Motivational Enhancement Therapy (MET) Manual: Financial Incentives, Randomization with Stepped Treatment (FIRST) Trial

Social Worker

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Table of Contents

Introduction to the Study 3
Introduction to Motivational Enhancement Therapy (MET) Intervention 5
Overview 7
Phase I: Building Motivation to Change in MET (Sessions 1-2) 8
Summary of Phase I 17
Phase II: Strengthening Commitment to Change in MET (Sessions 1-2) 18
Phase III: MET Booster Sessions (Sessions 2-4) 22
FIRST Trial Feedback Form – Appendix 1: Change Plan Worksheet 24

Introduction to the Study

The major purpose of this randomized clinical trial is to determine the efficacy of contingency management (CM) plus stepped care that includes **Motivational Enhancement Therapy (MET)** for unhealthy alcohol use in HIV-positive patients. This manual is designed to guide Social Workers (SWs) in the delivery of the motivational enhancement interventions.

Context of Intervention Delivery

Before describing the intervention, it will be useful to provide some context for the study. Participants in the study will be individuals with HIV infection who present for primary care appointments for medical reasons and are invited to participate in a brief screening regarding their alcohol use. Those who meet initial screening eligibility will be invited to participate in the baseline assessment. Upon completion of the baseline assessment, participants who meet final study eligibility criteria will be invited to participate in the treatment study focused on modification of drinking patterns and will be randomly assigned to 1 of 2 intervention conditions – Treatment as Usual or Contingency Management (CM) plus Stepped Care. Patients in the CM plus Stepped Care arm who have phosphatidylethanol (PEth) > 8 ng/ml at Week 12 will progress to Step 2 and receive on-site treatment with Addiction Physician Management (APM) and MET from the SW. MET will be provided in 4 sessions, ideally preceding the initial and follow-up APM visits. The first MET visit should occur between Weeks 13 and 15 (as soon after the Week 12 PEth test results are available). After the initial visit, 3 follow-up sessions can be scheduled before the end of Week 21, with at least 1 week in between sessions (i.e., sessions should occur in separate calendar weeks).

Patient Recruitment Sites

Patients for the clinical trial will be recruited from 1 of 6 HIV primary care clinics at the VA Medical Centers in Atlanta, Houston, Manhattan/Brooklyn, Bronx, Los Angeles, and Washington, D.C.

Criteria for Patient Participation in the Study

In order for patients to be eligible to participate in this study, they must meet several criteria of inclusion and exclusion.

The* inclusion criteria *are as follows:

1. HIV-positive.
2. Recent significant alcohol consumption as determined by a PEth greater than 20 ng/ml.
3. Able to provide informed consent.
4. Meet at least one of the following criteria for unhealthy alcohol use:
   a. **At-risk Drinking** – consume > 14 drinks per week or > 4 drinks per occasion in men < or equal to 65 years old and > 7 drinks per week or > 3 drinks per occasion in women and men over 65.

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Introduction to the Study *(continued)*

b. Medical condition impacted by alcohol –

1. Detectable HIV viral load (>200 copies/ml);
2. Smoked at least 100 cigarettes in their lifetime and who now report smoking cigarettes every day or some days and have an exhaled carbon monoxide test >6 ppm;
3. Detectable HCV virus (antibody positive, confirmed detectable HCV RNA viral load);
4. Liver fibrosis with a FIB-4 >1.45 (a measure of liver fibrosis based on laboratory data);
5. Patient Health Questionnaire (PHQ-9, validated measure for depression) score greater than 9; or
6. Current (at least 30-day supply in the past 90 days) prescription for a psychoactive medication that interacts with alcohol, including benzodiazepines, opioids, antipsychotics, antidepressants, sleeping medications, muscle relaxants, and anticonvulsants.

c. Alcohol Use Disorder – Meet DSM-5 criteria for alcohol use disorder, not in remission.

Exclusion Criteria –***No participant may:***

1. Be acutely suicidal, or with an active psychiatric condition that affects their ability to provide informed consent or participate in counseling interventions (e.g., psychotic, dementia, delusional).
2. Be currently enrolled in formal treatment for alcohol use (excluding mutual-help, e.g., Alcoholics Anonymous).
3. Have medical conditions that would preclude completing or be of harm during the course of the study.
4. Be a pregnant or nursing woman or women who do not agree to use a reliable form of birth control.
5. Have a current diagnosis of or be in remission for a gambling disorder, given the gaming nature of CM, based on positive screen to the item "Have you ever tried to stop or reduce gambling because it was causing you problems?" followed by >4 positive criteria on the National Opinion Research Center DSM Screen for Gambling Problems (NODS).

Introduction to Motivational Enhancement Therapy (MET) Intervention

This MET condition is derived directly from a treatment manual by Miller, Zweben, DiClemente, and Rychtarik (1994), experts in motivational interviewing (MI). This manual summarizes the major points about MET and the specific application of MET principles, but assumes clinicians have a good degree of familiarity with those principles and methods. In this clinical trial, MET is presented as an individual intervention in four sessions. The initial session, occurring between Weeks 13 and 15, is designed to last 30 to 45 minutes. There are also three follow-up sessions that occur after the initial session up to Week 21, respectively, and that last 20 to 30 minutes each. Because of these parameters, considerable adaptation of the Miller et al. (1994) Project MATCH intervention is required, since that version of MET covered four sessions over three months and followed a far more extensive baseline assessment protocol than what is used in this study.

Major General Points About Motivational Enhancement

Motivational Enhancement Therapy (MET) is based on the work of U.S. psychologist William R. Miller and began to appear in the research and clinical literature over 30 years ago. This foundation of MET is an integration of concepts from motivational psychology, social psychology, and the theory and practice of psychotherapy. ***The foundation of MET may be distilled into four major points:***

1. Individuals have the inner resources to change their own behavior.
2. Change can be initiated and sustained successfully if the individual becomes aware of the benefits of changing and of the disadvantages of not changing (i.e., if the individual becomes "motivated" to change).
3. The process of changing a behavior may be described by Prochaska and DiClemente's stage of change model. The present version of the model includes five main stages, in the following sequence, from not motivated to change to engaging in and sustaining change activities: precontemplation – contemplation – determination (or preparation) – action – maintenance. When individuals are in the precontemplation or contemplation stages regarding changing a problem behavior, the idea is to facilitate a process that can help them to the determination or action stages, where their inner resources will take over and drive whatever behavior changes are required to meet the individual's goals.
4. MET may be thought of as a therapeutic approach to initiate and accelerate the individual's progress from precontemplation or contemplation status to the determination or action stage.

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Introduction to (MET) Intervention *(continued)*

MET also is organized around general principles that have been hypothesized to explain the effectiveness of brief interventions for changing patterns of alcohol consumption. They have been summarized by the acronym **FRAMES**.

FEEDBACK	Provide nonjudgmental, neutral feedback about the patient's behavior/health status in order to make salient the possible risks of continuing to engage in that behavior.
RESPONSIBILITY	Convey the message, implicitly and explicitly, that it is always up to the patient to change and, if that choice is made, that the responsibility for change lies with the patient.
ADVICE	Provide advice with permission in a clear manner about whether a change would be in the patient's best interests and, if so, what degree of change would be needed.
MENU	Provide several options, a "menu," for how the patient can make changes, not just one to enhance personal choice.
EMPATHY	Express an understanding of the patient's thoughts, feelings, and concerns. Empathy refers loosely to the capacity to put oneself in another's place. The technical application of empathy in MET is discussed in detail later.
SELF-EFFICACY	Help instill within the patient the belief that they have the capacity to make the changes that are desired.

MET is a "brief" (relative to the duration of traditional alcohol treatment) intervention that, in the Project MATCH version, consists of four sessions with a patient. In that format, the first two sessions cover the main content of the intervention, and the remaining two sessions are considered "booster" sessions. The main content of the intervention consists of two phases, (a) building motivation to change, followed by (b) strengthening commitment to change. In the context of the FIRST Trial, the goal of these sessions will be to help the patient be ready to make changes in their behavior that will foster abstinence from alcohol consumption. Thus, a goal of the MET sessions will be to increase the patient's motivation to receive recommended treatment from the Addiction Psychiatrist, which may include medications such as naltrexone (Vivitrol or Revia), disulfiram (Antabuse), and acamprosate (Campral) to address alcohol cravings.

Overview

There are four MET sessions. The first lasts 30-45 minutes, and the remaining sessions last from 20 to 30 minutes each. Three follow-up sessions occur after the first session. These sessions can be scheduled up to the end of Week 21. Only one follow-up session can be scheduled within the same calendar week. At the beginning of each session, the SW will decide whether or not breath alcohol testing is necessary. If the SW suspects that the patient is intoxicated, then testing will be administered. If a positive blood alcohol is observed, then the patient's session must be rescheduled. Phase I focuses on building the patient's motivation to change, and Phase II focuses on strengthening this commitment to change. For some patients, these two phases can be completed within the first session. For other patients, however, who are ambivalent about change, these two phases are best conducted in two sessions. The final phase, Phase III, involves reviewing progress, renewing motivation, and reinforcing commitment. Depending on how many sessions were used to conduct Phases I-II, Phase III occurs during sessions 2-4. See Table 1 below for an overview of the counseling phases and sessions.

Table 1. Summary of MET Counseling Phases

Counseling Phase			
	Phase I	**Phase II**	**Phase III**
Session Number	1-2	1-2	2-4
Length	25-30 minutes	15-20 minutes	20-30 minutes
Goal	Build motivation to change	Strengthen commitment to change	Reinforce motivation and commitment to change
Content	• Introduce treatment • Open-ended discussion about alcohol use • Provide feedback and review reactions	• Open-ended discussion to foster commitment to change alcohol use • Complete Change Plan Worksheet	• Review progress • Open-ended discussion about recent drinking • Review/revise change plan
Key Principles	• Elicit change talk • Listen with empathy • Question • Affirm • Reframe • Manage sustain talk/discord • Summarize	• Communicate free choice • Review pros of action and cons of inaction • Convey information and advice with permission • Manage sustain talk/discord	• Apply principles of Phases I and II

Phase I: Building Motivation to Change in MET (Sessions 1-2)

The goal of the first phase is to help motivate the patient to make changes toward abstinence from alcohol by making salient the advantages of changing and the disadvantages of not changing. This goal is accomplished through a specific structure (reviewed in Part 1) using the specific therapeutic style of MET (reviewed in Part 2).

Part 1: What to Cover – Structure of Phase I MET Sessions

Session 1

Introduction and preliminaries (5 minutes). The session begins with any introductions of the patient and SW that may not have already occurred. The SW answers any questions that the patient may have and thanks the individual for agreeing to participate in this research. It is also important at this time to remind the patient of confidentiality limits in general and specific to the study (i.e., use of audiotapes). Then, it is useful to describe to the patient the purpose of these sessions, and to describe some general features about the MET approach. The following is adapted from the Miller et al. (1994) MATCH manual.

> ***SW:*** *"Thank you for participating in the study. Before we begin, let me explain the purpose of this phase of the study and how we will be working together. We will meet four times. During these sessions, we will talk about your health, including your alcohol use and other behaviors. I'll present you with a lot of information about yourself, and maybe some advice, but what you do with all of this is completely up to you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do. But the decision to change and how to change is up to you. How does that sound?"*

Most patients accept this introduction and explanation of approach, and the intervention can then proceed. However, if the patient expresses some concerns, the SW should address them as well as possible. For example, again following the Miller et al. manual, the SW might say something like:

> ***SW:*** *"I understand your concerns. It is perfectly understandable that you would be unsure at this point. But let's just get started, and we'll see where we are after we've had a chance to work together. How does that sound to you?"*

Brief, open-ended discussion about patient's alcohol use (15 minutes). After introductions, the SW will transition into the feedback portion of the session. Before providing the patient with feedback, however, it is important to engage the patient in a general discussion about their alcohol use and overall situation to help the SW better understand the patient's perspective and to help foster change. When the SW senses that major themes or concerns have been elicited from the patient, the SW should provide a summary of what was discussed (see Phase I, Part 2 below for more details about Summarizing as a MET strategy). If the patient finds the summary acceptable, the SW's next step is to provide feedback from the initial assessments.

> ***SW:*** *"In a moment, I will share with you personalized feedback about your health status, including alcohol use, using your responses to questionnaires from the baseline assessment and your laboratory test results. Before*

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

> *we discuss this feedback, however, I would like to better understand what you think about your health and behaviors. Since you agreed to participate in the study, I assume that you have some concerns or questions about your use of alcohol, your HIV disease and your health in general. What are some concerns you may have?"*

Here the SW is attempting to hear the patient's viewpoint and, in the process, eliciting change talk. Specific MET therapeutic strategies for eliciting such statements are described in Phase I, Part 2 below, and should be applied here. In this regard, the SW should remember here that if the patient is slow in expressing change talk, the SW could use strategic open questions (described below) that focus on the concerns about the relationship between heavy drinking, HIV and health problems. Given the patient population and recruitment sources of patients in this study, this is a broad area of concern that virtually all participants should have in common. Other key MET strategies to use include:

1. reflecting to help the patient expand and elaborate upon initial statements of concern,
2. affirming the patient, and
3. managing sustain talk/discord.

Provision of feedback (10 minutes). The SW gives the patient a copy of the FIRST Trial Personal Feedback Form and reviews it step-by-step with the patient using the recommended feedback approach described below in Phase 1, Part 2. After going through the feedback, the SW asks for the patient's overall response. The patient is given a copy of the feedback, along with a copy of "Understanding Your Feedback Report" (adapted from Project MATCH).

> ***SW:*** *"I've given you quite a bit of information here, and at this point I wonder what you're making of all of this and what you're thinking."*

Both the feedback and this question often elicit change talk that can be reflected and used as a bridge to the next phase of MET. After the patient's response to the feedback, the SW offers an additional brief summary, including concerns raised in the first eliciting process and information provided in the feedback. This may be viewed as the transition point to Phase II of MET. **If the patient is not ready to make any changes, the SW is encouraged to continue using MET skills and not proceed to Phase II.**

Schedule next session with the patient.

Part 2: How to Conduct Phase I MET Sessions

There are 8 MET strategies that can help to shift the patient's perception of change. This section of the manual outlines the overall therapeutic approach to use with patients to build motivation in Phase I – (i.e., "How to do it.")

1. Eliciting Change Talk Statements

This first strategy refers simply to *having patients generate the statements themselves* that lead toward change.

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

This may involve, for example, being open to information about the risks of heavy alcohol consumption and expression of a need or desire to change. In essence, the idea is to encourage people to "tell themselves" that change makes sense for them, rather than having therapists or other professionals tell them. The words are viewed as being more persuasive if coming from the individual rather than from somebody else.

Several strategies have been suggested to help elicit change talk from individuals who present for treatment of problem drinking. However, in this study, patients did not initially present to their clinic setting for alcohol problems per se, but ostensibly because of their need for HIV care. Therefore, it may be useful to begin eliciting change talk from patients by use of general questions, such as, ***"I assume that since you are here, you have some concerns or questions about your use of alcohol and your HIV care in general. What are some of your concerns?" Another possibility is, "What is the biggest risk to you about your drinking and health?"***

An important note in applying this strategy is that patients may at first be slow to generate change talk statements. In such cases, it may be helpful for SWs to give specific cues relevant to alcohol and risk, particularly regarding health (HIV, HCV, other). Of course, this must be done in a way that does not result in further inhibiting the patient. For example, the SW might say, ***"Alcohol is known to affect the body in a lot of ways. For example, our liver, other parts of our digestive system, our heart, our ability to adhere to medications such as antiretrovirals, and our thinking can be affected in the long run by alcohol. In what ways does your use of alcohol negatively affect your physical or psychological health?"***

2. Listening with Empathy

Eliciting change talk, and other responses from patients, will likely be more effective if SWs listen empathically to what patients are saying. In MET, this therapeutic skill is also called reflecting, active listening, or understanding. In this context, empathic listening goes beyond the dictionary meaning; it involves listening to what the patient says, and "reflecting" it back, often in a modified or reframed form. Many times the reflection includes acknowledgement of the patient's feelings. The reader may recognize the influence of the work of Carl Rogers on the use of reflective listening to build motivation.

An important aspect of reflecting is that the ***therapist may reflect selectively, reinforcing certain thoughts or feelings the patient has expressed.*** Therefore, patients hear themselves say a motivational statement, and immediately hear the SW provide it back to them. In addition, reflective responding often encourages the patient to elaborate on the change talk statement. Some examples of reflective responding follow.

> ***SW:*** *"What concerns you about your drinking?"*
>
> ***Patient:*** *"I'm not too concerned, but sometimes I wonder if drinking might have something to do with my feeling dragged out all the time."*
>
> ***SW:*** *"You feel dragged out much of the time."*

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

Patient: *"Yeah, like finding it hard to get going in the morning the day after I drink, feeling tired during the day, that sort of thing."*

SW: *"So you think that your lack of energy might have something to do with how much you're drinking."*

Patient: *"Yeah, maybe it does, at least sometimes."*

Notice that in this (contrived) example, the SW uses information that the patient has expressed and, through summarizing (a form of reflecting) the content and feelings back to the patient, has encouraged further elaboration. *Also, notice that the SW gives no direct advice, and asks no direct "why" or similar questions.* Another example of reflective listening follows.

Patient: *"I like alcohol, but sometimes I wonder about it."*

SW: *"You're not always sure how you feel about alcohol."*

Patient: *"Yeah, that maybe it's not always worth the fun that you have with it."*

SW: *"You think that alcohol may not always be just fun."*

Patient: *"That's right, like it might cause arguments."*

SW: *"Arguments may happen while drinking that might not take place if you weren't using alcohol."*

It is important to note that reflective listening may appear simple, but to do it well takes a SW with specific skills. The SW must be an alert listener who is attuned to the patient, who is able to respond quickly to capture the most compelling thoughts and feelings that the patient is expressing at the moment, and is able to reflect them back to the patient in a way that is meaningful and that encourages elaboration. Accordingly, the SW makes use of the patient's nonverbal as well as verbal cues in formulating reflections. Notice again that true reflecting does **not** involve giving advice, agreement or disagreement, teaching, or suggestions. Instead, the SW responds to the patient in a way to encourage elaboration of the patient's own thoughts and feelings. To repeat, reflective listening seems easy, but takes considerable skill to do well.

Of course, reflecting also may involve the SWs' inferring a bit what the patient is feeling. For example:

Patient: *"If I stop drinking, I'll lose all my friends."*

SW: *"It's hard for you to imagine having any social life if you stop using alcohol."*

Capturing patient fears such as those expressed in this example and reflecting them back cogently is crucial in making MET effective.

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

Another point about reflecting is that patients may express ambivalence, or may "counterpoint" your reflection to take the other point of view. For example, in the case of ambivalence, the patient might say:

Patient: *"I know that drinking less makes sense, but life just wouldn't be the same."*

SW: *"You're afraid life wouldn't be as much fun, yet you think it's smart to drink less."*

Here the SW is making an inference in part about what the patient is expressing and reflecting back the ambivalence in a way that encourages the patient to go on with their thoughts. Notice again that the SW does not use the patient's statement as a cue to teach or instruct that one can still have a good time without drinking or with drinking moderately. Also, when reflecting ambivalence, it is important to end the reflection with the change talk made by the patient in an effort to encourage additional change talk.

An example of the pendulum of patient viewpoint swinging as a result of a SW reflection:

Patient: *"I'm worried about how much I drink."*

SW: *"So you think that you drink enough that it may be a problem for you."*

Patient: *"Well, not really a* ***problem.****"*

SW: *"There are things you like about drinking, yet you also have some concerns about it."*

In this case, the SW goes with the patient's counter-reaction to the first reflection with an attempt to restore "balance" by reflecting the patient's ambivalence.

One final point about reflective listening is that it is not a strategy that has a specific, circumscribed application in MET, but one that is used throughout its course. Although reflecting is not the only way the SW responds to the patient, it is a predominant style of interacting within MET.

3. Questioning

This third strategy is a style of the SW's response in MET that, like reflecting, may be used throughout the course of treatment. It refers to asking patients open questions (versus closed) about their thoughts and feelings, rather than telling them. This style of interaction is based on the idea that the patient is the best source of information about what their internal workings are.

4. Presenting Personal Feedback

In MET, a major way of making the risks of a patient's drinking salient is to present formal, written feedback regarding their alcohol use and its consequences. This feedback may take any form suitable to the context of an intervention. However, the format is standard: written feedback comparing what patients do or how they perform on some standardized psychological test with some standard. Typically,

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

the standard is one of "low-risk" behavior. The goal of giving feedback is to identify clearly what the patient is doing to place themselves at higher risk for developing alcohol problems, or for developing more severe problems. Through such recognition, concerns arise in the patient about their drinking. And it is through raising these concerns that movement toward behavior change happens.

An important part of providing feedback again is how the SW responds to the patient's reactions to the information. Reflecting plays a major part in this interaction. For example:

> ***Patient:*** *"I never realized the chances I've been taking with the amount I drink."*
>
> ***SW:*** *"This information surprises you."*

Another example involves the SW reflecting both sides of the patient's reaction:

> ***Patient:*** *"I drink as much as all of my friends do, but that amount may not be too safe."*
>
> ***SW:*** *"You feel that you really haven't been doing anything too unusual, and yet drinking that much may not be the safest way for you."*

It is possible that patients will have little to say, nor show much nonverbal reaction to the feedback. In that case, it works well if the SW asks directly what the patient's reaction is. For example, questions such as, "***What do you make of this?"***, ***"What surprises you about this information"***, or ***"What concerns you about this?"*** help to further the change process. In this regard, to restate the major aim of providing feedback to patients, *it is a way to make salient to them what risks they are incurring by engaging in a pattern of behavior, which may raise concerns in them that are expressed by them.* Such concerns are the bedrock of initiating behavior change. In the FIRST Trial, this feedback will take the form of the "FIRST Trial Feedback Form" to provide tailored information regarding the impact alcohol may be having on the patient's health (e.g., lab abnormalities). This feedback should be followed with a statement that reinforces the importance that the patient meets with the Addiction Psychiatrist to discuss the role of medications to help decrease cravings for alcohol use.

5. Affirming the Patient

This fifth strategy is another style of interacting with the patient that the SW uses throughout MET. It refers to genuinely reinforcing the patient for giving effort and time to considering and taking concrete steps to change a given behavior. According to Miller and colleagues, therapist affirmation may have several effects that further patient change: it strengthens the working relationship, enhances the patient's attitude of self-responsibility and empowerment, reinforces effort and change talk statements, and sustains and increases patient self-esteem. A few examples of SW affirmation statements are, ***"You've taken a big step in receiving this feedback today and being willing to discuss it with me,"*** and ***"You show a lot of strength going through this feedback and using the information to make some changes."***

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continue)*

6. Managing Sustain Talk/Discord

Previous iterations of MI used the term "resistance" to describe the patient arguing for the status quo (Miller & Rollnick, 2004). Traditionally, resistance has referred to patients' failure to comply with the clinician's instructions and is further indicated by counterproductive behaviors by the patient. In an effort to tip the balance toward change, counselors were to "roll with the resistance" so as to not trigger or incite any further increase of it. In the third edition of MI, Miller and Rollnick (2013) decided to use the terms sustain talk and discord to describe when the discussion in a therapeutic encounter does not go according to plan. A patient with conflicted feelings about changing a behavior can express one side of the ambivalence with sustain talk (i.e., reasons not to change or maintain the status quo) even if change talk is hidden within it. Counselors can use reflecting to acknowledge anti-change arguments and to reveal the change-oriented other side of the coin. It is important to note that ambivalence around changing a behavior and the accompanying sustain talk that may result is a normal part of the change process.

Unlike sustain talk, which is an intrapersonal phenomenon focusing on the patient's own reaction to behavior change, discord represents an interpersonal issue manifested as a rupture in the therapeutic relationship. As such, counselors must always be attentive to patient language that signals discord, such as arguing, dismissing, ignoring, interrupting, and negating, to name a few. In responding to discord, reflecting can be an effective way of repairing the therapeutic relationship, as can apologizing, shifting focus to another topic, and affirming.

Both sustain talk and discord in the relationship may occur at any point in the course of an intervention, and how it is handled makes a difference. Studies have shown that how counselors interact with patients influences the degree and frequency with which progress occurs. This differs sharply from the more traditional view, held especially in addictions treatment, that resistance is a product of a patient characteristic, such as "denial" of their problem behavior, which only serves to unfairly pathologize the patient. With this alternative approach, it follows that therapists can learn a style that typically results in reducing certain patient utterances within the clinical encounter in an effort to minimize sustain talk and discord. Such a style is a matter of *not* doing certain things, and of *doing* others.

The available research suggests that SWs should **not**: argue with, disagree with, or challenge the patient; judge, criticize, or blame the patient; warn the patient of dire consequences of their behavior; try to persuade the patient by using logical argument or data; interpret the patient's lack of progress; confront the patient by pulling authority or "rank" (by virtue of the SW's expertise); or use sarcasm or disbelief.

Miller and Rollnick (2013) offer several suggestions about what SWs can *do* to reduce sustain talk and discord within the session. Reflecting the ambivalence or concerns the patient expresses is a good first step. This can result in eliciting the opposite (change talk) response from the patient. Along these lines, the SW might try an amplified reflection, which involves exaggerating what the patient is saying to the point that the patient is likely to adopt a more moderate stance. For example:

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

> ***Patient:*** *"I may drink heavy once in a while and forget to take my medications, but so what? I haven't died from it."*
>
> ***SW:*** *"So you think what you're doing is perfectly safe."*
>
> ***Patient:*** *"Well, I wouldn't say that; what is perfectly safe after all?"*
>
> ***SW:*** *"Oh, so you think maybe there is some risk in drinking heavily and forgetting to take your medications."*

As Miller and Rollnick say, using this approach is somewhat risky for the SW, because if it is carried too far or timed poorly it may elicit further sustain talk from the patient.

Another strategy is to use a double-sided reflection, which emphasizes the ambivalence in what the patient may be saying and/or feeling. This refers to acknowledging the sustain talk along with the change talk that was provided at some point in the conversation. For example:

> ***Patient:*** *"I don't want to think of life without alcohol! Most of the fun would be gone."*
>
> ***SW:*** *"You think that stopping drinking would take the fun out of life, yet at the same time you see that drinking can make your HIV disease worse."*

Yet another way that has been proposed to handle sustain talk or discord is to shift focus, which means that the SW shifts attention away from the issue causing the tension in the session.

> ***Patient:*** *"I can't stop drinking, but that seems to be the only way you think I'll get better."*
>
> ***SW:*** *"We may be getting ahead of things here. Totally stopping drinking may not be the only way to lower your risk for problems. Let's finish going through this feedback, and later we'll talk about what may make sense for you."*

Finally, another method that has been suggested is to emphasize autonomy, meaning that the ultimate decision as to what course of action to take is up to the patient.

> ***Patient:*** *"But I can't cut down drinking that much. My life would change in too many ways."*
>
> ***SW:*** *"I can see your concern, and you may decide when we're through with this that you want to continue drinking the way you are now. Change might not be something you want to consider at this point. The choice will be yours to make."*

Ultimately, the purpose of these strategies is to elicit change talk statements from patients.

7. Reframing

This strategy was made popular by cognitive therapists and involves encouraging patients to examine their perceptions from a different slant or in a reorganized form. This often results in the patient

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Phase I: Building Motivation to Change in MET (Sessions 1-2) *(continued)*

discerning new meaning from what is said. Reframing may also result in putting behavior in a more positive light, which may give hope to the patient that a problem is solvable and that behavior change is possible.

> ***Patient:*** *"Why is everyone always getting on me? My mother's always getting into my life about my drinking."*
>
> ***SW:*** *"It sounds as if your mother cares about what happens to you."*

Another example is:

> ***Patient:*** *"Drinking is a way that my girlfriend and I have a good time. It keeps things relaxed."*
>
> ***SW:*** *"You've been going along drinking with your girlfriend so that you can keep your relationship peaceful and satisfying. Most people like that kind of relationship. Yet at the same time it seems you're uncomfortable with drinking that much."*

In this latter example, note that the SW has placed heavy drinking in a positive light for the patient, but concurrently opens a door for the patient to express concerns about their drinking.

8. Summarizing

Part of MET is to summarize periodically during the course of a session, especially toward its end. Most important is to reflect back the patient's change talk statements, so they are heard yet another time. It also may be useful in summarizing to include some of the patient-expressed sustain talk, so as to prevent a counter-reaction that could occur if they hear only a series of motivation to change statements. If this is to be done, the sustain talk should be summarized first, followed by the change talk statement.

Summary of Phase I

The goal of Phase I in MET, shifting of incentive from maintaining the status quo to change, is achieved through a variety of strategies. These are designed to elicit from the patient an awareness of risk of and concerns about their drinking. Such concerns are the foundation of patients making a commitment to behavior change.

MET prescribes no number or frequency of use of the eight principles outlined earlier. Rather, the use of the strategies is determined by the intervention context. The only constants are the goals of eliciting patient concerns and change talk statements, and of making risk more salient to them through feedback about the consequences of their drinking. Indeed, rather than a collection of discrete strategies, they together constitute a **therapeutic style** that defines MET and that, for the most part, permeates its course.

Phase II: Strengthening Commitment to Change in MET (Sessions 1-2)

Once sufficient motivation to change is achieved, the next step is to develop a plan for action (change). Typically, no clear "signal" goes off when this point is reached. Instead, the SW looks for different patient behaviors or comments that suggest readiness for change. For example, the patient may stop making sustain talk statements, or may ask fewer questions. The patient may be direct about it as well, and communicate their readiness for change. The important points here are, first, that when time for an action plan seems right, it should be seized. Furthermore, the patient's making a commitment to change does not necessarily mean that ambivalence about such change has disappeared. The SW must always be prepared to use the strategies discussed in Phase I of MET to fortify the patient's motivation to change. As in the discussion of Phase I of MET, several strategies are highlighted for use in Phase II, once readiness for change has been identified. The specific structure of Phase II is reviewed in Part 1 below, followed by a review of specific therapeutic strategies in Part 2.

Part 1: What to Cover – Structure of Phase II MET Sessions

Session 1 or 2

If Phase II is completed in Session 1, then the content proceeds with the open-ended discussion below. If Phase II is completed in Session 2, then the session begins with a brief summary of what happened in the first session. Session 2 is used to reinforce the motivational processes that were begun in Session 1. As before, the SW does not offer training in coping skills, nor does the SW prescribe a course of action for the patient. Rather, the same motivational and commitment to action strengthening principles that were applied in Session 1 are also applied in Session 2. In addition, the follow-through principles described earlier are used here, namely, reviewing progress, renewing motivation, and reinforcing commitment.

Open-ended discussion to foster commitment to change (10 minutes). Using cues from the patient (see recognizing readiness to change), the SW elicits from the patient thoughts, ideas, and plans for what might be done to address their concerns, including their readiness to attend a visit with the Addiction Psychiatrist and discuss use of medications to help with alcohol use. **If the patient has any of the contraindications to a moderation drinking goal (e.g., has a medical condition potentially affected by alcohol [detectable HIV viral load, untreated hepatitis C infection, depressive symptoms, smokes cigarettes, liver scarring based on a FIB-4 score>1.45] or is prescribed a medication that may potentially interact with alcohol), then the SW should point out such risks to the patient clearly and advise abstinence, if the patient seems to be leaning toward a moderation goal.** Besides that consideration, however, here the usual MET posture of the patient having freedom of choice of goals and solutions holds. Similarly, the basic MET client-centered stance of reflecting, questioning, affirming, reframing, and managing sustain talk indirectly is maintained throughout Phase II of MET. Phase II proceeds with working toward confirmation of a plan to change. In this regard, the SW seeks to get whatever commitment to change that is possible from the patient. It is helpful here to have the patient record their goals, reasons for change, and so forth on the Change Plan Worksheet (Appendix 1), including moving the patient toward a commitment to attending sessions with the Addiction Psychiatrist.

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Phase II: Strengthening Commitment to Change in MET (Sessions 1-2) *(continued)*

This point marks the end of the first MET session (or potentially the second MET session, if completed over 2 sessions). The patient is given access to web-based resources. If the patient has completed a written action plan, it can be taken home as well (the SW keeps a copy in the patient's research file).

Schedule and plan for next session. The SW should phone shortly before the next appointment to remind the patient of its scheduled time.

Part 2: How to Conduct Phase II MET Sessions

1. Discuss a Plan

As is apparent, this involves developing a plan for change. The SW starts the process by making any of several open questions, such as, ***"What do you make of all this?"***, ***"What do you think you want to do about it?"***, or ***"Now that you've come this far, I wonder what you're thinking you'll do about your concerns."*** The major goal here is to get the patient started generating their ideas about what changes to make, and how to make them. **It is essential that the SW not prescribe changes for the patient, or tell the patient how to make changes that are desired.** Rather, the major role of the SW once again is to use reflections, open questions, and affirmations to generate solutions from patients.

2. Communicate Free Choice

This is a reiteration of a core feature of MET, the communication to the patient that, in the final analysis, it is their choice of whether to change, and of what changes to make. SWs communicate this message frequently in MET by making comments such as, ***"It's up to you what to do about your drinking", "No one can decide about this but you", and "You can decide to go on drinking the way you have been or you can consider making some changes".***

3. Review Consequences of Action and Inaction

An excellent method for furthering commitment to change is to make a list of positives of changing and the negatives of not changing. At this point, the goal is to have the decision weighted on the side of change.

4. Convey Information and Advice

Many patients regard knowledge as important to them in deciding whether to change. The giving of advice is a little trickier, given the philosophy of MET that has been articulated here so far. Patients tend to ask SWs – even demand from them at times – advice about what to do. This is natural, in that the SW is viewed as an expert on the topic at hand. However, an essential feature of MET is that motivations and solutions come from patients and are not imposed by SWs. One way to resolve this dilemma is by the SW offering an opinion about a topic, but at the same time maintaining clearly that it is *only* an opinion, and that the final choice stays with the patient. Moreover, it is suggested that the advice focus on a "whether" (e.g., "Should I reduce my drinking?") and not on a "how" (e.g., "How should I go about cutting back on my drinking?") question. If patients ask a direct how question, the SW should put the question right back in the patient's court, such as by saying "How do you think you could do that?" In this way, solutions are still coming from the patient.

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Phase II: Strengthening Commitment to Change in MET (Sessions 1-2) *(continued)*

An approach that can be helpful in increasing the chances that the patient will be receptive to information given by the SW is called Elicit-Provide-Elicit. In this approach, the SW first elicits from patients their understanding of the topic. Then, with permission, they *provide* the necessary information, and end by *eliciting* from patients their understanding, interpretation, or reaction to the information. The goal of taking this collaborative stance is to minimize the chance of SWs coming across as lecturing or falling into the expert trap, thereby prompting "yes, but" sustain talk statements. Rather, the Elicit-Provide-Elicit approach promotes respect for the patients' knowledge and supports the patients' autonomy in what they make of the shared information. Another note here is that if a patient asks the SW for information on a topic and the SW does not know the answer, then the SW should say so. Between that time and the next session, the SW can find out the correct answer and tell the patient when they meet next, or the SW may phone the patient with the correct information.

5. Manage Sustain Talk

As alluded to earlier, sustain talk statements may show up in the commitment phase of MET. As in Phase I, the idea is to use reflecting and reframing to manage these statements. Autonomy support and conveying a belief in self-efficacy may also be used to help empower the patient to make beneficial decisions. For example, the SW might say, ***"You might decide that you want to keep on drinking heavily, even though you're aware of the risk in that."*** The idea is that such a statement may elicit a more tempered response from the patient, i.e., that the patient does not want to continue drinking heavily.

6. Complete The Change Plan Worksheet

Part of MET as applied in Project MATCH is the formal development of a plan for change. This exercise involves the patient's addressing 6 points with written answers. A worksheet, which appears in **Appendix 1 (on page 24)**, is used for this exercise. Discussion of the patient's answers with the therapist follows.

The six points are:

1. ***The changes I want to make are...*** In what ways does the patient want to change? (Give specific answers). Miller et al. (1992) suggest using goals that are positive (things I want to do) as well as negative (things I want to stop doing).

2. ***The most important reasons I want to make these changes are...*** What are the likely consequences of action and inaction? What motivations for change seem most compelling to the patient?

3. ***The steps I plan to take in changing are...*** How does the patient plan to achieve their goals? How could the desired changes be accomplished? Within this overall goal, what are some specific, concrete first steps the patient can take? When, where, and how will these steps be taken?

4. ***The ways other people can help me are...*** In what ways could other people help the patient take these steps toward change? How will the patient arrange for such support?

5. ***I will know my plan is working if...*** What does the patient hope will happen as a result of this change plan? What benefits might be expected from this change?

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Phase II: Strengthening Commitment to Change in MET (Sessions 1-2) *(continued)*

6. ***Some things that could interfere with my plan are…*** Help patients anticipate situations or changes that could undermine their plans. What could go wrong? How can the patient stick with the plan in the face of obstacles or setbacks?

7. Recapitulating

Toward the end of the commitment phase, it is useful to bring together all that has transpired so far, to reinforce both change talk statements and a commitment to change. This general summary should include a repetition of reasons for concern discovered in Phase I, as well as new information revealed in Phase II. The basics to be covered include the patient's change talk statements, the patient's plans for change, and the perceived positive consequences of changing and negative consequences of not changing.

Phase III: MET Booster Sessions (Sessions 2-4)

As developed for Project MATCH, MET includes three booster sessions. According to the Miller et al. (1994) manual, three processes are involved in these sessions: (1) reviewing progress, (2) renewing motivation, and (3) reinforcing commitment.

Part 1: What to Cover – Structure of Phase III MET Sessions

Review what has happened since last session; discuss different drinking situations that may have occurred since last session (10 min). Booster sessions begin with a **review** of what has happened since the last session. The SW discusses with the patient what commitments and plans were made, and explores with the patient what progress has been made toward these. Complete each booster with a summary of where the patient is now, and with their perceptions of what steps should be taken next. The previous plan for change is reviewed, revised, and if previously written down, rewritten. Again, the SW responds with reflecting, questioning, affirming, and reframing. The SW and patient collaboratively determine the extent to which previously established goals and plans have been implemented.

Part of booster sessions, as relevant, includes review of two types of drinking situations that may have occurred since the first session: those in which the patient drank more than was desired or than was safe; and those in which the patient adhered to desired and safe levels of alcohol use. For the first type of situation, the SW discusses how it occurred. In this process, the *SW remains empathic, avoids a judgmental tone, and does not prescribe solutions*. Instead, the SW uses the discussion to renew motivation, eliciting from the patient change talk statements by asking for the patient's thoughts, feelings, and reactions. In addition, key questions are used to renew commitment: ***"So what does this mean for the future?"*** and ***"I wonder what you need to do differently next time?"***

For the situations in which the patient drinks at desired and safe levels (including zero), the SW reinforces the patient's self-efficacy by asking the patient to clarify what was done to cope successfully in these situations. In addition, the SW affirms the patient for small steps, little successes, and even minor progress.

Reinforce motivational processes begun in Session 1 (5-10 min). Booster sessions are used to reinforce the motivational processes that were begun in Session 1. As before, the SW does not offer training in coping skills, nor does the SW prescribe a course of action for the patient. Rather, the same motivational and commitment to action strengthening principles that were applied in Session 1 are applied in Sessions 2, 3 and 4. In addition, the follow-through principles described earlier are used here, namely, reviewing progress, renewing motivation, and reinforcing commitment.

Schedule and plan for next session. The SW should phone shortly before the next appointment to remind the patient of its scheduled time.

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Phase III: MET Booster Sessions (Sessions 2-4) *(continued)*

Termination (Last Session Only)

Termination is discussed at the last session. As indicated in the MATCH manual, these points are covered:

1. Review the most important factors motivating the patient for change, and reconfirm these change talk themes.
2. Summarize the commitments and changes that have been made so far.
3. Affirm and reinforce the patient for commitments and changes that have been made.
4. Explore additional areas for change that the patient wants to accomplish in the future.
5. Elicit change talk statements for maintenance of change and for further changes.
6. Support patient self-efficacy, emphasizing the patient's ability to change.
7. Deal with any problems, such as obstacles to continued safe drinking, that the patient may anticipate.
8. Remind the patient of continued follow-up evaluations, and thank the patient for participating in the FIRST Trial.

Part 2: How to Conduct Phase III MET Sessions

The Phase I processes can be used again to **renew motivation** for change. How much renewal is needed is determined by the SW's judgment of the patient's current commitment to change. One way to evaluate this commitment is to ask patients what they remember as the most important reasons for changing their drinking.

Booster sessions also may be used to **reinforce the commitments** made earlier and, again, reinforce the importance of attending visits with the Addiction Psychiatrist to discuss medications (naltrexone, disulfiram, acamprosate) to help with alcohol cravings. In some cases, this may simply be a reaffirmation of the earlier plans. However, if the patient has met some problems or doubts in implementing their plans, it may be a time for re-evaluation of goals and plans, and of developing new ones. It is important here that the SW reinforces the patient's sense of autonomy and self-efficacy – the ability to carry out self-chosen goals and plans.

FIRST Trial Feedback Form – Appendix 1: Change Plan Worksheet

1. The changes I want to make are...

2. The most important reasons I want to make these changes are...

3. The steps I plan to take in changing are...

4. The ways other people can help me are...

5. I will know my plan is working if...

6. Some things that could interfere with my plan are...