations.

Chapter 4 contains the results and discussion of the study which was to explore the barriers that practitioners experienced when implementing MI.

Chapter 5 offers a conclusion of the study, recommendations for the practitioner and for practice, and the discussion of the research limitations.

Chapter 2

Literature review

2.1 Introduction

This chapter consists of a review of the literature related to motivational interviewing and its implementation. This literature review consists of three sections. The first section summarizes studies evaluating the effectiveness of MI, the second section explores factors that impede the implementation of MI, and the third section describes the theoretical framework that I drew from in my study.

2.2 The effectiveness of MI

MI as an intervention for behaviour change has demonstrated efficacy in many studies (Barnes & Ivezaj, 2015; Holland & Holden, 2016; Naidu, Nunn & Irwin, 2015; Satre et al., 2016; Van Buskirk & Wetherell 2014; Rendall-Mkosi et al., 2012). For example, a randomized, controlled, clinical trial study conducted by West, Dilillo, Bursac, Gore, Greene, (2007) in Alabama examined whether motivational interviewing improves weight loss in women with type 2 diabetes, with a total of 217 overweight women. In the study, patients who were receiving five individual sessions of motivational interviewing and an 18-month weight control program were compared with participants who only received the 18-month group-based behavioral obesity treatment. The study reported significant weight loss in the experimental groups when compared with the control groups. Women in the motivational interviewing group lost significantly more weight at 6 months (P = 0.01) and 18 months (P = 0.04) (West et al., 2007) than women in the control group.

Another RCT by Rendall Mkosi et al., (2012) demonstrated the effectiveness of MI in reducing attitudes towards alcohol intake to prevent the risk of foetal alcohol syndrome during pregnancy. The intervention recruited 165 non-pregnant women from the Western Cape who were at risk of developing alcohol exposed pregnancy. Participants were randomly allocated to an experimental group that received five MI sessions (n = 82) or a control group that received usual care (N = 83). The researchers found MI was effective in reducing alcohol intake group and

showed a significant difference in the decline of women at risk at three months (P= 0.004) and at 12 months (*P* = 0.009) (Rendall Mkosi et al., 2012). This locally conducted study indicates the benefits of MI in low-resource contexts.

MI has been used to increase health-related knowledge. For example, one study conducted in Eastern Trinidad, compared the effect of a MI intervention aimed at improving dental health. The experimental group (n = 25) received a talk on dental health using the MI approach and two follow-up telephone calls, while the control group (n = 54) received a traditional dental health talk. There was a significant difference in the increase of healthcare knowledge, attitudes and behaviour of participants in the experimental group compared to the control group ($p < 0.05$ *t*-test). However, one of the limitations of this study was the small sample (Naidu, Nunn & Irwin, 2015).

MI was also evaluated as a brief motivational psycho-education intervention in changing parents' attitudes toward corporal punishment. Forty-three mothers were randomized to either the intervention group (n = 23) or the waitlist crossover group (n = 23). The intervention group received one psycho-education MI individual session that took place 10 days after the assessment. The post-intervention session occurred 48 hours after that session. The waitlist group received a discussion eight days after the baseline questionnaire. Mothers in the MI group showed more reductions over time in corporal punishment attitudes ($p < 0.05$ *t*-test). This study demonstrates the effect MI as an approach had on effective change in attitudes and behaviours in corporal punishment (Holland & Holden, 2016).

MI has also been used to supplement usual outpatient care amongst patients with depression to reduced use of substances (Satre, et al., 2016). In this study a three session MI intervention was compared to a control group that received an educational brochure to reduce risky substance abuse amongst patients suffering from depression. The researchers recruited 307 participants diagnosed with depression over the age of 18 years. Each patient received a 45 minute individual MI session. The individual session was followed up with a 15 minute telephone

session after 3 and 6 months. Each of the participants also received information with their permission about the risks of substance use for people with depression. The control group received the usual care which was an assessment, psychotherapy, and medication management with one two-page brochure on the risks of substance use but not a MI counselling session immediately after the completion of the baseline survey (Satre et al., 2016). While both groups reported improved levels of depression, participants in the MI group significantly reduced their cannabis use and hazardous drinking at six months than the control group (Satre et al., 2016). The study concluded that MI was an effective intervention for reducing alcohol intake and substance abuse.

Van Buskirk and Wetherell, (2014) investigated the effectiveness of MI in a systematic review by analysing 12 RCT's that compared MI to other usual care in primary care settings. The review included telephone and face to face interventions. Studies tested the efficacy in reducing substance abuse (n=5), improving dietary and exercise-related goals (n=2), improving adherence to medication and colorectal screening (n=2) and reducing exposure to passive smoking in homes (n=3). Nine studies reported significant results and the reviewers concluded that MI was an effective intervention in clinical settings when compared to usual care.

Barnes and Ivezaj, (2015) synthesized the results of RCT's that examined the efficacy of MI for weight loss in primary health centres. The MI intervention groups were compared with standardized dietary advice or usual care. The interventions ranged from 3 months to 6 months. Most trials (n=18, 75%) utilized individual therapy, while the rest (n=6, 25%) utilized a mixed model that included individual and group therapy. From the 24 studies, 12 studies reported no significant weight loss when comparing experimental and control groups. Nine out of the 24 studies reported significant weight loss in the experimental groups when compared with the control groups. One study had a weight loss over 5kg and only 2 (8.3%) provided MI to both conditions. Despite the contradictory results, the authors of the review concluded that MI was an effective, time-limited

approach because most of the interventions took place in busy primary health centres (Barnes & Ivezaj, 2015).

The studies cited above indicate that MI is an effective tool in changing behavior among clients relating to a range of areas from substance use to corporal punishment.

2.3 MI as an unsuccessful intervention

There are however studies that found that MI was not a successful intervention when experimental groups were compared to control groups (Dewing et al., 2013; Fernandez et al., 2017; Lundahl et al., 2013; Pladevall, Divine, Wells, Resnicow & Williams, 2014; Petersen, Albright, Garret, & Curtis, 2007; Smeerdijk et al.,2012). For example, an RCT that assessed the difference between the MI counselling style (i.e. non-judgmental partnership between client and practitioner with respect for client's perspectives and ideas) and a directive counselling approach (i.e. providing information) to improve medication adherence for diabetes and lipid control found that one MI session was not effective (Petersen, Albright, Garret, & Curtis, 2007). In this study, participants were assigned to one of three groups. The first group received usual care (n = 567), the second group received medication adherence information (n = 569) using a directive style, while the third group received one session face to face motivational interviewing and adherence information (n = 556). Directive counselling approach can be define as an approach in which the psychotherapist directs the course of therapy by asking questions and giving advice or recommendations (Pam, 2018). After 12 months of follow up, the mean diabetes and lipid control was not significantly different between treatment arms. The study demonstrated that one MI session was not sufficient for lasting behaviour change (Petersen, Albright, Garret, & Curtis, 2007).

Similarly, Petersen et al., (2007) failed to find significant differences after 12 months follow up between an MI intervention group and a control group aimed at pregnancy and STD prevention intervention. The prevention group of 146 women received two MI counselling sessions at the beginning and again two months later, while the control group (n = 146) only received one general

counselling session when enrolling in the project. Both groups were followed-up after 12 months and no statistically significant differences were found. The suggestion for future research was that more intensive and longer periods of MI sessions could assist and motivate the women to use their preventative methods to reduce unwanted pregnancy and STD (Petersen et al., 2007). The studies examined above indicate that while MI is an effective intervention for behaviour change, it is not always successful. In order for MI to effective, clients may need exposure to multiple sessions. One shortcoming of this research was that that researchers failed to examine perspectives of interventionists. These perspectives may provide some insight into why MI interventions were unsuccessful. In the next section I will focus on studies that tell us more about possible reasons why practitioners experience challenges with the application of MI.

2.4 General barriers that hinder the effective implementation of MI

Two qualitative studies have identified barriers that impede the implementation of MI in practice. In the first study, Amodeo et al., (2011) evaluated and compared staff reports of the implementation barriers most regularly reported of four evidence best practice (EBP's) in addiction treatment centres. The study compared staff reports on the implementation of Motivational interviewing (MI), Adolescent community reinforcement approach (A-CR), and Assertive community treatment (ACT).

Among MI practitioners, several barriers were identified. These barriers included (1) limited time for clinical processes, (2) insufficient training, (3) staff resistance, (4) struggles to adjust to MI techniques, (4) variance in staff training and perspectives, (5) conflicts with philosophical underpinnings of MI, (6) staff turnover, (7) lack of space for services, (8) client resistance and (9) working with mandated clients. As is evident, these barriers are located at the practitioner, the organization and the client (Amodeo et al., 2011).

In the second study, Malan, Mash and Everett-Murphy, (2015) conducted a qualitative study with 41 primary care providers on how to offer brief behaviour change counselling (BBCC)

using 5 A's which consists of ask, alert, assess, assist and arrange. The researchers implemented the 5 A's with a patient centred guiding style derived from MI on risk factors for non-communicable diseases in South Africa. The clinicians gave verbal feedback during and after the training programme. The researchers then conducted in-depth interviews with 12 primary care providers about their perception and their ability after implementation of what they've learned in their clinical practices. Participants reported that they had difficulties in adjusting to the new approach and suggested that MI should be introduced in their undergraduate training. The researchers also found that the training increased the participant's confidence. The barriers that they identified were lack of time, language barriers, administrative problems, understaffed facilities and a lack of support for training. The results of the study highlighted the importance of attitude towards the adopting of the new model (Malan, Mash & Everett-Murphy, 2015).

The following sections provide more detail on specific factors that may impede the implementation of MI. These include (1) environmental and practical factors, (2) practitioner-related factors, and (3) client-related factors.

2.5 Environmental and practical factors that impede the implementation of MI

The context where the transfer of skills takes place can have an impact on the clinical practice of MI. The onus rests on the interventionists whether they apply MI after the training or not (Madson, Loignon & Lane, 2009). However, environmental and practical factors can hamper the implementation of MI. The environmental and practical factors identified include the organizational barriers, the training of MI practitioners, barriers within training programmes and supervision and support.

2.5.1 Organizational barriers that impede the implementation of MI

One of the practical factors which limits the implementation of MI is the context in which interventions take place. Systematic reviews indicated that most research done using MI interventions were conducted in primary health care settings that are often very busy (Barnes & Ivezaj, 2015; Lundahl et al., 2013; Van Buskirk & Wetherell, 2014). These reviews showed that

MI interventions were implemented in additional to practitioners' daily care appointments in 75% of studies. (Barnes & Ivezaj, 2015; Lundahl, et al., 2013; Satre et al., 2016; Van Buskirk & Wetherell, 2014). The inclusion of MI therefore increases the workload on practitioners and can be taxing on them.

Primary care practitioners such as nurses and doctors are often tasked with conducting the MI interventions. Nurses and doctors are expected to perform a good deal of clinical examinations in a limited time and cannot always attend to integrate MI as an additional therapy in their sessions with clients (Barnes & Ivezaj, 2015). Practitioners in several studies reported that they were too busy with their daily work routine and failed to record their MI sessions as requested (Bofill et al., 2015; Catley et al., 2012; Lindhardt et al., 2015; Keeley et al., 2016). In addition, primary care practitioners reported that they did not have time for additional MI training (Barnes & Ivezaj, 2015).

Lundgren, Chassler, Amodeo, D'Ippolito and Sullivan, (2011) examined the relationship between staff perceptions about organizational capacity and staff experience of barriers to implementing EBPs. They collected data from a faith-based organization from 510 clinical staff participants and 296 directors. Multivariate regression analyses found a positive association between perceived stress within the organizations and barriers when implementing a new EBP. Among clinical staff only, lower levels of program requirements, working in less established programs, and implementation of MI in comparison with other EBPs were significantly associated with EBP barriers. These findings indicate that barriers among staff at different levels vary.

In a qualitative longitudinal study by Storholm et al., (2017), the researchers explored the barriers and the frequency with which they were reported in the range of care for opioid and alcohol use disorders (AOUD) in two primary care clinics. They assessed how the mentioned barriers change through the three phases of implementation which were the preparation, practice and full implementation. The intervention consisted of medication-assisted treatment and/or a six-session motivational interviewing- and cognitive therapy-based brief treatment. The

participants in the study consisted of clinic managers, who they conducted one on one interviews with, and mental health workers which they held focus groups with.

The largest barriers that they identified were non–adherence to policies and procedures of the clinics, a high staff turnover or lack of staff which cause continuous training challenges, time to spend on AOUD patients, a lack of motivation demonstrating by staff, concerns about insufficient training, self-efficacy and a lack of knowledge, and many challenges with dual diagnosis patients (Storholm et al., 2017). The literature indicates that there are several barriers to MI and the implementation of EBP's. The barriers to EBP's may be applicable in the context of MI.

2.5.2 Training of MI practitioner

Adequate practitioner training is important for practitioners to be effective interventionists and for the effective implementation of MI (Lundgren et al., 2011; Amodeo et al., 2011). Miller and Rollnick, (2013) assert that mastering the skills and techniques of MI over a consistent period requires time and consistent determination. Studies identified that a lack of knowledge of MI and lack of time to apply training materials are key barriers to the implementation of MI (Lundgren et al., 2011; Amodeo et al., 2011).

MI trainers play a key role in training and an important role in providing the appropriate support (Amodeo et al., 2011). Data from a systematic review about MI training, indicate that most of the interventionists reviewed in that studies were trained by MI trainers certified by the Motivational interviewing network of trainers (MINT) (Madson, Loignon & Lane, 2009) . In the study of Amodeo et al., (2011) the MI interventionists were mostly physicians, nurses, master's level therapists, health educators and counsellors. A systematic review from 12 RCT's of motivational interviewing conducted in primary health care facilities concluded that individuals with higher levels of professional training delivered more effective MI than individuals with no tertiary education (Van Buskirk & Wetherell, 2014). In addition, MI interventionists from a counselling background are more proficient in delivering MI interventions than interventionists

with no counselling background, who did not see MI as part of their professional role. For example in this review the substance abuse counsellors perform better than the other participants (Darnell, Dunn, Atkins, Ingraham, & Zatzick, 2016).

The importance of training was further demonstrated in a longitudinal study by Carpenter et al., (2012). In this study, 58 community-based addictions clinicians participated in a two-day MI training workshop and were then randomly assigned to one of three post-workshop supervision programs namely, live telephonic supervision, tape-based supervision, or no supervision. Data was collected before the training workshop and then at 1, 8, and 20 weeks post-workshop. The researchers found that baseline MI skill levels were the strongest predictors of both pre-supervision and post-supervision counselling performances. They also reported that the clinicians with degrees were more competent and stronger in their MI performance than those without formal education (Carpenter et al., 2012). These findings were confirmed with studies from Dewing et al., (2013) and Mash et al., (2008). Dewing et al., (2013) found that 39 lay counsellors struggled to apply elements of MI in a project aimed at increasing antiretroviral adherence. Similarly, Mash et al., (2008) found nurses to be more competent in applying MI than lay counsellors.

Lay counsellors are commonly recruited and trained as MI interventionists. Lay counsellors required more comprehensive training and practice to understand and master the complex elements of MI than professional trained counsellors (Dewing et al., 2013). Studies showed that lay counsellors struggled to focus on the client's need and motivation (Miller & Rollnick, 2013) and found it challenging to be flexible enough to handle complicated therapeutic issues that arose during counselling (Dewing et al., 2013). These advance and complex skills needed to do therapeutic work, forms part of the training of professional counsellors (Dewing et al., 2013).

A common barrier for implementing MI described by Amodeo et al., (2011), was not only insufficient training of the new EBP but also lack of continuous staff training. A workplace with

regular staff turnovers, needed continuous staff training to fill this gap (Amedeo et al., 2011). The staff who did not receive training could not align with the theory of MI, which made it difficult for the trained staff in the same facility to stay in the MI framework. There was a need for specialized training and an extensive amount of it (Amedeo et al., 2011). The study found that initially the participants struggled to learn and apply the new concepts of MI. The transition from previous theoretical orientations to MI was difficult due to the different backgrounds of the participants (Amodeo et al., 2011). The ease of learning a new approach also depend on how familiar or similar the approaches was that the therapist have used in the past (Lundgren et al., 2011). The studies cited above, demonstrate the crucial role that training and support play in the implementation of EBPs and MI.

2.5.3 Barriers within training programmes

The structure and content of a training programme play a vital part in the successful implementation of the intervention. The length of the training program should be sufficient to allow for trainees to grasp the intricacies of the theory and incorporate practical methods such as role-plays and peer observations (Carpenter et al., 2012; Mash et al., 2012).

Rigid training manuals are useful in training interventionists but can restrict the implementation of MI. A meta-analysis of MI studies concluded that manuals and structured guidelines hinder the natural flow of intervention sessions and can be problematic (Lundall et al., 2010), and this finding was confirmed by Dewing et al., (2013). In addition, structured manuals may have limited utility when clients present with diverse needs and characteristics, making it challenging to adhere to rigorously structured protocols (Dewing et al., 2013). Instead, it is recommended that interventionists listen with understanding to the client's perspective and reflect to the response from the client (Rollnick & Miller, 2013). This approach can change the direction and flow of the conversation (Rollnick & Miller, 2013). Therefore the interventionist can struggle to follow the guidelines in the manual (Lundall et al, 2010).

Practitioners report that concerns about lack of adequate training are barriers to MI (Storholm et al., 2017). An interventionist's proficiency in MI should be evaluated directly after training and not only after an intervention with a client (Carpenter et al., 2012). This may improve feelings of self-efficacy, resulting in better application of MI (Carpenter et al., 2012).

2.5.4 Supervision and monitoring

The need for ongoing supervision and support during and after training were reported in several randomized controlled studies (Amodeo et al., 2011; Carpenter et al., 2012; Dewing et al., 2013; Malan et al., 2015; Miller et al., 2004). Forsberg, Ernst and Farbring, (2010) conducted a randomised control study in two Swedish prisons with 45 staff members who were divided into three groups namely; (1) The Behaviour counselling change counsellors (BSF+) who received ongoing MI training and audio-recorded feedback, (2) a group of counsellors who received workshop only training (BSF) and (3) the regular prison staff continued with usual care for prisoners (UPI). The 296 prisoners were randomized into these three groups. The first recorded MI session of the five sessions were analyzed and measured with the Motivational Interviewing Treatment Integrity code (MITI; Moyers et al., 2007). At the final phase of the study only the 83 most recent recorded sessions were analysed. The BSF counsellors demonstrated better competence than the UPI group but there was no significant difference between the BSF+ group and the BSF group. The recommendation by the study was a need for more supervision and feedback after the training for a period as long as two years (Forsberg, Ernst & Farbring, 2010).

2.6 Practitioner-related factors that hampered the application of MI

Several personal factors related to the practitioner that impede MI have been identified. These include the attitude of counsellors and confidence as a barrier for implementing MI.

Barriers to implementing evidence-based practice were identified in a quantitative study in the Eastern Cape by Jordan, Bowers & Morton (2016). The study measured individual and organizational barriers to EBP among nurses (n=70) working in intensive care units. The researchers created a survey using two questionnaires constructed from four different

measurement instruments. Data was analysed using frequency distributions and Chi Squared analysis. The study found that nurses over the age of 40 years reported less knowledge of EBPs in comparison with nurses under the age of 40 years, but it was not statistically significant. The researchers hypothesized that exposure to technology of the under 40 year's age group and therefore easier access to research materials during their training, resulted in this phenomenon. However, the results indicated otherwise.

Responses to the survey indicated that most nurses based their knowledge of EBP on their basic training, rituals, traditions and information from their colleagues, which can be seen as a barrier to accept new evidence-based information. The nurses in the study reported difficulties in analysing and synthesizing the new information. Another barrier identified was nurses' resistance to change from their traditional practices to new EBP interventions because they were accustomed to their existing ways. Several organizational barriers were also identified (Jordan, Bowers & Morton, 2016). These included a lack of support from physicians and non-nurses, high staff turnover, lack of authority to facilitate the change to apply the new EBP, and the complexity of the model used. Other barriers the participants identified was a limited time to conduct counselling in the context of larger workloads and limited access to research. However, participants only represented nurses, in the context of one private intensive care which made it difficult to generalize the results (Jordan, Bowers & Morton, 2016).

2.6.1 The attitude of the practitioners

Attitudes and resistance to change from traditional way of practice to a new EBP, were highlighted as a barrier in several studies (Jordan, Bowers, & Morton, 2016; Storholm et al., 2017; Tacia et al., 2015). A critical literature review of studies relating to practitioner training over a period of 18 years found that attitudes towards EBP varied, with some practitioners in favour of it and others against it (Beidas & Kendall, 2010). The practitioners with younger careers were more in favour of the EBP than therapists that had many years of experience. The review demonstrated the importance of attitude in the implementation of EBPs. They concluded that training results in

improved therapist knowledge and attitudinal change. Active learning was required to ensure therapist competence, adherence and skill (Beidas & Kendall, 2010). Several other studies have described the importance of practitioner attitude in the successful implementation of EBP (Amodeo, et al., 2011; Lundgren et al., 2011; Rieckmann, Daley, Fuller, Thomas & McCarty, 2007).

In addition to attitude, low self-efficacy was identified as a personal barrier for the successful implementation of MI (Storholm et al., 2017; Malan, Mash & Everett-Murphy, 2015). Practitioners with low levels of self-efficacy usually displayed low confidence in their abilities to implement MI effectively (Storholm et al., 2017; Malan, Mash & Everett-Murphy, 2015). Students who are trained and are informed about the outcome of a course, are more confident in their performance (Carpenter et al., 2012). Self-efficacy was associated with knowledge (Storholm et al., 2017; Malan, Mash & Everett-Murphy, 2015). The study found that self-efficacy among practitioners increased over time as their knowledge increased (Carpenter et al., 2012). Bandura, (1977) suggested that encouragement is effective for increasing self-efficacy and become more effective when combined with mastering the skills.

2.6.2 Client-related factors that hampered the application of MI

Studies show that factors related to clients can also impact the efficacy of MI implementation. These factors include client resistance to interventions, psychiatric disorders and cognitive ability (Beidas & Kendall, 2010; Horsfall et al., 2009; Moore et al., 2015; Westra, 2004). It is important to understand these client characteristics as this will assist the therapist in implementing an evidence based approach like MI (Beidas & Kendall, 2010).

2.6.3 Resistance

Resistance is the tendency to refuse or adopt a new behaviour or to behave defiantly (Miller & Rollnick, 1991). Miller and Rollnick, (2002) described resistance as the product of the client's ambivalence, the reaction of the therapist as well as the interaction between the therapist

and the client. Ambivalence is seen as a normal part of the changing process and presents as a barrier in recovery (Miller & Rollnick, 2002). Clients who refuse treatment because they are ambivalent about changing, may therefore respond poorly to treatment or do not respond at all (Miller & Rollnick, 1991). Westra, (2004) presented a paper describing how MI could be applied to the management of resistance in cognitive behaviour therapy in three case studies with depression and anxiety symptoms. In these case studies resistance arose when clients did not comply using the CBT tools and the procedures in the treatment program. MI provides methods to motivate clients to move out of ambivalence to enable them to use the tools. The findings suggested that MI can assist as strategies for managing resistance to CBT (Westra, 2004). The practitioners in the study reported earlier stated that client resistance to counselling was a perceived barrier to EBP counselling (Amodeo et al., 2011). More research on resistance and effective MI implementation is required.

2.6.4. Psychiatric comorbidity as a general barrier to counselling

People with psychiatric diagnosis and co-occurring substance abuse posed challenges for psychosocial treatment (Horsfall et al., 2009; Cleary, Hunt and Walter 2009; Storholm et al., 2017). A review of randomized controlled studies assessed the effectiveness of psychosocial interventions for persons with dual diagnoses (DD) (Horsfall et al., 2009). Dual diagnosis in this case referred to people with a mental illness and a substance abuse problem. Patients with DD struggled with symptoms like delusions, auditory hallucinations, concrete thinking, flat effect, low energy levels, inability to focus on their goals and limited emotional expressivity. These symptoms can create barriers for engagement in any treatment. Moreover, dual diagnosis patients had less motivation, had a higher dropout rate, made slower progress and had more relationships problems than people with just one a mental illness (Horsfall et al., 2009).

The reviewers suggest that dually diagnosed clients may experience additional contextual barriers that influence their adherence and attitude towards treatment. These contextual barriers include basic needs such as housing and employment, family involvement and support. The

reviewers suggested that if family members had positive attitudes, attempted to understand patients better and communicated effectively, they could increase the patients' motivation for change (Horsfall, Cleary, Hunt & Walter 2009).

A quantitative, quasi-experimental study by Moore et al., (2015) investigated whether MI and CBT significantly improved the completion rate and increased self-efficacy among DD clients in intensive-outpatient (IOP) treatment. They randomly assigned 307 patients (210 males and 97 females) to three study groups and recorded the self-efficacy pre- and post-MI. The three groups were (1) a comparison group receiving CBT treatment alone; (2) a treatment group receiving MI and CBT treatment; and (3) a treatment group receiving MI and CBT where they recorded self-efficacy pre and post MI. A Chi-square analysis was conducted and the researchers found significant differences ($p < .01$) between groups in terms of the rate of successful completion of treatment based on receiving MI and CBT as compared to receiving CBT alone. The scores of participants with low self-efficacy increased by 30% after the MI and CBT sessions. The researchers recommend that DD client need motivation to change to increase their completion rate and their low self-efficacy (Moore et al., 2015).

2.6.5 Cognitive ability of clients understanding MI

The cognitive ability of a person plays a role in the way they understand a conversational process like MI. Clients with mild intellectual disabilities (ID) may find it challenging to understand complex communication processes (Lundahl & Burke, 2009) and may struggle with socially accepted behaviours (Chapman & Wu, 2012). To further complicate matters a review concluded that there was an alarming rate in substance abuse with adults with mild to severe cognitive disabilities (Chapman & Wu, 2012). The study demonstrated that substances abuse makes the treatment of CD clients more challenging. The researchers suggested a need for increased and effective treatment intervention tailored for people with dual disabilities which refers to more than one disability (Chapman and Wu, 2012).

MI techniques can be adapted to treat clients with mild intellectual disabilities. Naud and Frielink, (2013) found it necessary to use an inductive approach in their study, to identify how practitioners can adapt MI techniques to treat clients with mild intellectual disability and challenging behaviour. In this qualitative study, the 26 participants consisted of 9 clients, 3 parents and 11 professionals who had experience working with such clients. The study found that MI was a promising approach, but that it needed to be adapted enable professionals to use it with people with intellectual disabilities. Professionals may need additional time with clients because of the repetition of questions and reflections (Naud & Frielink, 2013). Furthermore, practitioners should be cognisant that people with cognitive disabilities may lack abstract reasoning issues related to short term and working memory, and comprehension, making it difficult for clients to understand and respond (Lundahl & Burke, 2009). The researchers recommended that professionals working with people with cognitive disabilities should be trained in adapting MI for their clients (Lundahl & Burke, 2009).

The discussion in Chapter 2 focused on the current literature regarding the effectiveness of MI, when MI was not successful and the barriers that practitioners experienced when implementing MI. I discussed the general barrier that impedes MI, the organizational related factors, the practitioner-related factors as the client-related factors that hindered the effective implementation of MI and other EBP's. In the final part of this chapter I present the conceptual framework that I drew upon in my study.

2.7 Conceptual framework

In my study, I explored barriers that therapists encountered that prevented/hindered their application of Motivational interviewing (MI) in clinical practice. In order to understand these barriers, I drew on a conceptual framework that provides a guide for delineating successful evidence-based practice. This framework is called the Promoting Action on Research Implementation in Health Services (PARiHS) and it attempts to explain how to implement evidence-based practice (EBP) effectively by reflecting on multiple factors involved (Kitson,

Rycroft-Malone, Harvey, and McCormack, Seers & Titchen, 2008). The framework can be used as an evaluative tool by practitioners (Kitson et al., 2008).

The PARiHS framework consist of three element and several sub-elements (Kitson et al., 2008). The first element is the context(C), i.e. the environment or setting in which the proposed EBP will be implemented. Context comprises of three sub-elements. The first is an understanding of the usual culture (i.e. how operations take place), the second is leadership roles; (i.e. taking ownership of the EBP and the management encouragement) and the final sub-element is organization's approach to measurement (supervision and monitory methods) (Kitson et al., 2008).

The new change should be relevant to the organization and fit with their structures and procedures. Another aspect that is important is the available resources and the use of a multi-disciplinary focus for successful implementation (Kitson et al., 2008).

Kitson et al., (2008) refers to Evidence as the second element. Evidence (E) refers to the nature and strength of the evidence and its potential for successful implementation. The sub-elements of evidence are (1) research evidence that can be adapted to apply in the local context, (2) clinical knowledge of practitioners, (3) patients' preferences and experience and (4) local information that consists of evaluation data, community's stories and the organizational culture needs. The implementation of this evidence will be the responsibility of the facilitator who will be looking at the costs and benefits with an understanding of the new intervention versus the costs and benefits of the older interventions (Kitson et al., 2008).

Kitson et al., (2008) refers to Facilitation (F) as the final element and refers to a broad term for support, supervision, counselling, learning and coaching by trained facilitators who supported people that needed help to change their attitudes, habits, skills and ways of thinking. The facilitator requires firstly to adopt and have insight of the evidence, within the context, with the appropriate facilitation skills, personal attributes, and knowledge (Kitson et al., 2008). The facilitator will be in

a specific leadership role to guide and evaluate the implementation of the evidence, doing assessments, and developing change strategies (Kitson et al., 2008).

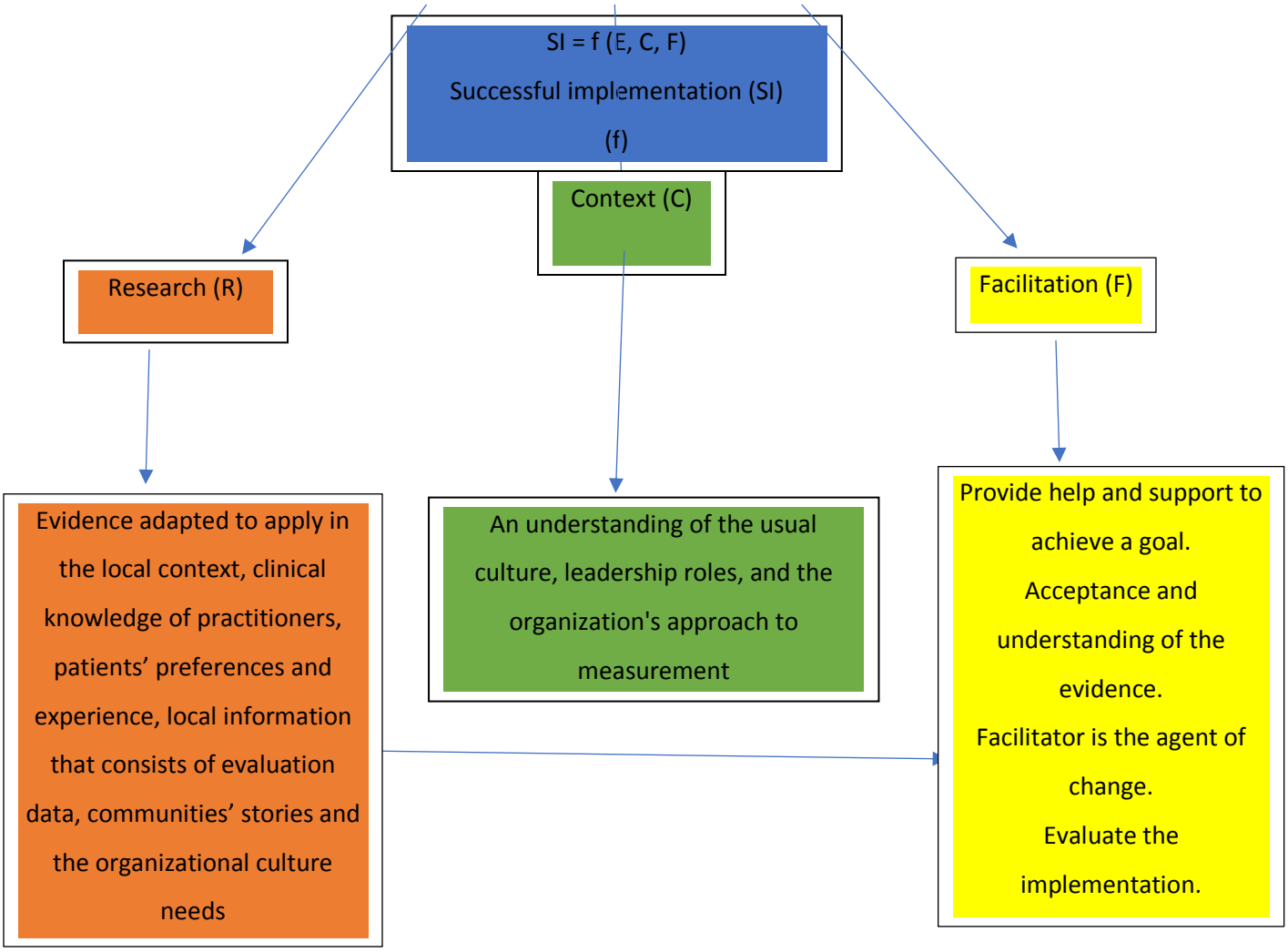
The method of facilitation depends on how the individual or team understand the new change and whether they accept the change in their context. The facilitator should provide help and support to achieve a goal of enabling individuals and teams to analyse, reflect, and change their own attitudes, behaviours, and way of living (Kitson et al., 2008).

The emphasis in this framework is on the facilitator as the agent of change to help and meet the patient's need. Successful implementation of evidence are more promising when the context is accessible to change and where there is effective facilitation (Kitson et al., 2008).

To be successful in the application of the evidence-based practice (EBP) according to Kitson et al., (2008), the whole system needs change which includes the individual and the organization. Successful implementation is dependent on the context, evidence and facilitation (Kitson et al., 2008).The interplay of these elements and their sub-elements makes it easier or difficult to implement new evidence based intervention (Kitson et al., 2008). I used this framework, (see diagram 1) to conceptualize my study as the implementation of MI can be a function of context, facilitation and evidence, as outlines in this model (Kitson et al., 2008).

I also used this framework to structure my interview questions. Therefore, the use of the PARiHS framework was an important conceptual framework useful for a lens to view the interplay between the evidence, context and facilitation for successful implementation of evidence-based practice (Kitson et al., 2008).

Diagram 1: Conceptual framework



Chapter 3

Methodology

3.1 Introduction

In this chapter I describe the research methods used in this study. Methodology refers to the systematic way of how research is done using procedures to describe, explain and predict a phenomena by which knowledge is gained (Mouton, 1996). The next sections describes the study setting and design, participant characteristics and recruitment. I then describe the data collection procedure and data analysis, trustworthiness of my findings, reflexivity as well as the ethical considerations for this study.

3.2 Research design

The aim of this study was to explore the barriers experienced by practitioners that prevented them from applying MI with their clients. I was curious to explore the thoughts and ideas of participants. I employed a qualitative approach that allowed me to discover deeper levels of understanding of the participants' experiences and allowed for deep and rich data description (Babbie & Mouton, 2008; Creswell, 2007). I used a cross-sectional research design, where data was collected and analysed from a subset of a population at one point in time (Creswell, 2007).

The study's framework fits within the interpretive paradigm. The interpretivist's approach includes the use of interviews, observations, recordings or photographs, including field notes as methods to collect data (Babbie & Mouton, 2008). Participants were generally asked to reflect on a phenomenon and this allowed me to report how they interpreted the phenomenon or practices (Babbie & Mouton, 2008). My goal as the researcher was to gain insight from the experiences of participants, in a collaborative and participatory way.

3.3 Study Setting

This study was conducted among social and health practitioners living and working in the Western Cape. All participants, who were trained in MI and found to be competent after the training. Participants worked in various settings, with some employed at local government facilities and others employed private treatment institutions. A detailed description of participants' employment can be found in the results chapter.

3.4 Participants

In keeping with the aim of the research, only practitioners who were trained in MI and achieved competency were allowed to participate in the study. In addition, participants had to have achieved this competency at least 6 months prior to being interviewed, to allow them sufficient time to have been able to practice MI with clients. Participants also had to be employed as social and/or health practitioners. Both males and females that could speak English or Afrikaans were considered eligible to participate. Participants who were found not competent after the training assessment as well as participants from other careers were not eligible to participate in the study.

3.5 Participant recruitment

I used two methods to recruit participants. Initially purposive sampling was used to recruit participants for the study. Purposive sampling is commonly used in qualitative research where judgment is made on the basis of available information about the population (Babbie & Mouton, 2003). In purposive sampling, members of the sample are selected according to specific pre-determined criteria (Ritchie & Lewis, 2003). The following criteria were selected in this study: either male or females, employed as social or health practitioners who successfully completed an MI course and who showed a willingness to take part in the study. I started with my recruitment using purposive sampling soon after receiving ethics approval for the study on 30 January 2018.

After obtaining ethical clearance to conduct the study, I proceeded to recruit participants through the Division of Family Medicine and Primary Care at the University of Stellenbosch. The

Division offers MI training to professionals. I consulted Professor Bob Mash, who runs the MI training, when writing my protocol. Professor Mash granted me access to his records containing the contact details of practitioners who completed a MI training course and who achieved competency in this course. Professor Mash's assistant created a list containing the email addresses of 30 candidates who were deemed appropriate candidates. I also received permission from the Department of Psychiatry and Mental Health to access to the database of past students who did MI as module as part of the Post graduate Diploma in addiction. The course administrator extracted the names and email addresses and send it to me (please refer to Appendix A for the email). I emailed all the candidates and invited them to participate in the study. Please refer to Appendix B for the invitation letter.

The practitioners who were interested in participating contacted me on the email address or telephone number provided. After these participants emailed me, I once again informed them of the nature of the study and asked them if they were willing to consent to participate in the study. I then conducted follow up phone calls and made appointments to meet with them in a private place of their choice to conduct the individual interviews. The responses on the first email were insufficient. Most of the email addresses on the list provided did not exist anymore.

I contacted Professor Mash's assistant to find out if she could provide me with an updated list. The assistant sent me another list of 20 participants' names and email addresses who completed a course in November 2017. I once again invited these candidates to participate in the study using the procedure outlined above. The response was poor with only four participants responding to my email. In addition, some of the practitioners responded but stated that they were not willing to participate in the study because they had either moved to another province or they had a busy schedule and could not find time to fit in an interview. Others responded and stated that they received training but never used the approach in their practices and therefore they did not feel comfortable to reflect on their experiences. Therefore after two rounds of recruiting participants via email I had to find an alternate recruitment procedure.

I submitted an amendment to my protocol to the Research Ethics Committee (REC), in which I included snowball sampling to recruit participants. This amendment was granted. Snowball sampling consists of asking people whom have already been interviewed, to identify and suggest other people who might fit the selection criteria (Richie & Lewis, 2003). I used this sampling procedure by contacting participants who I interviewed and asked them if they could provide my contact details to any candidates who met the criteria used in the study.

Potential participants contacted me and I emailed them the information about the study and asked them telephonically if they were willing to participate in the study. I made appointments to meet with the participants in a private place of their choice and conducted the interviews. At the end of the study I recruited and interviewed a total of 15 practitioners and was satisfied that data saturation was reached. I felt that adding more participants, would not have contributed to the other perspectives and information (Babbie & Mouton, 2011).

3.6 Data collection

The study design acted as a framework and shaped how I conducted the research activities. I arranged to meet participants who met the inclusion criteria of the study at a time and place that was convenient for them. Most of the participants were willing to meet me at their natural setting such as private homes, their workplaces which included outpatient treatment centres, inpatient treatment centres, at their offices as well as at my office in Somerset West. When it was not possible to meet at their workplace, we met at a coffee shop.

One of my goals during the interviews was to gain trust and build rapport in order to get as close as possible to establish worthiness and credibility (Babbie & Mouton, 2011). I began my interviews by introducing myself, telling them about the research project and thanking them for their willingness to participate voluntarily in the study. Participants were given a choice of being interviewed in Afrikaans or English. I then explained the ethical considerations of the study including audio-recording of interview, the availability of free counselling should they become distressed as a result of participating in the study and withdrawal from the study. After obtaining

written consent (please refer to appendix C for consent form), I obtained some demographic information (please refer to appendix D) before proceeding with the interview.

The interviews allowed me to have a conversation with the purpose of recording the opinions and experience of the participants (Babbie & Mouton, 2003). A qualitative interview is a collaborative conversation between the researcher and the participant (Babbie & Mouton, 2011). I conducted semi-structured interviews using a list of questions that gave direction to the discussion which afforded the participants flexibility and freedom in answering. I developed the interview schedule in consultation with my supervisor (please refer to appendix E for the interview schedule). The interview schedule consisted of 10 open ended questions that explored participants' overall perception of MI, their training experience, the workplace related experience of MI, the client-related factors and their professional and personal obstacles they experienced during implementing MI.

I listened attentively to the participants' reflections on their experiences using MI, made concise notes and recorded the conversations (Babbie & Mouton, 2011). I tried to be present throughout the interview, showing respect and acceptance for each participant's views, but mindful of my own subjectivities, that I needed the participants' own ideas and reassured perspectives for this study (Babbie & Mouton, 2011). The interviews lasted between 45 minutes and one hour. On average the interview duration was 50 minutes. At the end of the interview I thanked the participants and reminded them again of the free counselling that was available. The interviews lasted approximately 45 minutes to an hour. I personally transcribed the data from audio recordings after each completed interview.

3.7 Data analysis

I used thematic analysis to analyse the interviews. I transcribed the data myself and engaged with the data by listening to the tapes repeatedly. I also reread the transcriptions more than once to ensure correctness and to familiarize myself with the details of each interview. The analysis of the data was a multifaceted process because it took place in different phases. I

assigned pseudonyms to participants to allow for anonymity. I kept all data confidential, saved the transcriptions and recordings in an electronic file protected by a password on my personal computer and I kept the backup disk in a dry, safe place. My supervisor, had access to all the data. I uploaded the transcriptions to data management program Atlas Ti 8 to upload the transcriptions. Atlas Ti 8 is a computer-assisted qualitative data analysis software programme. Atlas Ti is used for data management and cannot code or analyse the unstructured data.

I conducted a thematic analysis using the guidelines provided by Clark and Braun, (2013) to analyse the data. Thematic analysis is a data analysis process within qualitative research which assisted me to identify patterns and themes within the data to interpret and to make sense of it (Clark & Braun, 2013).

The following six steps described by Clark and Braun, (2013) were important during the analysis: I prepared and processed the raw interview in the original language. (1) I familiarized myself with the data; (2) coded the data by generated labels for each code that emerged from the data; (3) organized the codes to assist me to search for themes; (4) defined the themes and (5) wrote a full analysis of each theme and (6) lastly I included analytic narratives and extracts from the data that tell the participant's story and integrated it with literature.

During step one I familiarized myself with the data. I conducted all the interviews, which allowed me to engage with the content. Although transcription and checking the data was time-consuming it allowed me to become acquainted with the data during the process. I listened to the audio-recording more than once during this process. I then read the data more than once and listed patterns of experiences. I was reminded of each participant, of where the interview took place and of what was said.

After familiarizing myself with the data, I coded the data by generating labels for each code that emerged from the data. I worked through each transcript, read each sentence to identify different pieces in the text with meaning and labelled what I interpreted in the sentence as being important. I found that I applied a technique called simultaneous coding (Saldana, 2009) to assign

multiple codes to one sentence. I searched and identified concepts that were relevant, to find relations between them and coded these segments (Braun & Clark, 2006). After I completed each transcript, I discussed and worked through it with my supervisor. As we worked through it we created and modified more codes. I created a list of elements that were evident through all the transcripts whilst keeping in mind the focus of my research question. Throughout the analysis process, Atlas Ti 8 automatically kept a record of all the codes which helped me to keep track of all the codes. Atlas Ti 8 organized the codes that I assigned to the data extracts in different categories. These categories were the attribute codes which consisted of the date and time and the duration of the interview as well as the demographic information of the participants and their pseudonym (Saldana, 2009). The second category was the descriptive codes where I assigned a code to which topic belonged to what segment of data, for example the time as a barrier, or supervision and support (Saldana, 2009). The third category I employed was in vivo codes where I used the exact language of the participants and assigned it as a code name (Saldana, 2009). I established certain patterns of data that was repeated as foundation to generate my themes.

Thirdly I organized the codes together into different themes (Braun & Clarke, 2013). Multiple codes were generated. With the help of my supervisor I used the list of codes and organized them into smaller groups to rule out repetition. From these groupings, I was able to identify possible themes that I could later organize in main themes and subthemes. At the end of this step the codes had been organised into broader themes that linked to the research question.

Fourthly I reviewed, modified and developed my themes and sub-themes and explored the connection between the different themes. I used Atlas Ti 8 to count how many codes supported each individual theme and how it connected with each other. The programme assisted me in generating a thematic map to see how each theme fitted into each other. During this phase I verified if whether the themes fitted into the full story and if it defined the nature of each individual theme.

In the last phase, I re-assessed the content of each theme (Braun & Clarke, 2006). I ensured that the themes made sense and that it was supported by the data (Braun & Clarke, 2006). I integrated themes that seemed to overlap with each other and searched for more themes. After I've defined the themes I wrote a full analysis of each theme considering how the themes worked in the context of all the interviews (Braun & Clarke, 2006). I added together analytic narratives and extracts from the data that told the whole story and integrated it with the domains in the literature review (Braun & Clarke, 2006). In this analysis, the barriers practitioners experience when implementing MI is the principal theme that is rooted in the other themes.

3.8 Trustworthiness

Trustworthiness is the extent to which the data and data analysis is believable and tests if the researcher has done justice to the research subject (Babbie & Mouton, 2006). The four strategies that I employed were credibility, transferability, dependability and confirmability.

3.9 Credibility

I invested a great deal of time during the interviews to build rapport, and asked open ended questions about participants' perspectives. I provided descriptions of the different treatment settings and the contexts in which the practitioner implemented MI. I spent time to obtain rich data from the conversation by probing for examples of their statements and provided rich descriptions data of the context in which the study took place (Creswell, 2014; Korstjens & Moser, 2017).

3.10 Transferability

The findings of the study may be applicable to different treatment environments but it can't be generalize. The participants were employed from different treatment environments and in different professional capacities (Creswell, 2014; Korstjens & Moser, 2017). The same investigation can be repeated with other practitioners in the same context (Babbie & Mouton, 2006).

3.11 Dependability

I discussed the analysis of each interview with my supervisor to ensure that my interpretations were suitable and meaningful and grounded in the data (Creswell, 2014; Korstjens & Moser, 2017). We had regular meetings during the process of analysis, looked at the different data sets that emerged throughout the analysis and whether the analysis process was in line with the guidelines of (Babbie & Mouton, 2006).

3.12 Confirmability.

My supervisor and I discussed data reduction and analysis, how to construct the themes, ensured the use of the correct research methods and reflect on the construction of the research instrument (Babbie & Mouton, 2006). I did my utmost to ensure that I reached saturation through detailed review and discussions of the data with my supervisor (Creswell, 2014; Korstjens & Moser, 2017).

3.13 Reflexivity

I am a registered counsellor working in an outpatient centre for the treatment of addictive disorders. I completed my first MI training as part of a Postgraduate Certificate in Management of Substance abuse with Professor Merwyn London in the UK. In 2005, I attended a training of new trainers in MI with Professor Stephen Rollnick in Stellenbosch. I've been a MI trainer ever since where I assisted with training in MI from 2011 to 2014 at the Division of family medicine and Primary care at Stellenbosch University.

I also has been working as a trainer on motivational interviewing (MI) for the Alcohol, Tobacco and Other Drug Research Unit (ATODRU) of the South African Medical Research Council (SAMRC) since 2006 until the recent project in 2018. I am currently doing MI training for practitioners from different organizations that work with behaviour change.

I described the study experience as a journey when reflecting on what happened during the process. Being involved in MI training, I found that I had so much to learn about the theory but also about challenges that could be faced with implementation of MI. I now understand the

frustrations of practitioners better and know that internal factors and external factors contribute to the successful implementation of any evidence based approach.

I could not understand why I struggled to get participants to take part in my study. For me the research question was so important, but it was not the same for everyone I contacted. I have spent more than a year recruiting participants and collecting data due to circumstances beyond my control. I enjoyed conducting the interviews with practitioners because they were knowledgeable and could communicate professionally about the topic. Most of the participants were passionate about the topic which made it interesting and stimulating the discussion. Most of them mentioned at the end of the interview that it was an opportunity for a reflection session about MI. I met with some participants in coffee shops and at their private homes and was initially worried about my safety but felt safe and comfortable. I met most of the participants at their workplace which gave me good insight on their circumstances in which they operate. Everyone understood the ethical considerations and allowed me to do recordings.

Transcribing was a time consuming exercise although I could familiarize myself with the data. The analysis and learning how to use Atlas Ti were challenging. My supervisor took me by the hand and assisted me with analysing and interpreting the data. It was not an easy journey, I experienced many frustrations, was impatient when I struggled to understand the process and could not initially enjoy the process. With support from many and hard work and sacrifice I managed to persist. I will now discuss the ethical considerations which also was also challenging but important.

3.14 Ethical considerations

Ethical clearance was important during the research because I entered the private space of my participants and wanted to ensure that the conditions were not harmful for the participants (Creswell, 2007). I had an obligation to respect the rights, needs, values and desires of the participants (Creswell, 2007).

I obtained ethical clearance and permission from the Department Ethics Screening Committee (DESC) and Research Ethics Committee (REC) before the study commenced (please refer too appendix F). I also obtained written permission from the Family Medicine and Primary Care of the University of Stellenbosch to access the records containing the contact details of practitioners who completed MI training. I discussed several issues that I considered during the qualitative research process.

Informed consent was important for the focus of the study, the expectations, purpose, nature, data collection methods, and date when the data collection would start. A consent form was issued to the participants before the interview, which stated that the information will be used for research purposes only. I made it clear to them that participating in the study was voluntary, and that should they for some reason want to withdraw, they were free to do so at any time. Written permission was obtained from participants to audio-tape the interviews.

The reflections of personal experience during the interview made it difficult to exclude possible psychological harm. I explained to the participants that there will be free counselling service available if participants should experience any emotional distress sharing their personal experience during the interview. No harm was indicated during the interviews or subsequently.

The importance of confidentiality was discussed with the participants and their privacy was respected at all times. I maintained confidentiality during the research process using pseudonyms. I did not use participant's real names in any documents but assigned pseudonyms to each participant. Participants chose a pseudonym that they were comfortable with that we used on all the documents in order to maintain confidentiality. Only the people involved in the study, had access to the participants information. The audio-tapes were stored on my computer and will be destroyed five years after completion of the study.

3.15 Summary

In this chapter I described the research methods used in this study which included the study setting and design, participant characteristics and recruitment. I also described the data collection procedure and data analysis, trustworthiness of my findings, reflexivity as well as the ethical considerations for this study. The next chapter I discuss the findings of the study.

Chapter 4

Results and Discussion

4.1 Introduction

In this chapter I will present my findings on the challenges that practitioners experienced that prevented them from using MI with clients. This chapter commences by describing the demographic information of the 15 participants. I then introduce and describe the main themes, which are (1) practitioner-related factors, (2) client-related factors, (3) lack of continuous training and support and (4) workplace related factors. I discuss each theme by situating it in the literature as described in chapter 2.

4.1.1 Demographic characteristics of the participants

The participants in this study were 15 people who received training in MI. Table 1 contains the demographic information of the participants. Thirteen participants were women and two were men. Participants' ages ranged from 27 to 64 years (average age = 37 years). Most of the participants were social workers (n=9), followed by registered counsellors (n=2), an educational psychologist, a life coach and an addiction counsellor. All participants resided in the Western Cape. Five of the social workers, the psychiatric nurse and the addiction counsellor worked at structured inpatient treatment centres. One social worker worked at a non-governmental organization that educated and supported farm communities affected with fetal alcohol spectrum disorder. The second social worker operated in private practice and focused on marriage counselling, while the two other social workers were employed at Social Development District offices in substance abuse programmes. The one registered counsellor worked as a research assistant and the other registered counsellor worked as an administrator, both in an academic environment. Both registered counsellor did counselling previously but were in non-counselling roles at the time of the interviews. The educational psychologist worked at a high school and the life coach ran her private practice where she worked mostly with post-graduate students enrolled for their masters' programmes.

Participants reported different degrees of experience in MI, with some participants reporting only using MI for one year and others up to 10 years. The majority of the interviews were conducted in English (n=12), while the remaining were conducted in Afrikaans (n=3). Some of the participants completed their MI training through Stellenbosch University as short course (n=9), while the others were trained in MI as a module as part of the Post Graduate course in addiction at Stellenbosch University (n=3) or at the University of Cape Town (n=3).

4.1.2 Table 1: *Demographic characteristics of participants*

Description	*Number*
Age (years)	
Range	27 – 64
Mean	37
Relationship status	
Single	2
Married / life partner	10
Divorced	2
Widowed	1
Language	
Afrikaans	3
English	12
Profession	
Social Worker	9
Registered counsellor	2
Coach (MPhil)	1
Addiction Counsellor	1
Psychiatric Nurse	1
Teacher (M.Ed.)	1
Total years of experience with MI	
One	10
Two	4
Three	3
Four	1
Five	7

4.2 Description of themes

The following four themes emerged from my analysis of the interviews. These themes represent barriers to the implementation of MI. I named the barriers as follows: (1) practitioner-related factors, (2) client-related factors, (3) lack of continuous training and support, and (4) workplace related factors. Each themes consists of subthemes that will be described using quotations from the participants.

4.2.1 Practitioner-related factors

A few practitioner-related factors emerged as barriers to MI. Practitioner-related factors can be defined as the internal and external factors emanating from the practitioner that acted as a barrier to the implementation of MI. I identified three of these barriers and named them (1) the therapeutic paradigm shift, (2) lack of confidence and (3) attitude towards MI.

4.2.1.1 The therapeutic paradigm shift of the therapist

A paradigm shift can be described as a mental shift in the mind of people, which results in changing of their perspectives (Amodeo et al., 2011). In MI, the therapeutic relationship can be described as a partnership. Participants stated that the process of understanding MI, required a cognitive shift from wanting to be in control to having a partnership with the client.

Participants identified the paradigm shift as a barrier when they initially started with MI. For them using MI felt familiar but also strange. Participants reported that they recognized some of the principles from previous counselling theories, such as building rapport and empathy, within the theory of MI. According to participants, using MI was quite difficult in the beginning with specific techniques of MI such as, keeping quiet, asking open ended questions, listening and reflecting. Participants stated that they tended to work from the perspective of an expert having the solution for the client's problems. The participants struggled with drawing the solutions from the client with reflecting and evoking techniques of MI.

Participants reported that they found it challenging to get their minds around MI because of the differences between MI as a counselling approach and other more directive counselling

approaches that most of the social workers and registered counsellors were used to. The focus in the most common directive counselling approaches is on the practitioner making decisions for the client, give advice and having the answers ready for the client, what to do and how to do it. In this study there was only one educational psychologist and a coach. The fact that they were trained in more direct approaches made it difficult for them to adapt MI.

Shifting from previous traditional counselling methods to using MI became the challenge for the participants. The requirements in MI were to give ownership to the client and not be in an authoritative position. Practitioners reported that they tried to control the process of change rather than facilitating the process of the change. Participants stated that they found it difficult to refrain from giving advice and allowing the client to solve their own problems. Overall, switching from being directive to guiding of the conversation was challenging for the participants. Niel, who was a social worker employed in a structured addiction treatment centre shared his experience about his paradigm shift.

"So MI brought a switch, actually a kind of deviation of what we've learn and how we've been taught. So it's now taking the back seat, and allowing the client to take the front seat. So it's now no more your pace but on the pace of the client. So a lot of paradigm shifts came about with MI which was not an easy one for a Social worker like me that for many years couldn't, like I said, had to be in the driving seat for clients."

4.2.1.2. Lack of confidence

Practitioners' lack of confidence in their ability to do MI, had a direct impact on their daily practice. Some of the participants reported feelings of insecurity about their competence in applying MI and therefore did not know if their application of MI was effective. Participants stated that they tended to revert to their old way of counselling when there was doubt about the principles and techniques of MI. They stated that their insecurity was the result of not knowing enough about the approach. The participants reported that they felt as though they received insufficient training.

For this reason, the participants reported that they experienced a lack of confidence and feelings of incompetence when implementing MI.

"There is a few obstacles that I would like to highlight from my perspective, the first was some personal stuff, some confidence issue, did I have the confidence to do MI well, were I doing it right, so with all the training, considering the addiction training and the short course training, we had some feedback but for me that wasn't enough to give me the confidence to practice it without anxiety."

Most of the participants attended a one-week short course for training in MI. Some of them participated in a two-day follow up training, where after they submitted a recorded counselling session with a client to the trainers. The trainers used these recorded counselling sessions to assess participants for MI competency. One participant, Ingrid, who was part of a training team in the post graduate addiction course, stated that a few participants failed the first competency test. They had to submit a second recording before they were found to be competent. Participants reported a need for longer training sessions and more than one exposure to MI training to equip them better. John, the registered counsellor stated that he attended two courses and still lacked confidence. He then went to sessions with a personal coach. This was his recollection of his self-efficacy.

That's what I think. That's the way I see it, so I have to say that it, it's not any easy thing. It's was a very difficult thing to get my mind around in the beginning. It was hard and I got frustrated because I wanted to, to me what is the point sitting with someone for half an hour trying to elicit information out of them, but you get to grow to work with it. It's amazing how it work because it really works. For me there is personal not a doubt on the fact that it work.

4.2.1.3 Attitude towards MI

The attitude of practitioners toward MI determined how they engaged with clients using the principles and skills of MI and how effective they thought they would be with the approach during counselling. Most of the participants reported that even though there was a need for more

training in MI, they demonstrated a positive attitude towards the application of MI. Those who were positive, stated that learning the new approach was gratifying and stimulating**.** The participants stated they were willing to implement MI because of the benefits for themselves and for the client. Their attitude determined the therapeutic alliance with the client and how the client responded to the practitioner's approach. One participant stated that if practitioners had negative attitudes toward MI, they would either not practice MI correctly or not pick up on the things they should be aware of in order to motivate the client. Participants stated that their openness to the approach assisted them in their eagerness to learn more about MI. Some of the participants responded that the therapist's insight and their self-motivation to learn, determined how the therapist adopted and applied MI. Peter, the social worker in a structured alcohol detox and treatment centre, shared his attitude towards MI.

"I think it motivates me and also give me self-motivation to change things in my own life. Yes I enjoy working in this field now that I know the MI approach. I think it is more part of my personality and I think that MI is more in line with most people's personality make-up that work in the field of human support services. I think people like it more than the old destructive confrontation from the old days."(Translated)

MI aims to minimize power dynamics in the client-practitioners relationship. Several participants reported that power dynamics played a role in the attitude of the practitioners when they engaged with their clients. Those participants who reported these challenges, stated that these unequal power relations mostly exist in traditional rehabilitation programs for example the 12 steps program. These participants stated the facilitators in these programs believed that in the therapeutic relationship, the counsellors are in control and draw up the intervention plan which create an uneven power relationship. Participants further explained that this approach does not align with the MI principles. They stated that there should be a partnership and collaboration with the client about their treatment plan. Two participants shared their experience about power dynamics in therapeutic relationships.

Ingrid was experienced in facilitating family interventions, where the practitioner allowed the family members to confront the client and thereby established power dynamics. In these sessions the family members told the clients how their behaviour should change and what the family members expected from the clients. She stated that the family's behaviour was shaming and blaming, and there was a lack of mutual respect and collaboration.

Sarah, a nurse by profession, who worked in a private addiction centre, stated that in the nursing profession she also saw a display of uneven power dynamics. Traditional nursing teaching programs taught nurses they were in control of the healing process because nurses are the experts and not the client. This attitude had a direct influence on how they treated patients that resulted in nurses not allowing the patient to take ownership of their healing process. She made the following statement.

"Ethically I think nurses are not supposed to do any of those stupid things (to be in control) but professionally, the way that we were taught is all around power dynamics you know, the power dynamic pile as the nurse, you need to take control of spaces and people that are less powerful than you and you obviously do, the patient or their family members."

Overall most of the participants had an optimistic view of MI as a counselling approach, although there were some that did not share the enthusiasm of the other participants. Participants stated MI was an approach that fitted some but not all of the practitioner's personalities. Participants said that practitioners that are dominating and liked to be in charge of the process, will find it difficult to embrace MI**.** This negative attitude was evident in the dialogues with two participants who stated that the traditional approaches worked better than MI.

One of the two participants, Manie, who was a recovering addict, worked in an addiction secondary care house and received counselling in the past, stated that his past experience shaped what he thought was the best treatment plan for his clients. For him the optimal treatment was to give advice rather than explore the solutions for the problem from the client. The participant did not place much emphasis on the MI principles because it was not what he

experienced as effective. He stated that MI focussed too much on positive reinforcement which did not allow him to be confrontational. He wanted the freedom to confront clients as he deemed that a successful strategy. He said that he found MI to be too soft and congratulatory. Manie stated that MI within a group therapeutic setting may make the counsellors feel vulnerable in front of the group, which was not conducive for group dynamics. Manie stated that he demanded the respect from the group for what he achieved in his personal journey and feels that they don't respect him when he use softer approaches such as MI. In his interview, Manie acknowledged that his frustrations and reactions towards the process of MI hindered application of MI. He described why he had a negative attitude below.

"Ja, I prefer to speak from my own experience, or to give the type of advice. If they're not doing that, it's up to me to point that out to them and particularly in a group environment where I having to exercise a lot, I can't…., it can't just always be positive reinforcement. You know, it's got to be a little more interjecting, cutting to the chest, what about this and very often I am not liked and I've learn to be fine with that. The way I earn their respect more, the clients respect more and then I share from my personal you know, experience. I am in recovery from 2005 and I found that, that helps."

In summary, participants reported that they initially found it difficult to make the mental shift from the traditional way of doing counselling to integrating it with the new principles and techniques in MI. These difficulties impacted on their attitude to adopt the approach, as outlined in the PARiHS model (Kitson et al., 2008). This finding in my study was similar to those of Amodeo et al., (2011) and Jordan, Bowers and Morton, (2016) who found that therapists reported difficulty in changing these paradigm shifts. Söderlund, (2008) suggested that it can be challenging to learn new counselling behaviours and to unlearn previous practices. Rollnick, Miller & Butler, (2007) described MI as a difficult and complex clinical skill and concluded that one can only be competent, if skills and techniques are intentionally refined during the practitioners' career. These

studies found that most of the therapist's opinions towards the approach changed after became familiar with practicing MI (Amodeo et al., 2011; Jordan et al., 2016).

The finding of my study relating to practitioner confidence in practicing MI relates to self-efficacy. A lack of knowledge can act as a barrier to developing self-efficacy (Storholm et al., 2017). Storholm et al., (2017) found that therapists' lack of confidence resulted in decreased motivation. Training therefore plays a vital role in establishing feelings of competence among practitioners according to the participants of this study. This results was similar with Carpenter et al., (2012) who found that practitioners' attributes like self-efficacy, can enhance their ability to the effective implementation of MI.

An interesting finding was that participants in my study acknowledged that their negative attitudes toward MI resulted in them not wanting to use MI techniques and principles in their work with clients. These results are consistent with the findings of other studies that recognized that personnel with negative attitudes were resistant to implementing new EBP's (Amodeo et al., 2011; Decker & Martino 2013; Lundgren et al., 2011). Storholm et al., (2017) asserts that training can change therapists' attitude. However, this assertion was not consistent with the findings of the present study, as participants' negative attitudes towards MI did not change as a result of training. Perhaps this was due to training inefficiency or additional training may result in a change in attitude. For many participants, their approach to therapy as well as their qualification to counselling was the reason for these attitudes.

The practitioner-related factors identified above provide some information about barriers to the implementation of MI that were located within the practitioner. I will now discuss how client -related factors can be a contributory factor that hinders the effective implementation of MI.

4.2.2 Client-related factors

Several client-related factors emerged as barriers to implementing MI for practitioners. Client-related factors are the barriers that practitioners experienced originating from clients that impeded the implementation of MI. These barriers were located both within the client and the broader community where clients resided. This theme consists of several sub-themes namely the community, lack of family support, psychiatric comorbidity, cognitive ability and resistance. It is important to note that these are factors that practitioners regarded as barriers to MI, not factors that clients regarded as barriers, as clients were not interviewed. Furthermore, many of these barriers can be regarded as barriers to therapeutic interventions in general, and may not related to specifically MI.

4.2.2.1 The community

Participants reported that the circumstances that they worked in had a direct impact on the way they counselled their clients. Many reported that they worked in communities with difficult socio-economic circumstances. Many participants also reported that their clients lived in poverty and did not always have access to basic resources such as food and money. Participants explained that many of their clients would rather use their money to buy food than spend it on the taxi or bus to the facility for counselling because most of them were unemployed. Participants reported that their clients did not attend their counselling sessions regularly. This poor attendance was considered an important factor as it limited their available time for intensive counselling sessions. In the following statement, Ingrid, a social worker that worked in a substance abuse programme described the barriers that was evident for her.

"Yes, a lot of children came from different backgrounds. Some did not attend school and some came from the streets. They are in a sense under-developed. They were also exposed to poverty and trauma that also impacted their cognitive development. Like I said, it is difficult to do MI with them".

4.2.2.2 Lack of family support

Participants reported that some of their clients' family members did not support their clients. The participants felt that their clients' families lacked knowledge and insight into understanding the psychological processes of behaviour change, which MI targets. Several participants identified clients' family as sources of hindrance to the MI process. This was especially challenging when working with adolescent clients. According to these practitioners, some clients' parents needed to have control over the therapeutic process and outcomes, and were at times impatient with the process of MI counselling. Participants stated that parents' expectations were at times unrealistic and not congruent with the expectations of their children. Bianca, a social worker who often worked with teenagers, reported that parents who did not acknowledge the challenges facing their children, made it difficult for their children to progress through the phases of change required.

Participants stated that both adult clients and families undergo different stages during behaviour change. Counsellors reported that family members of those who received MI did not get the same education as their clients. The participants' reported that clients sometimes moved ahead of the family. Participants stated that in some cases clients accepted that they needed help, however family members denied the problem. Participants hypothesized that in these circumstances family members may not have progressed from the pre-contemplation phase and therefore struggled to support the client. Noel, a counsellor who was working at an alcohol detox and treatment unit, stated that the family should be informed of the processes of the cycle of change, so that they can understand it in order for them to move along with the client.

"I think of course the lack of insight from families, I do not think it is only the client that should go through the cycle of change. I think their families should also. I asked my patients every time they are admitted, how do your wife or your children or your mother feel about you being here?"

4.2.2.3 Psychiatric comorbidity

Some participants reported that they worked with clients who were diagnosed with psychiatric conditions such as bipolar mood disorder or schizophrenia in addition to the substance use disorder. These participants reported that the therapeutic process was prolonged in clients diagnosed with a mental illness who did not use their prescriptive medication. Participants stated that they experienced that these clients became resistant to MI treatment and any other kind of treatment. Some practitioners reported that clients with substance-induced psychosis were particularly challenging because they were dysfunctional. These clients were difficult to engage with and did not focus during the sessions. Practitioners stated that the clients with psychiatric comorbidities struggled to respond in a clear and cohesive way. Clients sometimes reacted as if they lost contact with external reality. Participants stated that client's had false beliefs. These included paranoid beliefs that people wanted to harm them and hallucinations. Participants further stated that these difficulties were evident in the early stages of recovery such as when clients experienced substance abuse withdrawal symptoms while going through a detoxification phase. Participants reported that when clients stopped using drugs, they had less substance-induced symptoms. Clients' suffered from substance-induced psychosis that resulted from the poisonous effects of the chemicals of drugs. Participants reported that clients may therefore have been incapable of participating in recovery activities. It was challenging for those participants that were not trained in clinical psychology or psychiatry to manage patients with psychiatric features because they were not equipped to do so. The quote below is Sarah's, a psychiatric nurse, recollection of an engagement with a dual diagnosis client.

"So I had one client who, I wanted to try motivational interviewing with because he was not very compliant, starting to drop, he was very conflicting about taking his meds. He didn't feel that the diagnosis of psychosis (his condition) was fair. He was quite resistant to psychiatry and

was resistant to not using and he was pretty resistant to come here but I found with the guys are very, that have much more mental illness, is like a continuing factor."

While most participants reported that MI was challenging when dealing with clients with psychiatric comorbidity, a few participants reported that it was possible to do MI with these clients. The condition for this was that the clients were stable and treatment-compliant. In the statement below, Ingrid, a social worker who worked at a state hospital comments on working with clients with mental illnesses.

"Ja, initially that is what I also thought, especially when I was working in Bonteheuwel, I saw quite a few, slightly, what is the word they used, I think they used the word like mild mental retardation and schizophrenia and those kind of disorders. So initially I was also like, this can't work on people like that. But now working at the (hospital setting) and these people had other disorders and you could see the changes. Though it can work with any illness, depending on how you work with your client. I don't think it got limits."

4.2.2.4 Cognitive ability of client

Several of the participants reported that the different intellectual or cognitive abilities of the clients also played a large role in applying MI. Some participants reported that a few of their clients lacked insight into their problems and lacked the language to be able to convey their internal thought-processes. Carmen, a social worker with more than ten years' experience in MI, reflected that clients with a bigger vocabulary found it easier to engage with MI.

"I think there are people with high intellectual level. They got more vocabulary and I think it makes it much easier. And the guys can't really express themselves."

One participant stated that in such cases she opted for a more direct approach than that used in MI. This participant reported that she did not adhere to the principles of MI and gave participants advice and direction. This practitioner that worked with children, stated that she tried to practice MI with children younger than 10 years because she was taught in the training she attended, that she could apply MI to any age group. However she was unable to, due to their less-

developed cognitive abilities in comparison with adults. This practitioner was Ethel, a social worker with 7 years' of MI experience. She reflected on her need to use a direct approach with some clients in the following interview extract.

"Think for clients who really lack insight that there is a need for them to change, I think with those clients, some clients need a more directive approach. I don't know why but they want to be guided, they want steps, so for some clients who don't have the capacity to do some introspection, for them it would be easier to be more directive as where, when a client can really do introspection and see that there is a need for change, with them you can continue with the MI."

Participants reported that their workplace programmes were too theoretical for clients with learning difficulties and that they adapted them into practical activities, to convey the content of the session to those clients. Haley, a social worker at a structured assessment programme for children, spoke about these difficulties.

"Fetal alcohol syndrome, and then we found, children of addicts, a lot of children of addicts coming through. They all have different diagnosis like sensory process disorder, attention deficit, a lot of issues, big learning disabilities. When I started of here, I had a lot of worksheets, but you can't always use the worksheets with all the groups, you need to adapt the whole program."

4.2.2.5 Client resistance

The final client-related factor that impeded the implementation of MI in this study was resistance. Resistance in this context refers to a client's refusal to accept that he/she has a problem and an unwillingness to change. Some participants reported that they felt that resistance from a client was a challenge for MI, while others reported that MI worked well with clients who were resistant.

The participants who reported resistance as a challenge, mentioned that they worked with clients who were not ready to change. These clients indicated limited interest in sobriety or harm reduction interventions, which were the fundamental treatment outcomes. Participants reported

that some of these clients were directed by their families to attend these programs. They were either scared to lose custody over their children or lose their privileges at home. They attended the sessions to please their family. They showed resistance to the program because they did not accept that they had a possible behaviourial problem.

Participants also described resistance present within some mandated clients, mostly referred by a court through a diversion program in response to a crime committed. Such clients would either go to a rehabilitation program or a community project. Many of these clients committed petty crimes in response to the need of the addiction or while they were intoxicated. Other clients spent the last period of their sentencing in the treatment centre as a requirement of their probation. These clients were only interested in completing the duration of the substance abuse treatment program. Participants reported that these clients displayed no motivation to change and were generally not mentally present during their sessions. The duration of these structured programs was between five to sixteen weeks depending on the length of the specific program. Some participants stated that these clients were their typical clients and that they were resistant to change.

One participant reported that resistance was not the ideal reaction towards treatment. The participants stated that the client should first move out of resistance by accepting their problem before they can do MI with them. Amy, a social worker, with 8 years of MI experience, who worked in a structured treatment centre for adults, made this statement.

"When you worked with clients that had been committed, or are referred by court process and the resistance and reluctance is really always a huge challenging factor. Ones one have gotten through that to diminish resistance, the whole process becomes more effective."

However the other group of participants stated that they used MI to move the client out of resistance and treated it as a normal state forming part of the cycle of change. Some participants reflected and stated that in some cases clients may have had good reasons for their resistance to change. The participants stated that they had the ability to move the client when they are within

a good therapeutic relationship, trying to understand the explanation why the client struggle to change. They also suggested a technique referred to as roll with resistance, where the practitioner avoids arguing for change, reflects skillfully to minimize resistance, explores the negative and positive consequences of change and focuses on the problem and not the person (Miller & Rollnick, 2013). Sarah who worked at a private treatment centre in Cape Town as an addiction counsellor reflected gave an example of a specific client who were resistant.

"And I could see this one guy who were a heroin user, he was resistant the whole time. He was acting out and you could see he could not find himself in the group, very distant, very like defendant. And I had a wonderful conversation with him about his resistance and no one has ever named it. They were just cross at him all the time because he was not compliant."

Several client-related factors were identified as barriers to implementing MI in this study and these factors were supported by other published research (Amodeo et al., 2011; Chapman & Wu, 2012; Horsfall et al., 2009; Moore et al., 2015; Naud & Frielink, 2013;Storholm et al., 2017; Westra, 2004). First, the finding that support that family members played an important role in implementing MI was confirmed in the review by Horsfall et., al (2009). Second, the role that a poor socio-economic circumstances play in clients' lives have also been highlighted in previous research. Moore et al., (2015) reported that a lack of basic needs such as housing and employment were barriers for the implementation of MI. This is understandable when one considers Maslow's hierarchy of needs (1943), which states that basic physical needs must first be met before higher levels needs such as psychological needs can be met.

The participants in the present study reported that they found it challenging to implement MI with clients who had a dual diagnosis. Several studies also reported the challenges in working with such clients but also state that clients who adhere to taking their medication are amenable to MI (Horsfall et al., 2009; Moore et al., 2015; Storholm et al., 2017). According to these researchers medication may stabilize clients, thereby increasing their self-efficacy and ability to complete to treatment (Moore et al., 2015).

While some participants in the current study reported that they found it challenging to implement MI among clients with learning difficulties, other participants found ways in which to do so. Other researchers have indicated that it is possible to implement MI among such clients when they adapt their communication techniques by allowing for more time to allow clients to reflect and by repeating questions (Chapman & Wu, 2012; Naud & Frielink, 2013).

Finally, the finding that client resistance was a barrier to MI implementation was not surprising as it was reported in several studies (Amodeo et al., 2011; Horsfall et al., 2009; Westra, 2014). In the current study, resistance was a common feature among clients who were forced by family members or mandated by court to attend counselling. The resistance was therefore expected. Some participants reported that they were able to work with resistant clients. Despite these statements, there were participants that reported that MI worked well with clients who are resistant because the practitioner accepted their status of ambivalence and worked with that.

The client-related factors identified by the practitioner that contribute towards the challenges according to the participants were the community factors, lack of family support, the psychiatric comorbidity, cognitive ability and client resistance. I will now discuss how continuous training and development can be a contributory factor that hinders the effective implementation of MI.

4.2.3. Lack of continuous training and support

The theme named continuous training and support refers to the training and post-training support that played a negative role in implementing MI among participants. This theme consists of the following sub-themes: (1) impact of previous qualification on MI, (2) training related barriers, (3) continuous development training related barriers and (4) supervision after training.

4.2.3.1 Impact of previous qualification on MI

A broad range of qualifications were evident in the participants. One was an educational psychologist, two were registered counselors, eleven of them had a degree in social work and one had a nursing degree. One participant held a degree but no previous professional counselling

training. The majority of the respondents reported that their limited prior counselling training was useful for the understanding and the application of MI. Their prior training allowed them to recognize certain concepts used in MI. One of the participants stated that he recognized the familiar concepts of empathetic understanding from the Rogerian client-centred counselling methods.

Respondents reported that their exposure to basic concepts of counselling, such as active listening and responding, laid a foundation for the new concepts. The participants stated that their previous counselling knowledge assisted them in differentiating between MI and other counselling approaches. Their respective qualifications assisted them to understand the new MI skills and how to integrate these skills with the existing skills. Noel, a social worker working at an alcohol detox facility made the following statement.

"For me, even if you think about other counselling styles, there has to be some background and some training. Luckily some of my training was person-centred, which is very similar or close to MI, this laid a good foundation to grasp some of the concepts and it also helped to develop my style and that's why I think MI got me hooked."

However, there were three participants who reported that their qualifications did not contribute to their understanding of MI regardless of the professional background but that it rather delayed their application of MI. Manie had a degree in a related social science field and stated that his degree helped him to understand language and theory described in the MI course, but that he had no exposure to basic counselling skills and therefore his qualification did not enhance the application of MI. Neville's professional training was in counselling psychology. He reported that his professional training delayed the application of MI because he did not learn about MI during his professional training. Ingrid, the registered counselor, obtained her postgraduate degree in Psychology through distance learning. MI was not part of her undergraduate or postgraduate curriculum. Ingrid reported that she spent limited time during the course on the practical part of counselling. She further stated that she completed her six month practical at a

children's home without learning much about counselling. Ingrid stated that she had a theoretical knowledge of counselling from her previous psychology degrees, but that she used the MI training as a practical component because she never had any practical experience in counselling. Ingrid made the following statement:

"You know I did my Honours in psychology, you know long distance, but I don't really think the study contributed. However, MI contributed greatly to my understanding of psychology itself, the understanding of why people think and do and behave the way they do. MI contributed to the understanding of that. So I don't think the psychology degree has helped me with my understanding of MI, MI has actually helped me to understand Psychology."

There were some participants in this present study who reported that they experienced their qualification as a hindrance. Their formal training did not include MI as a counselling approach and they reported that the inclusion of MI in their formative training could have assisted them to grasp MI better. The other participants reported that they found their qualification was not relevant as a foundation to practice counselling or understand the theory of MI.

4.2.3.2 Training related barriers

Participants reported that some of their experiences during training sessions were barriers to the effective implementation of MI. One participant, Noel, reported the MI training sessions were too theoretical because students received a lot of reading to do on their own without any guidance. There were students who disliked the role-play sessions because participants felt exposed in front of the other students.

For some participants, the negative behaviour of other students during a training session made the training experience unpleasant. As a result of the atmosphere in the class, students were not motivated to attend the class. The training experience had a negative impact on their attitude towards MI. According to the participants, the negative attitude of the students towards the approach caused them to become resistant to learning about MI. Some participants reported

that there was an adversarial atmosphere during their training and in some cases this resulted in heated discussions that took time away from learning about MI.

Ingrid, a registered counsellor recalled her observation from a training session.

"It is a challenge to have participants with different educational background in the same class. Some of them must have had maybe undergraduate psychology or something similar but generally they were people who came up through the ranks of life, not people who are professionals who get into addiction. I would say they were people who had their own personal experience of recovery but there were definitely the kind of split, so it wasted a lot time because they debated with her."

It was not only the environment where the training took place but also the content and the quality of the material presented that played a role in the training. Manie, who completed the MI course as part of the Post Graduate Diploma in Addiction Course, reported the course was very prescriptive in terms of a case study and understanding what the client was all about. Manie reported the facilitator used videos from YouTube with outdated case studies that was not relevant for the training session. He made the following statement.

"We were like we don't understand this, we don't get it. What is it about, like the roleplaying we had to do and watching bad videos from the 1980's on you tube. I think she took it personally because she's a big fan of it and she had a baby and she was properly not get enough sleep."

While training is seldom experienced uniformly by trainees, participants reported the above issues which they reported impacted their implementation.

4.2.3.3 Continuous development

Participants reported a lack of confidence in their ability to do MI and felt insecure when implementing MI, as a result of not having enough knowledge about MI. The perceived inadequate training and continuous development, specifically related to MI, acted as a barrier to using MI. In order to practice and master the skills and techniques of MI, participants expressed the need for

continuous development to assist them in gaining confidence and competence. Through continuous training workshops practitioners will improve their skills, which will play a crucial role in them becoming effective in MI.

The majority of the participants reported that they attended only one training course with no follow-up courses. Participants reported that follow-up workshops could assist them in keeping up with any new developments of the approach. Darvin, a social worker in private practice responded:

"Everyone can apply some of the principles but can they constantly and repeatedly apply and stay within the principles and the style of MI? I think that needs an advanced or more than one session of training as well as continuous development in the approach of MI. I think it's like riding a bicycle; as soon as you can master it, you can always ride a bicycle but you still need practice it to keep your balance and keep your knowledge up to date."

4.2.3.4 Supervision after training

Almost all the participants emphasized the importance of supervision and support after their MI course to reach treatment fidelity. Treatment fidelity ensures to the quality of the MI delivered by the practitioners measured after training and during supervision.

Participants reported the need for supervision to assist them in applying MI correctly because it was a new approach to them. They reported that the lack of confidence in their ability to apply MI would have been addressed if they had supervision after their training. Participants stated that they were insecure and scared of doing MI and had self-doubt about their ability to do MI. Many stated that they needed guidance to stay motivated to use MI and to be more effective in their practice. However, the participants reported limited or no support and supervision from the trainers after the MI training and at their workplaces. Some participants stated that their supervisors/managers at their workplaces were not trained in MI and therefore not equipped to

assist them or provide guidance. Fellen, a social worker who worked in a district office, stated the following:

"I did get a supervisor in this environment but she's not MI trained and it's not going to be a place where I'm going to get support around that because I'm already busy to look for a supervisor who is also passionate about MI."

Previous qualifications of the participants in this study was seen as both a barrier and a facilitator to understand and master MI. Participants who did not have relevant qualifications for counselling, identified their qualification as a barrier. While I did not assess competency of participants, their perception of the impact of their previous training and qualifications may be relevant. Previous studies demonstrate that professional counsellors trained in MI were better able to implement MI than non-professional counsellors with training in MI (Carpenter et al., 2012; Dewing et al., 2013; Van Buskirk & Wetherell, 2014). Non- professional counsellors in my study who had no professional training had difficulty in implementing MI in their practices. They chose to do counselling from their own experience as ex-addicts.

Insufficient training was another barrier that participants identified in this present study. Participants stated that one short course was not enough to master the skills required for MI and that more to MI was required to improve participants' confidence in applying MI in their daily work. This is in line with studies by Amodeo et al., (2011), Lundgren et al., (2011), Petersen et al., (2007), and Storholm et al., (2017), which suggests that maintenance of MI skills is important but requires continuous training, supervision and support. Dewing et al., (2013), Jordan et al., (2016) also found that practicing MI techniques continuously is important to become more skilled at using the strategies. The studies confirmed the complexity of MI skills required continuous training and support.

Supervision and support after training were highlighted as an important factor to enhance the application of MI in the present study. This was seen as an important barrier that hinders the continuous motivation to adhere to the MI principles and techniques. Supervision can be part of

the organization's approach to measurement whether or not the implementation of MI was effective (Kitson et al., 2008).This finding was not unique as several other studies reported that a lack of support and supervision post-training was a barrier to the implementation of evidence-based practices (Carpenter et al., 2012; Dewing et al., 2013 ; Forsberg, Ernst, & Farbring, 2010; Malan et al., 2015).

The barriers relating to continuous training and support provide an indication of the role that training plays in the implementation of MI. I will now discuss how workplace related factors can be a contributory factor that hinders the effective implementation of MI.

4.3.4 Workplace related factors

Workplace related factors refer to barriers in the work environment, which participants reported hindered their implementation of MI interventions. The theme consists of the following sub-themes: (1) management as a barrier and (2) time as a barrier.

4.3.4.1 Management as a barrier

The work-place should be conducive for the application of interventions. Participants reported that there were barriers toward the application of MI in their workplaces. One of the reported barriers was that management expected certain performance outcomes from the participants, which did not align with the application of MI. Participants reported management did not allow adjustments to the structure of their programmes to accommodate MI as a new counselling approach. Participants stated that they felt as though their managers focused on targets and not on the importance of the process during the intervention. An example of these targets were the number of clients participants were requirement to meet with. Participants reached the expected total number of clients when they used more directive techniques than prescribed by MI as this required less contact sessions and interaction with clients than MI. Participants stated that this resulted in them resorting to using more direct techniques, thereby

not adhering to MI. Therefore, in order to reach their targets, the participants stated they tended to revert to their old counselling behaviours. Participants suggested that time allocation within programmes should be adjusted to accommodate MI.

According to participants, they did not feel supported in their practice of MI by their managers because their managers failed to allocate enough funding for necessary training and study leave. In addition, participants reported that their employers could not allow them adequate leave to attend training due to heavy caseloads and small staff complements.

Participants stated that the ideal would be if all therapeutic staff were trained in MI but this was seldom the case. Participants reported that only some of their staff members were trained in MI, resulting in practitioners within the same organisation's not having similar treatment outcomes or similar counselling knowledge. Carmen used an example, where staff members who were trained in MI focused on moving the client on the continuum of the change cycle using MI skills and techniques. The other staff members focused on exchanging advice and information about the substance use disorder. These differences resulted in misunderstandings in the multidisciplinary meetings during the planning sessions. Carmen, the social worker who managed a substance abuse facility, shared her dilemma with her management.

"They (the managers) look at time, they look at money, you know how you going to manage your facility in the absence of ... So those are some of the factors that make it difficult for us because…. I remember even when that one Social worker went away, we had to actually getting the other disciplines to like yoh! Occupational therapist, or nursing staff to assist with case management."

The barriers identified at the work-place in the present study, were management who were not trained in MI. They could not understand why they should change the structure of the workplace programme to adapt to the longer timeframe needed for a slower counselling approach. Participants identified that extra time is needed to build a therapeutic relationship but also to evoke response for solutions from the clients and not just giving advice and information.

Facilitating the changes in these organization was the responsibility of management. Yet management was often limited by lack of funding, which may have ultimately been the barrier that practitioners faced.

4.3.4.2. Time as a barrier

Most of the participants stated that the time allocated in their structured programmes was not long enough for them to use MI as their preferred counselling method. Some participants stated the duration for individual sessions were approximately 15-30 minutes per person and that this was not enough time to implement MI. MI is a more time consuming approach than other counselling approaches because more time is spent on establishing collaborative conversation with the client in order to reach a positive outcome.

Furthermore, individual sessions were preferred where participants reported that they used MI. Therefore the allocation of sufficient time for individual sessions was important to them. Participants reported the structured programs focused mostly on group therapy sessions which they thought was not amenable to MI. Four social workers who worked for government institutions stated that more time was allocated for group therapy than individual therapy.

Three participants shared a different opinion about the time constraints on MI. These participants reported that whether a practitioner used five minutes or an hour for behaviour change, the principles and techniques of MI could still be relevant. The participants agreed that the first five minutes of a brief intervention could focus on establishing rapport. This brief intervention can be done in the atmosphere of empathetic understanding and eliciting information that will set the tone for the rest of the intervention. Karla, the life coach made the following statement.

"Look that idea of I don't have the time. I don't get that at all, if you are in the field and you try to help someone, and remember coaching is also about change, everything is about change. Whether you're coaching or counselling, or whether you do therapy, it's all about change or a

different type of change. I just can't see that you don't have time, that you don't have time for them."

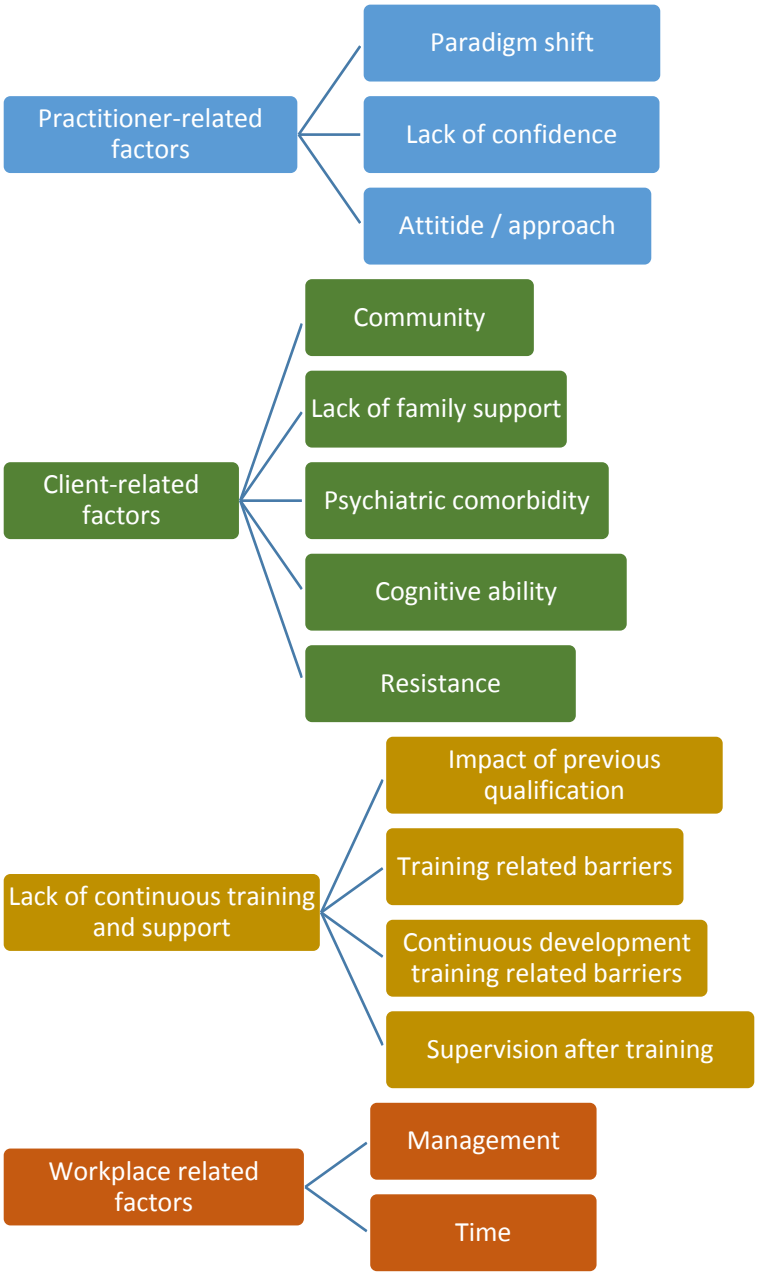
Programme managers play a key role in deciding which interventions are used. Participants reported that their managers were not trained in MI and may not have been able to understand the condition required to implement MI. Therefore, even if they recommended that practitioners receive training in MI they may have acted as a barrier towards the implementation of MI. Furthermore, high staff turnover and a lack of staff were also identified as barriers to the implementation of MI. These results about the work-place barriers are consistent with those mentioned in previous research (Amodeo; 2011; Barnes & Ivezaj, 2015; Lundgren et al., 2011; Storholm et al., 2017). The need for enough trained staff was reported in these studies. It was therefore difficult for unequipped staff to adhere to the organizations policies and procedures. Malan et al., (2015) confirmed the need for more staff that understand the home language of the client, a lack of resources, administrative problems and training for not just the counsellors, but also for other staff members that had contact with clients.

A lack of time was one of the most indicated barriers that was highlighted by the participants of this study. Participants reported a need for more time allocated for clients during counselling sessions. They also emphasized the fact that they needed to spend more time with clients with learning difficulties and psychiatric problems because of the special needs of these clients. This barrier was also reported by many other studies (Amodeo, 2011; Barnes & Ivezaj, 2015; Dewing et al., 2013; Lundgren et al., 2011; Malan et al., 2015; Petersen et al., 2007; Storholm et al., 2017). These studies reported the need for more time spent on training, the adjustment of the time allocation in the program, the importance of time allocated for more supervision and support and a lack of time for implementation because of a big workload and a lack of staff.

4.5 Summary

In this chapter I described the findings of my study. I described the various barriers to the implementation of MI. A visual representation of my findings can be found in Figure 1. In the next chapter I conclude my thesis, describe the limitations of my study and make recommendations for future research and clinical practice.

Figure 1: Visual description of findings



Chapter 5

Summary of key findings, limitations, recommendations and conclusion

5.1 Introduction

This chapter contains a summary of the key findings of the study, the potential limitations of the study, recommendations for future research and practice, contribution to the Subject and Body of Knowledge and the conclusion. The purpose of the study was to explore the barriers that prevented practitioners from practicing MI with their clients**.** I used semi-structured interviews to collect data from 15 practitioners who were trained in MI. Thematic analysis resulted in several themes, namely practitioner-related barriers, client-related barriers, barriers with continuous training and support, and workplace related barriers.

5.2 Integrating theory and findings

This study is imbedded in understanding the underpinnings of the theoretical framework of Kitson et al., (2008) Promoting Action on Research Implementation in Health Services (PARiHS). I felt that this framework help me understand the different elements that may be necessary to implement a successful evidence based intervention like MI.

By identifying and understanding the barriers that may impede the successful implementation of MI, the study allows for suggestions and interventions to improve the implementation of MI. For a successful implementation of MI, the theory suggested that practitioners need knowledge of research evidence from clinical knowledge, experience of practitioners, clients, evaluation data and information of local context.

Having knowledge and experience may have assisted practitioners in the acceptance and understanding of the evidence (Kitson et al., 2008). Practitioners need clinical knowledge of MI to be able to implement it successfully. The qualification and training was important, but also the ability to adapt the evidence to the local context (Kitson et al., 2008). The evaluation of the implementation was an important factor to ensure quality service delivery (Kitson et al., 2008).

The importance of the relevant qualification of the participants may assisted the participants in understanding the clinical knowledge. Participants' understanding of the clinical knowledge could be linked to their qualifications. Sufficient training are pivotal in applying the knowledge.

The context in which the interventions took place include an understanding of the usual culture, leadership roles, and the organization's approach to measurement which are important for an effective intervention. Several client-related factors emerged as barriers for the effective implementation of MI. These barriers fit in the element context of the client, the understanding of the usual culture in which the research was implemented which are underpinned in the theoretical framework of Kitson et al., (2008). I discussed how workplace related factors can hinder the implementation of MI. The study also found that the role of management is vital for the successful transition from one model to another.

The facilitator is the agent of change. According to the conceptual framework of Kitson et al., (2008), the facilitator is in a specific leadership role to guide and evaluate the implementation of the evidence, do assessments, and develop change strategies. The practitioners should understand their role as change agents (Kitson et al., 2008). A positive attitude towards counselling determined the therapeutic alliance with the client and how the client responded to the practitioners' approach (Rollnick & Miller, 2013).

Kitson et al., (2008) described the importance of the practitioner as the agent of change who should accept and understand the evidence (MI) in order to implement the EBP successful.

5.3 Summary of key findings

The role of the practitioner is to facilitate the process of change in clients by using evidence-based tools such as MI effectively in the given context. The study found that practitioner-related factors influenced the implementation of MI. These are the internal and external factors deriving from the practitioner that acted as a barrier to the implementation of MI. We found three factors

that the therapeutic paradigm shift of the practitioner, a lack of confidence and their attitude towards MI, emerged from the study.

- The first factor was termed the therapeutic paradigm shift: I found that practitioners stated that a cognitive shift was required to embrace and implement MI. This finding was echoed by previous research that concluded that practitioners found it difficult to make that mental shift (Amodeo et al., 2011).
- Second, I identified a lack of confidence as an important barrier to the effective application MI. Confidence in MI application can be increased, as research demonstrated that increased knowledge in MI resulted in self-reported confidence in using the technique (Storholm et al., 2017).
- Finally, some participants' attitude toward MI was also identified as a major obstacle to the implementation of MI in counselling. For these participants, training did not result in a positive change in attitude toward MI. This finding was surprising, as it differed from several studies that found that training and increased knowledge in MI improved negative attitudes of participants, resulting in the increased application of MI (Amodeo et al., 2011; Decker & Martino, 2013).

Client-related factors located both within the client and the broader community where clients resided were also identified as impeding the implementation of MI. Several factors that emanated from clients were identified namely community, lack of family support, psychiatric comorbidity, cognitive ability and resistance.

- I found that community factors acted as a barrier against the effective implementation of MI. The interplay of poor socio-economic circumstances and the lack of family support were highlighted as contributory factors by the participants. While this was found in the present study it is not unique to MI and extends to therapeutic interventions in general (Horsfall et al., 2009).

- Participants indicated that cognitive-impaired clients were also a challenging factor when implementing MI. This finding echoes those in several studies which indicated that cognitive-impaired clients need more time and simplified concepts of MI in order for the practitioner to use it effectively (Chapman & Wu, (2012); Naud & Frielink, (2013).
- Client-resistance to MI was an important barrier in the study. Some participants found client-resistance challenging but acknowledged that MI could work well if the practitioner accepted the clients' status of ambivalence and worked with it. Client resistance as a barrier to MI implementation was reported in several studies (Amodeo et al., 2011; Horsfall et al., 2009; Westra, 2004).

Continuous training and support was found to be an important contributing factor for the effective application of MI. The findings described the impact of previous qualifications on MI, training-related barriers, continuous development training and supervision after training on the implementation of MI.

- I found that previous counselling qualifications were beneficial to those learning MI as it contributed to their understanding and subsequent implementation of MI. Participants who did not have a formal counselling or related qualification reported that they struggled to understand the concepts used in MI. This finding was similar to those identified in several studies, namely that qualified counsellors that had extra MI training were more effective in implementing MI than unqualified counsellors (Carpenter et al., 2012; Dewing et al., 2013; Van Buskirk & Wetherell, 2014).
- Participants indicated that short courses were not sufficient to learn and understand the complex concepts of MI and that lengthier training would improve their perceived self-efficacy in delivering MI. Dewing et al., (2013) and Jordan et al., (2016) also found that longer training sessions and continuous training were important to understand and implement the principles and techniques of MI.

- Post-training supervision was identified as an important barrier to the implementation of MI. Participants reported that they did not receive post-training supervision and therefore lacked confidence in their ability to implement MI in their work with clients. This finding correlates with several other studies showing that a lack of support, supervision and post-training were barriers to the implementation of evidence-based practices (Carpenter et al., 2012; Dewing et al., 2013 ; Forsberg, Ernst, & Farbring, 2010; Malan et al., 2015).

Finally, Management and time were identified as barriers to MI counselling. Participants stated that they did not have enough time with clients to implement MI. This was a feature of the organisations where they worked, which often promoted therapeutic sessions that were too brief for MI or were group-based.

- Finally, several participants reported that they were not supported by their managers to implement MI. This strongly suggested that the managers were not knowledgably about the MI and its implementation. And that often, their managers, which meant that they did not know what environmental factors could fosters the implementation of MI. The findings also showed that there was a lack of resources and not enough trained staff members in the organizations that possibly caused barriers to practitioners which may contributed as a barrier to the practitioner when attempting to implement MI in the workplace. These results about the work-place barriers are consistent with those mentioned in previous research (Barnes & Ivezaj, 2015; Lundgren et al., 2011; Storholm et al., 2017; Amodeo et al., 2011).

5.4 Limitations

The study was not without limitations. The main limitation of this qualitative study was the small sample size that was not necessarily representative of the target population. Participant recruitment proved to be a challenging endeavor and the recruitment methods may have played

a role in this. However, the small sample allowed for in-depth interviews and I sampled until saturation (Babbie & Mouton, 2008).

A second limitation related to sampling was the inclusion of only social and mental health practitioners, which is not necessary a representation of all professional fields. This may also be a result of the sampling procedure, but the literature indicates that MI is most commonly practiced in these fields. Similarly, participants were only sampled from the Western Cape and not from the other provinces in South Africa, therefore generalisation cannot be made with full confidence to the entire population of MI-trained counsellors. Another limitation of this study's target group was that it only explored the perspective from the practitioners' side and not from the client's point of view.

5.5 Recommendations

5.5.1 Recommendations for researchers conducting similar studies

This study did not include the perspectives of practitioners in other fields and future studies can include the barriers experienced in implementing MI from as the perspectives of other professionals such as teachers, businesses, the film industry and pastoral counselling. Further studies could also include the client's perspectives and understanding of the barriers for MI counselling. Future research could focus on the barriers that clients experienced in their MI counselling sessions. Their experiences might be different than those of the social and health practitioner.

5.5.2 Recommendations for practice and organisational policy

Recommendations for future studies for practitioners can include the adaptation of an MI manual that can be used by the practitioner with clients with learning difficulties. Further research into the development of a monitoring and evaluation tool is needed to assist supervisors and practitioners to support and measure the effective implementation of MI in their practices.

Further research into the availability of support services for continuous development and ongoing supervision, such as support groups or supervision from training institutions, will be important to support the practitioner in effective implementation of MI.

Finally, the identification of barriers to the implementation of MI has identified several areas for intervention that can facilitate the implementation of MI or indicate the applicability of MI within particular settings, and this needs further exploration.

5.5.3 Contribution to the Subject and Body of Knowledge

The primary aim of the researcher in this study was to identify is the barriers that hinder the effective application of MI. This study focused on the barriers identified by practitioners working in different fields of behaviour change. These findings may contribute to the effectiveness of therapeutic interventions in the mental health field as well as the social services field. The study provides the practitioner with knowledge to eliminate possible challenges that hinder the effective application of MI. The findings also contribute to the successful treatment for the individual which includes behaviour change, ownership of the intervention and the empowerment of the individual.

5.6 Conclusion

Several barriers that prevented practitioners from using motivational interviewing effectively as a counselling approach with their clients was identified in the current study. These are multi-levelled and are located within the client, practitioner, training programmes and context where counselling occurs. Recommendations for future research and practice relating to MI are provided.

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Appendix A

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

25 August 2017

Dear Debbie

RE: DATABASE ACCESS

Hereby, I am giving you permission to access the database of people that have completed MI training with us during the period 2011-2016. We will provide you with their names and email addresses.

This information will be extracted from the short course files by Marianna James the current administrator.

Unfortunately I will not be able to invite the people to participate in your research project myself. Once you have the names and email addresses you will need to contact the people yourself.

Good luck with the project.

Best wishes,
Bob

PROFESSOR BOB MASH
EXECUTIVE HEAD: FAMILY AND EMERGENCY MEDICINE

Appendix B

Department of Psychiatry and Mental Health

Groote Schuur Hospital (J-2), Anzio Rd, Observatory 7925, Cape Town, South Africa

URL: http://www.health.uct.ac.za/departments/psychiatry/about/

Graeme Hendricks

Convenor: Post Graduate Diploma in Addictions Care

Email: Graeme.hendricks@uct.ac.za

Tel: +27 21 404 6294

28 March 2018

Dear Debbie Bell,

RE: DATABASE ACCESS

Hereby, I am giving you permission to access the database of past students from the Postgraduate Diploma in Addictions Care at the University of Cape Town that have completed the Motivational Interviewing training as part of the Diploma during the period 2011-2017. We will provide you with their names and email addresses.

This information will be extracted from data files by Ms Shaheema Allie, the course administrator.

Unfortunately I will not be able to invite the people to participate in your research project myself. Once you have the names and email addresses you will need to contact the people yourself.

All the best with your project.

If you need further information, please do not hesitate to contact me.

Yours Sincerely,

Mr Graeme Hendricks

Course Convenor: PgDip Addictions Care

PSYCHIATRY
UCT

Appendix C

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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Dear Social Service Practitioner

My name is Debbie Bell and I am a Masters Psychology student and researcher. I would like to invite you to participate in a research project entitled 'exploring the challenges that prevent practitioners from implementing motivational interviewing in their work with clients.'

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

What is this research study all about?

This research aims to explore the challenges that social service practitioners, such as psychologists, social workers, nurses, and counsellors experience in applying motivational interviewing (MI).

The study will be conducted in the Western Cape. Participants will be recruited by the Division of Family Medicine and Primary Care at the Stellenbosch University. If you agree to participate, you will be interviewed about your experiences in relation to the implementation of MI.

Interviews will be conducted with 20 participants who will be asked to speak about the experience about MI in their daily work environment. The interviews will be conducted by the

researcher who is a registered counsellor and has experience in conductive interviews. Interviews will last approximately and 45 minutes to an hour and be conducted in English or Afrikaans.

If you have any questions or concerns about the research, please feel free to contact me [debbiebell@telkomsa.net; 0832814035] or my supervisor, Dr. Rizwana Roomaney [rizwanaroomaney@sun.ac.za; 021 8083973].

RIGHTS OF RESEARCH PARTICIPANTS: You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

You have right to receive a copy of the Information and Consent form.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the investigator.

DECLARATION BY PARTICIPANT

By signing below, I ……..……. agree to take part in a research study entitled…….

……. and conducted by Debbie Bell.

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- All issues related to privacy and the confidentiality and use of the information I provide have been explained to my satisfaction.

Signed on ……..…….....

Signature of participant ……..

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant]*. *[H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*other*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____ _____

Signature of Investigator: **Date:**

Appendix D

QUESTIONS FOR SEMI STRUCTURED INTERVIEWS (ENGLISH)

Interview schedule

I am going to ask you a few questions about the challenges that prevent practitioners from implementing motivational interviewing in their work with clients Please take your time to answer the questions, providing as much or as little information as you feel comfortable sharing. The information that you share will be treated as confidential. If at any time you would like to end this interview you are free to do so.

1. What is your overall perception of MI as a counselling approach?
2. Can you tell me more about your experience with MI and do you still use MI?
3. How did you find the MI training?
4. What is the impact of the MI after your training in your daily work? For example: was it necessary, useful and appropriate to implement MI?
5. Tell me about any obstacles that your experience in implementing MI after your training.
6. How do your personal/individual factors such as your workplace influence the decision to learn more about MI?
7. How did your professional level contribute or delay the application of MI?
8. How do client-related factors influence the implementation MI?
9. Describe the support or supervision you received after MI training.
10. What will assist you in having a better understanding of MI? / In the effective application of MI?
11. Describe how your attitude towards MI contributes or hinders the implementation of MI

Appendix E

BIOGRAPHICAL INFORMATION

Dear Participant

Please complete the information sheet about your demographics before we start the interview.

Demographic characteristics of validation of participants

Age:

_____

Gender:

_____

Marital Status:

_____

Total years of experience in MI

_____

Highest Education:

_____

Current Employment:

_____

Languages spoken or written:

_____

Town or city where you live:

_____

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NOTICE OF APPROVAL

REC Humanities Amendment Form

28 June 2018

Project number: 1516

Project Title: Exploring the challenges that prevent practitioners from implementing motivational interviewing in their work with therapeutic clients

Dear Mrs Lenie Bell

Your REC Humanities Amendment Form submitted on 27 May 2018 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
27 October 2017	26 October 2018

GENERAL COMMENTS:

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (1516) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Default	D Bell Proposal 220318 (6)	28/03/2018	6
Default	Letter for Debbie Bell_March 2018.pdf UCT	28/03/2018	1
Default	D Bell Proposal 220318 (7)	25/05/2018	7

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides