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Motivational Interviewing in Addiction Services: An Exploratory Study of Training Needs

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Motivational Interviewing · Addiction services · Training · Workforce

Abstract
Introduction: The effectiveness of Motivational Interviewing (MI) in addiction treatment has been proven many times. Many national treatment guidelines throughout the EU recommend MI as a method in the treatment of addiction-related and comorbid disorders. However, little is known on the availability of workforce that is able to provide sufficiently quality-secured MI. The aim of this study was to investigate the level of training and the use of MI among addiction care professionals in Germany. ***Methods:*** In a quantitative, anonymous cross-sectional survey, 262 professionals from the addiction care system were asked about their training in MI, their level of knowledge, the motivation of their clients, and the use of MI in practice. All data analyses were carried out using SPSS. ***Results:*** Among the professionals, 54.8% (n = 143) reported having had at least 1 day of training in MI. 64.3% (n = 90) of the trained professionals felt sufficiently trained for their area of responsibility. 31.0% (n = 83) of the total sample stated that further training, quality circles, training courses, or similar had been set up at their facility. Results of an ordinal logistic regression indicated that the use of MI in practice could be predicted by MI-specific training (OR = 0.23, 95% CI = 0.13–0.38, $p < 0.01$) and the availability of MI support structures in the institution (OR = 0.48, 95% CI = 0.28–0.81, $p < 0.01$). ***Conclusions:*** The results suggest a divergence between medical treatment recommendations for the use of MI and the level of training required for this in the German addiction treatment landscape.

Introduction

Throughout Europe clinical practice guidelines for addiction treatment recommend the use of Motivational Interviewing (MI) in various settings, e.g., Norway [1], the UK [2], France [3]. In light of the recent call for standardized education and training for addiction professionals across Europe [4] and the European Drug Agency's

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(EUDA) focus in 2024 on "empowering the workforce" (https://www.lisbonaddictions.eu/lisbon-addictions-2024/), it is crucial to explore the specific training in MI among addiction service providers in Germany. This investigation serves as a vital first step in evaluating the structural quality of addiction services, emphasizing the importance of MI training in improving treatment outcomes. MI is a conversational approach designed to strengthen individuals' motivation for behavioral and attitudinal change [5]. Within the realm of addiction treatment, MI has demonstrated to effectively help people reduce risky behaviors or enhance commitment to change across diverse demographic groups, substances, and associated maladaptive behaviors [6–12]. Notably, MI exhibits efficacy comparable to that of longer interventions when delivered in shorter formats [13]. The integration of MI with other evidence-based therapeutic modalities, such as cognitive-behavioral therapy, has been associated with enhanced and sustained therapeutic outcomes [14–16].

In both inpatient and outpatient addiction treatment contexts MI can be utilized as a client-centered brief intervention for enhancing intrinsic motivation to change by exploring and resolving ambivalence. MI is predicated on principles of partnership, an evocative approach toward the client, respect for the client's autonomy – thereby affording them freedom of choice and action – and genuine empathy. It is essential that communication transcends mere cognitive understanding; the emotional significance of the client's statements must also be reflected upon, a process operationalized through "reflective listening." By adopting an MI mindset and consistently employing various techniques (e.g., open-ended questions, affirmations, reflective listening, and summarizations), discrepancies between an individual's current behaviors and their values or life objectives are elucidated. The overarching goal is to enhance the client's confidence in their capacity for change and to minimize resistance during the interaction [17]. The successful implementation of MI in practice is contingent upon several factors, including the acceptance of MI principles and the practitioners' competence and level of training.

MI methods can feel counterintuitive for many professionals, especially in environments where respecting client autonomy conflicts with rule enforcement. Offering advice only with permission can be challenging when the professional's role is to guide. Unlearning the habit of arguing with clients in favor of reflective listening and open-ended questions is also difficult. Proper training for addiction service practitioners is essential for delivering evidence-based treatment.

Research on MI training for professionals predominantly originates from projects in the USA [18, 19]. Meta-analyses indicate that such training significantly enhances practitioner behavior change compared to no training or merely reviewing a treatment manual. Furthermore, training that includes consultation or supervision has been shown to be more effective than training alone [20]. Additionally, Carpenter et al. [21] identified that clinicians with graduate degrees exhibited higher levels of MI skills post-workshop compared to those without advanced degrees. A notable trend in MI training research is the shift from traditional workshop-based formats to those that integrate coaching and feedback [22].

In Europe, training in addiction care varies significantly across countries, with numerous nations lacking formal education in addiction medicine and addiction psychology [4]. Studies show that many countries' guidelines for treatment of substance use disorders recommend MI, among other psychological methods [23]. There are European countries like the Netherlands, Germany, and the UK that recommend MI in their national addiction treatment protocols (German S3 guideline for alcohol screening, diagnosis and treatment; drug misuse and dependence: UK guidelines on clinical management; Dutch Multidisciplinary Addiction Treatment Protocol). However, there are very few data on how MI is actually implemented in the addiction services.

Germany has 1,230 outpatient addiction care facilities (180 in North Rhine-Westphalia) and 325 inpatient facilities [24]. Outpatient addiction support typically serves as the initial point of contact for individuals affected by addiction, encompassing counseling, motivational assistance, and outpatient treatment interventions. In contrast, access to inpatient addiction support involves a higher threshold and typically includes treatment programs such as detoxification, medically supervised withdrawal, crisis intervention, management of comorbidities, and inpatient rehabilitation. While inpatient addiction care in Germany is mainly funded by nationwide health insurance and pension funds, outpatient addiction care is most often an optional service provided and paid for by municipalities. Outpatient care typically involves 15 contacts per episode, while inpatient care lasts about 3 months [24]. MI, effective in brief formats [25], is well suited for both settings and is considered a cost-efficient approach. While MI is recognized in addiction care education and widely known among German addiction care professionals [26], its implementation is inconsistent. German treatment guidelines, including the S3 guideline for alcohol screening, diagnosis, and treatment, recommend MI for managing addiction and comorbid disorders. However, research shows MI-based interventions are not as widely available as national guidelines suggest. A survey in Bremen found that 39% of professionals offered brief interventions, 89% of which were MI-based. Due to the survey method, the reported use of MI may include interventions intended to be motivating but not formally aligned with MI principles [27]. It is important for surveys to differentiate MI from other motivational treatments. To our knowledge, both MI Implementation and its facilitating factors in addiction care institutions in Germany remain unknown. Hence, this study aimed to investigate the level of training and the use of MI by addiction care professionals in Germany.

Given the limited duration of contact, especially in outpatient settings, it can be beneficial to assess the client's stage of change to determine whether MI or other approaches would be most effective. This helps in prioritizing training focus and allocating resources, such as combining MI with cognitive-behavioral therapy. Stage-based approaches tailor interventions to a person's specific phase of change, with earlier stages benefiting from harm reduction and MI, while later stages are more suited for a combination with cognitive-behavioral approaches focused on problem-solving, lifestyle changes, and relapse prevention [28].

Methods

This study adheres to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines [29]. The questionnaires utilized were developed in accordance with the recommendations provided by the Motivational Interviewing Network of Trainers (MINT) and were informed by the German version of the Motivational Interviewing Skill Code (MISC-d 3.1).

Design

For this study, data were collected from German inpatient and outpatient addiction care professionals through an online cross-sectional survey conducted between May and July 2023. The survey was disseminated via email distribution lists of various national and regional addiction care associations, with a particular emphasis on the North Rhine-Westphalia region (e.g., ginko Stiftung für Prävention, Suchtkooperation NRW). Participants accessed the survey through a URL link and were provided with information regarding the study's purpose, data protection measures, and were subsequently asked to provide informed consent. Participation was voluntary and anonymous, with assurances that the data collected would be utilized solely for research purposes. The study was reviewed and approved by the Research Ethics Committee of the Catholic University of Applied Sciences, North-Rhine Westphalia, Approval No. 2024/1.

Sample

A total of 317 professionals were initially identified for inclusion in the study. Cases that did not respond to at least 75% of all survey items were excluded from the analysis. Consequently, the final analytical sample comprised 262 cases.

Occupational Information

Participants were asked about their educational qualifications, specifically whether they held a diploma, bachelor's, or master's degree in social work, psychology, medicine, or other fields. They were also asked to specify their primary area of work, which included a range of options representative of the addiction services work areas, such as addiction counseling, integration assistance, prevention, outpatient medical rehabilitation, inpatient medical rehabilitation, low-threshold support, withdrawal therapy, involvement in the justice system, research, employment assistance, and other. These work areas were subsequently categorized into three groups: outpatient services (including addiction counseling, prevention, outpatient medical rehabilitation, and low-threshold support), inpatient services (comprising inpatient medical rehabilitation, withdrawal therapy, integration assistance), and other addiction care roles (encompassing research, employment assistance, and justice system involvement).

Furthermore, participants were required to identify the substances or addictions relevant to their primary focus of work, selecting from options such as alcohol, cannabis, heroin, cocaine, amphetamines, methamphetamines, methadone, tobacco, other opioids, buprenorphine, and others. Additionally, they indicated the proportion of their work that involved direct client contact, selecting from ranges such as none, <25%, 25–50%, 50–75%, or more than 75% of their working time.

MI Training

The extent of training in MI was evaluated through questions regarding the duration of training received, categorized as follows: <1 day, 1–3 days, more than 3 days, or none, during both initial professional education and subsequent continuing education. Anyone who reported at least 1 day of MI training was considered MI-trained. Untrained was defined as no MI training or <1 day of MI training. Additionally, participants were asked to indicate any MI-specific credentials they had attained during their basic and continuing education, including titles such as MI consultant, MI supervisor, MI trainer, other designations, or none. The categories were created based on the typical duration of MI education sessions and the standard credentials for MI in Germany.

Self-perceptions of MI proficiency after training were measured by assessing the level of agreement with the statement: “Do you feel sufficiently trained in MI for your area of responsibility?” Respondents could select from options ranging from fully agree to disagree on a 5 point Likert scale. Based on the responses, a categorical variable was constructed with three classifications: confident, partly confident, and unconfident. Specifically, responses of “strongly agree” or “somewhat agree” were aggregated under the “confident” category, those indicating “partly agree, partly disagree” were classified as “partly confident”, while those indicating “less agree” or “disagree” were classified as “unconfident.”

MI-Supportive Institutional Services

A multiple-select question was employed to document the availability of MI-supportive services within the participants’ institutions. The options provided included internal MI training courses, MI-centered supervision, MI-specific quality circles, other services, or none. Additionally, participants were inquired about the services they would prefer to be implemented at their institutions, with response options including external training, internal training, MI-specific supervision, regular refresher courses, none, or other services.

MI Application

In the inquiry regarding the application of MI in practice, respondents were prompted to specify the frequency with which they intentionally employed MI during client interactions, expressed as the number of out of ten typical client contacts (every contact, 9 out of 10, 8 out of 10, down to 1 out of 10, or never).

Client Motivational Stage

The questions were derived from the Transtheoretical Model of Stages of Change in Motivational Interviewing (TTM) [30], given its widespread recognition among professionals in German addiction care. Participants were queried about their familiarity with Prochaska and DiClemente’s TTM (yes/no) and were asked to identify the stage of change in which most of their clients were situated at the onset of their collaboration. The stages included precontemplation, contemplation, preparation, action, and maintenance. Brief descriptions of each stage were provided to assist those unfamiliar with the TTM in accurately applying the model.

Statistical Analyses

All statistical analyses were conducted utilizing the Statistical Package for Social Sciences (SPSS) Version 29. Descriptive statistics were calculated for demographic, occupational, and MI training data, as well as for MI-supportive institutional services. Odds analyses (chi-square tests) were performed to evaluate the association between the primary area of work and training status.

To examine the influence of MI training status on MI application in the practice setting, an independent samples Mann-Whitney U test was performed to assess the number of clients, out of ten typical clients, on whom MI was consciously implemented, in relation to the presence or absence of MI training. An ordinal regression analysis was executed to predict the frequency of MI application (categorized as 0–3 clients, 4–7 clients, or 8–10 clients), with the area of work (outpatient versus inpatient), MI-specific training (untrained versus trained), and the presence of MI-supportive institutional structures (absence vs. presence) as predictor variables. The change in odds resulting from a unit change in the predictor variable was calculated. To differentiate inpatient and outpatient primary areas of work, chi-square tests were conducted to examine the association with MI training, self-reported MI proficiency, and the client motivational stage.

Results

Description of the Sample and Occupational Information

The sample characteristics of N = 262 participants are summarized in Table 1. Overall, 47.5% of the participants were below 41 years old, 68.2% were female, and 56.7% came from the federal state of North Rhine-Westphalia. 81.3% had a bachelor’s, master’s, or diploma degree in social work, social pedagogy or pedagogy. Among the main areas of work, addiction counseling (37.8%), integration assistance (16.0%), and inpatient medical rehabilitation (12.2%) were the most represented. Outpatient addiction care was more frequent as primary area of work (63.0%) compared to inpatient addiction care (31.7%). The most frequently mentioned substance or addiction in the primary area of work was alcohol (82.8%), followed by cannabis (71.4%), stimulants (59.5%), and opioids (59.2%). 91.1% of the sample had direct contact to clients in at least 25% of their working hours.

MI Training

Results on MI Training are presented in Table 2. More than half of the respondents (54.8%) had received an MI-specific training in their basic professional education or

Table 1. Sample characteristics (N = 262)

	N	%
Age		
≤30 years	58	22.4
31–40 years	65	25.1
41–50 years	45	17.4
51–60 years	70	27.0
>60 years	21	8.1
Gender		
Male	82	31.8
Female	176	68.2
Federal state		
North Rhine-Westphalia	148	56.7
Baden-Württemberg	28	10.7
Bavaria	7	2.7
Berlin	5	1.9
Hamburg	4	1.5
Hessen	10	3.8
Lower Saxony	14	5.4
Rheinland-Pfalz	34	13
Saarland	4	1.5
Saxony	1	0.4
Schleswig-Holstein	5	1.9
Thüringen	1	0.4
Professional qualification (multiple answers possible)		
Social work/social pedagogy/pedagogy	213	81.3
Psychology	17	6.5
Medicine	7	2.7
Nursing/geriatric care	11	4.2
Other	32	12.2
Main focus of professional activity		
Addiction counseling	99	37.8
Outpatient medical rehabilitation	20	7.6
Inpatient medical rehabilitation	32	12.2
Integration assistance	42	16
Low-threshold support	26	9.9
Prevention	20	7.6
Withdrawal therapy	7	2.7
Justice	2	0.8
Research	2	0.8
Employment offers	1	0.4
Other	11	4.2
Main substances/addictions (multiple answers possible)		
Alcohol	217	82.8
Cannabis	187	71.4
Medication	129	49.2
Opioids	155	59.2
Stimulants	156	59.5
Tobacco	90	34.4
Behavioral addictions	56	21.4
Other	16	6.1
Direct contact with clients		
No	4	1.5
<25% of working hours	19	7.3
25–50% of working hours	47	17.9
50–75% of working hours	112	42.7
>75% of working hours	80	30.5

thereafter, defined as at least 1 day of MI training. In analyses comparing outpatient and inpatient data, cases that could not be classified into either category were excluded, resulting in an analysis sample of N = 248 cases. Professionals working in outpatient addiction care were more likely to have had at least 1 day of training (61.2%) than professionals working in inpatient addiction care (44.6%) ($\chi^2(1) = 6.19$, $p < 0.05$, OR = 1.963).

Feeling sufficiently trained in MI is reported by 64.3% of the 140 respondents who were MI-trained. However, 22.7% of those classified as untrained professionals report feeling sufficiently trained, 48.2% do not feel sufficiently trained in MI (see Table 3). There was a significant association between MI training status and MI proficiency ($\chi^2(2) = 51.299$, $p < 0.001$). Although there was a higher percentage of trained professionals feeling confident among those working in outpatient addiction care (68.0%) compared to those working in inpatient addiction care (54.3%), this difference was not statistically significant ($\chi^2(2) = 2.978$, $p = 0.235$, see Figure 1).

MI-Supportive Institutional Structures

MI-supportive institutional structures at work were reported by 31.7% of the sample. Respondents reported internal MI training courses (n = 70, 26.7%), MI-centered supervision (n = 6, 2.3%), MI-specific quality circles (n = 3, 1.1%), and other (n = 8, 3.1%). Professionals (N = 251, missing: n = 11) wished for refresher courses (31.5%), external further education (25.5%), internal further education (23.9%), MI-specific supervision (7.6%), nothing (11.2%), and other (0.4%).

MI Application

MI-trained professionals had significantly more clients per ten typical clients that they were using MI with (Mdn = 6) than MI-untrained professionals (Mdn = 4) (U = 9,968.5, $z = 5.77$, $p < 0.001$, $r = 0.37$, medium effect). The ordinal regression on MI application frequency yielded a significant improvement of the final model over the baseline model ($\chi^2(3) = 46.87$, $p < 0.001$). Both the Pearson chi-square test ($\chi^2(11) = 18.04$, $p = 0.081$) and the deviance test ($\chi^2(11) = 18.18$, $p = 0.077$) were not significant, suggesting a good model fit. Significant positive predictors of MI application included MI training ($p < 0.001$) and MI-supporting institutional structures ($p = 0.006$), while work area was not significant ($p = 0.153$). Having had MI training increases the odds of applying MI with more clients by 4.44. An MI-supportive structure at the institution increases the odds of applying MI with more clients by 2.10. Table 4 provides an overview of all ordinal regression results.

Table 2. MI training overall, among outpatient and inpatient addiction care professionals

	MI-specific training (*N* = 261)		MI in basic professional education (*N* = 262)			MI-specific further education (*N* = 262)		
	no	yes (≤1 day)	no	1–3 days	>3 days	no	1–3 days	>3 days
Overall (*N* = 262)	118 (45.2%)	143 (54.8%)	161 (61.5%)	84 (32.1%)	17 (6.5%)	157 (59.9%)	72 (27.5%)	33 (12.6%)
Outpatient addiction care (*N* = 165)	64 (38.8%)	101 (61.2%)	93 (56.4%)	61 (37.0%)	11 (6.7%)	88 (53.3%)	53 (32.1%)	24 (14.5%)
Inpatient addiction care (*N* = 83)	46 (55.4%)	37 (44.6%)	60 (72.3%)	17 (20.5%)	5 (7.2%)	60 (72.3%)	16 (19.3%)	7 (8.4%)

Table 3. MI proficiency among trained and untrained addiction care professionals

	MI-trained professionals ($N = 140$)[a]		MI-untrained professionals ($N = 110$)[b]	
	N	%	*N*	%
MI proficiency				
Not confident	16	11.4	53	48.2
Partly confident, partly unconfident	34	24.3	32	29.1
Confident	90	64.3	25	22.7

[a] $n = 3$ (missing data). [b] $n = 8$ (missing data).

Client Motivational Stage

Of the 262 respondents, 76.3% ($n = 200$) reported to know the TTM. In outpatient addiction care, the most frequent phase was phase 2 (Contemplation), whereas in inpatient addiction care frequencies were more even among different stages of change, with the most frequent phase being phase 4 (action), χ^2 (4) = 45.732, $p < 0.001$ (see Fig. 2).

Discussion

The survey reveals key insights into MI training in addiction care, including its prevalence, support structures, and frequency of practice. Despite MI's assumed prominence in German addiction care [26], only slightly over half of participants had completed at least 1 day of MI training, with inpatient professionals particularly lacking training. Almost two thirds of those trained felt adequately prepared, while more than one fifth of untrained respondents likely overestimated their MI competence.

When MI training was undertaken, its duration typically ranged from one to 3 days. Training sessions rarely exceeded 3 days; particularly in the context of initial vocational education, such as social work programs, only a minority of respondents reported training durations exceeding this limit. In further education, the rate doubled to about one in eight professionals who reported to have had 3 days or more of MI-specific training.

This indicates that the majority of professionals trained in MI are unlikely to have engaged with all eight stages of MI learning as recommended by Miller and Moyers [31] within the limited timeframe of their training. Furthermore, MI training typically encompasses two distinct phases: (1) employing common counseling factors alongside specific MI techniques to enhance client motivation for change, and (2) reinforcing commitment and facilitating action for change through MI-specific techniques and the development of an action plan [32]. The extent to which these various components of MI are covered in the training programs remains unclear.

Despite this, evidence suggests that even brief MI training yields superior MI skills compared to no training or merely reviewing the treatment manual [20]. With regard to training methods, it has also been shown that

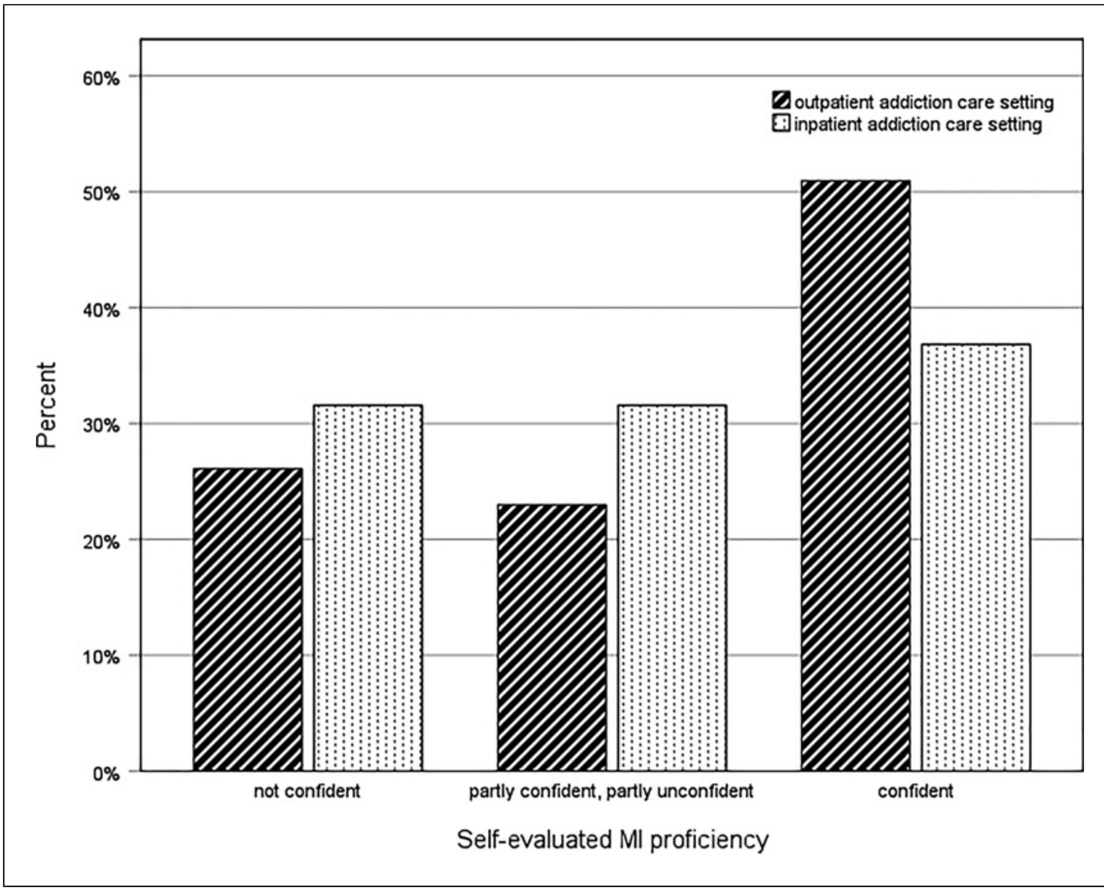

Fig. 1. Self-evaluated MI proficiency among trained professionals in outpatient ($n = 100$) and inpatient addiction care ($n = 35$).

Table 4. MI application

	Estimate	SE	Wald	df	*p* value	95% CI for odds ratio		
						lower bound	odds ratio	upper bound
Threshold								
0–3 client contacts	−1.84	0.33	31.11	1	<0.001	0.08	0.16	0.30
4–7 client contacts	0.25	0.30	0.67	1	0.415	0.71	1.28	2.31
Outpatient addiction care	0.39	0.27	2.04	1	0.153	0.87	1.47	2.50
Inpatient addiction care	0			0			1	
No MI-specific training	−1.49	0.27	30.56	1	<0.001	0.13	0.23	0.38
MI-specific training	0			0			1	
No MI-supporting institutional structures	−0.74	0.27	7.45	1	0.006	0.28	0.48	0.81
MI-supporting institutional structures	0			0			1	

$N = 238$, $R^2 = 0.18$ (Cox & Snell), 0.20 (Nagelkerke). Model $\chi^2(3) = 46.87$, $p < 0.001$. SE, standard error; df, degrees of freedom; *p*, significance; CI, confidence interval.

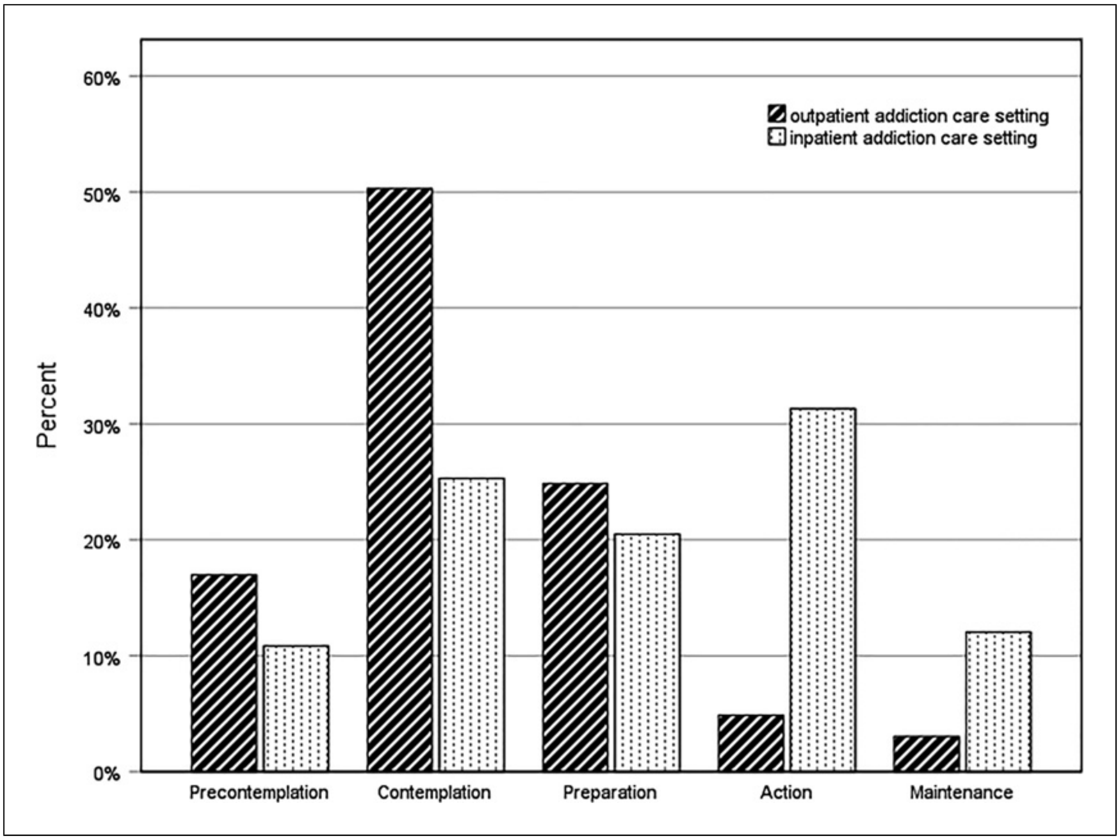

Fig. 2. Stages of change among clients of outpatient and inpatient addiction care professionals. $N = 248$.

expert-led training is more cost-effective than self-study or train-the-trainer methods [33]. Moreover, training effectiveness is enhanced when supplemented with consultation or supervision, regardless of whether it is delivered face-to-face or online. In a meta-analysis, Schwalbe et al. [34] demonstrated that an average of three to four feedback or coaching sessions over 6 months is necessary to sustain the MI skills acquired for addiction treatment. While a single workshop can bolster MI skills, research indicates that practitioners may still resort to MI-inconsistent methods, such as urging change, even when applying fundamental skills like open questioning. This raises concerns regarding the efficacy of very brief training interventions [35].

The identified need for enhanced MI training opportunities aligns with the finding that only approximately one third of respondents reported the presence of MI-supportive structures within their facilities. Notably, supervision and monitoring of MI quality were reported as exceedingly rare among the mentioned services. Participants expressed a desire for refresher courses as well as both internal and external training opportunities.

Self-reported application of MI in practice was predicted by the level of prior MI training and the availability of MI-supportive structures such as internal training courses and MI-specific supervision. This association held true regardless of whether the employees operated in outpatient or inpatient environments. While it cannot be dismissed that MI application may be inaccurately reported as being more prevalent than it is, dependent on the training received, the results indicate that MI trainees are actively attempting to implement MI techniques in their practice. Furthermore, the data suggest that additional training initiatives could facilitate increased application of MI practices beyond basic MI training courses.

In analyzing the responses to the TTM stages of change exhibited by clients, it is evident that phase 2 (contemplation) is predominantly observed among outpatient professionals, whereas subsequent phases are more commonly seen among inpatient professionals. This trend aligns with the higher prevalence of MI training among outpatient professionals, and the emphasis on behavioral change implementation in the inpatient setting. However, all stages of change were observed in inpatient settings, suggesting that MI should be an integral component of treatment practices in these settings, potentially combined with CBT and other MI-compatible approaches. With MI being a widely recommended intervention in various forms and stages of addiction throughout Europe, further studies should investigate European differences and also aim on how to improve structural quality of MI education, as general education in the field of addiction seems very different [36].

Limitations

The limited representation of psychologists and physicians in the sample, consistent with previous studies, restricts profession-specific inferences [26, 37]. Furthermore, future research should focus on assessing MI effectiveness in actual client interactions and conducting qualitative interviews to explore institutional barriers and facilitators for MI implementation. The findings on MI application and training should be viewed cautiously, as the voluntary survey may overrepresent trained professionals, likely inflating the proportion of those trained in MI within German addiction care.

Conclusions

The implementation of effective MI training for professionals in addiction care constitutes a fundamental strategy for facilitating evidence-based approaches to addiction treatment and prevention. Currently, effective MI training remains insufficiently developed within the German addiction care system. There is a pressing need to broaden MI training programs beyond the confines of 1–3 day workshops and to include components such as supervision, quality monitoring, and ongoing professional education. As efforts to facilitate guideline-adherent treatments intensify, it is essential to establish the necessary conditions for institutions and professionals to learn and implement MI effectively.

Statement of Ethics

This study protocol was reviewed and approved by the Research Ethics Committee of the Catholic University of Applied Sciences, North Rhine-Westphalia, Approval No. 2024/1. The consent form was presented online and required participants to agree before proceeding with answering survey questions. Written informed consent was obtained from participants prior to the study. All data were anonymously collected.

Conflict of Interest Statement

Prof. Dr. Reinout W. Wiers was a member of the journal's Editorial Board at the time of submission. The remaining authors have no conflicts of interest to declare.

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Author Contributions

Nuri Wieland contributed to formal analysis, methodology, visualization, and had the lead in writing the original draft. Helle Larsen and Reinout W. Wiers reviewed and edited the manuscript. Julia Kühling and Wiebke Brunner contributed to formal analysis, methodology, and study design. Ulrich Frischknecht contributed to formal analysis, study design, methodology, editing and reviewing the manuscript, and had the lead in project administration and supervision. All authors approved the final manuscript.

Data Availability Statement

The data that support the findings of this study are not publicly available since participants were not informed about the publication of individual-level data. However, data are available from the corresponding author (U.F.) upon reasonable request.

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