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Motivational Enhancement Therapy with Drug Abusers

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Preface

This is a clinical research guide for therapists in applying Motivational Enhancement Therapy (MET) with drug abusers. MET is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991), and incorporates a "check-up" form of assessment feedback (Miller & Sovereign, 1989; Miller, Sovereign & Krege, 1988). This integrated MET approach was delineated in a detailed therapist manual (Miller, Zweben, DiClemente, & Rychtarik, 1992) developed for Project MATCH, a multisite trial of alcoholism treatments funded as a cooperative agreement by the National Institute on Alcohol Abuse and Alcoholism (NIAAA; Project MATCH Research Group, 1993).

This document is an adaptation and extension of the Project MATCH MET therapist manual. Thanks are due to Drs. Allen Zweben, Carlo DiClemente, and Robert Rychtarik for their collaboration in the preparation of the original MET manual. The background, clinical approach, and procedures described in that manual are directly applicable in treating clients when the drug of choice is other than alcohol. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications with drug abusers, and the entire section on assessment feedback has been changed to reflect drug-focused measures.

This manual was prepared as part of a treatment development project funded by the National Institute on Drug Abuse (NIDA; R01-DA08896). Starting with an initial draft, the content of the manual was adjusted and amended based on clinical experience during the two-year study. Therapists collaborating in the development of this manual were Robert J. Meyers, Nancy Handmaker, Joseph Miller, Edward Nash, Tracy Simpson, and Carolina Yahne.

This manual was developed specifically to guide the treatment of drug abusers during the second phase of the NIDA treatment development study. The first phase offered treatment for significant others (e.g., family) who were concerned about the drug use of a loved one who was not seeking treatment. Phase I interventions sought to engage the drug user in treatment. When the Phase I intervention succeeded, the drug user was offered admission to the study, carefully assessed, and given outpatient treatment that began with this MET approach. Further treatment was then provided, or referral was made to other agencies as appropriate. Because the significant other (SO) was already involved in the study by participating in Phase I, emphasis was given to the inclusion of the SO in the MET phase.

No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MET are well-grounded in clinical and experimental research, the specific efficacy of MET as outlined in this manual remains to be tested. Clinical trials are underway. In the interim, this manual offers a detailed description of MET procedures for use with drug abusers. All manuals of this kind should be regarded as "under development," and subject to ongoing improvement based on subsequent research and experience.

MOTIVATIONAL ENHANCEMENT THERAPY WITH DRUG ABUSERS

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INTRODUCTION

Overview

Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources. It may be delivered as an intervention in itself, or may be used as a prelude to further treatment. This manual was prepared for MET offered in an outpatient setting, although its application in residential settings is also feasible. MET may be particularly useful in situations where contact with clients is limited to one or a few sessions. Treatment outcome research strongly supports MET strategies as effective in producing change in problem drinkers. Although MET has also been used to address other drug problems (Baker & Dixon, 1991; Saunders, Wilkinson & Allsop, 1991; van Bilsen, 1991), outcome studies remain to be done to evaluate its efficacy with drug abuse.

Research Basis for MET

For over two decades, research has pointed to surprisingly few differences in outcome between longer, more intensive treatment programs and shorter, less intensive, even relatively brief alternative approaches in the treatment of alcohol problems (Annis, 1985; Miller & Hester, 1986b; Miller & Rollnick, 1991; U. S. Congress, Office of Technology Assessment, 1983), drug problems (MacKay, McLellan & Alterman, 1992), and mental health problems more generally (Kiesler, 1982). One interpretation of such findings is that all treatments are equally ineffective. A larger review of the literature, however, does not support such pessimism. Significant differences are found, for example, among alcohol treatment modalities in nearly half of clinical trials, and relatively brief treatments have been shown in numerous studies to be more effective than no intervention (Holder, Longabaugh, Miller, & Rubonis, 1991; Miller et al., 1995).

An alternative interpretation of this outcome picture is that many treatments contain a common core of ingredients which evoke change, and that additional components of some more extensive approaches may be unnecessary in many cases. This has led, in the addictions field as elsewhere, to a search for the critical conditions that are necessary and sufficient to induce change (e.g., Orford, 1986). Miller and Sanchez (1994) described six elements which they believed to be active ingredients of the relatively brief interventions that have been shown by research to induce change in problem drinkers, summarized by the acronym FRAMES:

FEEDBACK of personal risk or impairment
Emphasis on personal RESPONSIBILITY for change
Clear ADVICE to change
A MENU of alternative change options
Therapist EMPATHY
Facilitation of client SELF-EFFICACY or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Therapeutic interventions containing some or all of these motivational elements have been demonstrated in over two dozen studies to be effective in initiating treatment, and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking (Bien, Miller, & Tonigan, 1993). It is noteworthy that in a number of these studies the motivational intervention yielded comparable outcomes even when compared with longer, more intensive alternative approaches. Only one randomized trial to date has attempted to replicate with drug abusers the efficacy of this approach shown to be effective with problem drinkers: Stephens and Roffman (1993) reported motivational interviewing to be effective with marijuana dependent adults.

Further evidence supports the efficacy of the therapeutic *style* which forms the core of MET. The therapist characteristic of accurate empathy, as defined by Carl Rogers and his students (e.g., Rogers, 1957, 1959; Truax & Carkhuff, 1967), has been shown to be a powerful predictor of therapeutic success, even when treatment is guided by another (e.g., behavioral) rationale (Miller, Taylor & West, 1980; Valle, 1981). Miller, Benefield, and Tonigan (1993) reported that the degree to which therapists engaged in direct confrontation (conceptually opposite to an empathic style) was predictive of continued alcohol consumption among problem drinkers one year after treatment.

Stages of Change

The MET approach is further grounded in research on processes of natural recovery. Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change addictive behaviors, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviors. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behavior are described as being in PRECONTEMPLATION. The CONTEMPLATION stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behavior. As this individual progresses, he or she moves on to the DETERMINATION stage where the decision is made to take action and change. Once the individual begins to modify the problem behavior, he or she enters the ACTION stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to MAINTENANCE or sustained change. If these efforts fail, a RELAPSE occurs, and the individual begins another cycle.

The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with serious problems related to drug use, however, the process involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process.

Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the MET approach addresses where the client is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the ME therapist, the contemplation and determination stages are most critical. The objective is to help clients consider seriously two basic issues. The first is how much of a problem their drug use poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drug use toward change is essential for movement from contemplation to determination. Secondly, the client in contemplation assesses the possibility and the costs/benefits of changing the drug use. Clients consider whether they will be able to make a change, and how that change will impact their lives.

In the determination stage, clients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their drug use in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the ME therapist to empathize with the client, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

There is reason to believe that MET is particularly effective with less motivated clients. Rollnick and his colleagues (Heather, Rollnick, Bell, & Richmond, 1996) in a randomized trial with problem drinkers found that MET was significantly more effective than behavior-change skills training for clients who were in the precontemplation or contemplation stages of change. For more motivated clients (already to the action stage when presenting for treatment) the two approaches were equally effective.

In sum, MET is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in addictive behaviors. It draws on motivational principles that have been derived from both experimental and clinical research. This motivational approach is well supported by clinical trials with alcohol problems: its overall effectiveness compares favorably with outcomes of alternative treatments, and when cost-effectiveness is considered, an MET strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the client's inner resources, as well as those inherent in the client's natural helping relationships. MET seeks to support *intrinsic* motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy

1. Express Empathy

The ME therapist seeks to communicate great respect for the client. Communications that imply a superior/inferior relationship between therapist and client are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The client's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the client who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MET is *listening rather than telling*. Persuasion is gentle, subtle, always with the assumption that change ***is*** up to the client. The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice on "working with others" (Alcoholics Anonymous, 1976). Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of clients as they are, while also supporting them in the process of change.

2. Develop Discrepancy

Motivation for change occurs when people *perceive a discrepancy between where they are and where they want to be*. The MET approach seeks to enhance and focus the client's attention on such discrepancies with regard to drug use. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to *develop* such discrepancy by raising the client's awareness of the adverse personal consequences of his or her drug use. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the client enters

treatment in a later "contemplation" stage, and it takes less time and effort to move the client along to the point of determination for change.

3. Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the client's discomfort but do not alter drug use and related risks. An unrealistic (from the client's perspective) attack on his or her drug use tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand.

The MET style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt is made to have the client accept or "admit" a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the client to see accurately the consequences of drug use, and to begin devaluing the perceived positive aspects of drugs. When MET is conducted properly, *it is the client and not the therapist who voices the arguments for change* (Miller & Rollnick, 1991).

4. Roll with Resistance

How the therapist handles client "resistance" is a crucial and defining characteristic of the MET approach. MET strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. *Solutions are usually evoked from the client rather than provided by the therapist*. This approach for dealing with resistance will be described in more detail later.

5. Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self-efficacy* as a critical determinant of behavior change. Self-efficacy is, in essence, the belief that one *can* perform a particular behavior or accomplish a particular task. In this case, the client must be persuaded that it is possible to change his or her own drug use and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an *overall* optimistic nature that is crucial here. Rather, it is the client's *specific belief that he or she can change* the drug problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behavior. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

Differences from Other Treatment Approaches

The MET approach differs dramatically from confrontational treatment strategies such as Synanon, in which the therapist takes primary responsibility for "breaking down the client's denial." Miller (1989) described several contrasts between these approaches. MET places little emphasis on acceptance of a diagnostic label ("alcoholic," "addict"), whereas confrontational approaches often view such acceptance as a critical condition for change. MET emphasizes the client's personal choice regarding future drug use, whereas confrontational strategies may minimize the role of personal choice and describe drug abuse as a disease beyond the individual's control. Resistance behavior tends to be viewed as characterologic "denial" by confrontational therapists, whereas an MET approach views ambivalence as a normal stage of change. Consequently an ME therapist meets resistance with reflection rather than argumentation. It is noteworthy that this MET style is quite consistent with the original perspectives of Alcoholics Anonymous (1976; cf. Miller & Kurtz, 1994).

A goal of the ME therapist is to evoke *from the client* statements of problem perception and a need for change (see "Eliciting Self-Motivational Statements"). This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives ("You're an addict, and you have to quit using") and persuading the client of their truth. The ME therapist emphasizes the client's ability to change (self-efficacy) rather than the client's helplessness or powerlessness over drugs. As discussed earlier, arguing with the client is carefully avoided, and strategies for handling resistance are more reflective than exhortative. The ME therapist, therefore, does *not*:

argue with the client
impose a diagnostic label on the client
tell the client what he or she "must" do
seek to "break down" denial by direct confrontation
imply a client's "powerlessness"

The MET approach also differs substantially from cognitive-behavioral treatment strategies that prescribe and attempt to teach clients specific coping skills. No direct skill training is included in the MET approach. Clients are not taught "how to ..." Rather the MET strategy relies on the client's own natural change processes and resources. Instead of telling the client how to change, the ME therapist builds motivation and elicits ideas from the client as to how change might occur. Whereas skill training strategies implicitly assume readiness to change, MET focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual and his or her natural relationships may well suffice. Syme (1988), in fact, has argued that for many individuals a skill training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). It should be noted, however, that MET is not incompatible with, and could be used as a preparation for a skill training treatment approach.

Finally, it is useful to differentiate MET from nondirective approaches with which it might be confused. In a strict Rogerian approach, the therapist does not direct treatment, but follows the client's direction wherever it may lead. In contrast, MET employs systematic strategies toward specific goals. The therapist seeks actively to create discrepancy, and to channel it toward behavior change (Miller, 1983). The MET counselor offers feedback and advice where appropriate, and uses empathic reflection selectively to reinforce motivation for change. The *increasing* of conflict (discrepancy) is also a strategic element in MET. Thus MET is a directive and persuasive method, not a nondirective and passive approach.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counseling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MET focuses on developing the client's motivation to make a change in his or her drug use. Clients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family, employer, or legal authorities. Most clients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989; Miller, Sovereign & Krege, 1988). One side of the seesaw favors status quo (e.g., continued drug use as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drug use and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's drug use, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favor of change. Eight strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

There is truth to the saying that we can "talk ourselves into" a change. Motivational psychology has amply demonstrated that when people are subtly enticed to speak or act in a new way, their beliefs and values tend to shift in that direction. This phenomenon has sometimes been described as cognitive dissonance (Festinger, 1957). Self-perception theory (Bem, 1965, 1967, 1972), an alternative account of this phenomenon, might be summarized: "As I hear myself talk, I learn what I believe." That is, the words which come out of a person's mouth are quite persuasive to that person - moreso, perhaps, than words spoken by another. If I say it, and no one has forced me to say it, then I must believe it!

If this is so, then the *worst* persuasion strategy is one that evokes defensive argumentation from the person. Head-on confrontation is rarely an effective sales technique ("Your children are educationally deprived, and you will be an irresponsible parent if you don't buy this encyclopedia"). This is a flawed approach not only because it evokes hostility, but also because it provokes the client to verbalize precisely the *wrong* set of statements. An aggressive argument that "You're an addict and you have to give up all drugs" will usually evoke a predictable set of responses: "No I'm not, and no I don't." Unfortunately, counselors are sometimes trained to understand such a response as client "denial," and to push all the harder. The likely result is a high level of client resistance - which we will examine later.

The positive side of the coin here is that the ME therapist seeks to elicit from the client certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

1. being open to input about drug use and effects
2. acknowledging real or potential problems related to drug use
3. expressing a need, desire, or willingness to change
4. expressing optimism about the possibility of change.

There are several ways to elicit such statements from clients. One is to ask for them directly, via open-ended questions. Some examples:

> I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drug use. Tell me about those.
>
> Tell me a little about your drug use. What do you like most about the drugs you use? What's positive about these drugs for you? And what's the other side? What are your worries about using drugs?
>
> Tell me what you've noticed about your drug use. How has it changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems?
>
> What have other people told you about your drug use? What are other people worried about? (If a spouse or significant other is present, this can be asked directly.)
>
> What makes you think that you may need to make a change in your drug use?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc. If it bogs down, you can inventory general areas such as those contained in the Self-Evaluation of Drug Use. This inventory can be used as a structured inquiry, in which the pros and cons of drug use are weighed (see Appendix). Here are the areas included:

Amount and tolerance - Is the client's drug use increasing? Does the client seem to need larger doses of drugs to experience the same effect as before, or to tolerate large doses without showing much effect?

Behavior - Has drug use caused trouble with the law, neglect of responsibilities, inconveniences like having to move, financial problems, or embarrassing behavior?

Coping - Is the client using drugs to cope with problems and day to day difficulties? How well does it work in reducing (versus escaping) problems?

Dependence - How dependent or addicted is the client? How difficult is it to go without drugs?

Emotional Health - Does the client feel more anxious, guilty, upset, or depressed because of drug use? How does it affect the client's emotions?

Family - What effects does drug use have on the client's family?

Feeling **G**ood About Self (Self-Esteem) - How does drug use affect the client's self-concept? Does the person feel ashamed, guilty, out of control?

Physical **H**ealth - Has drug use contributed to illness, injuries, fatigue, poor eating habits, etc.?

Important Relationships - How does drug use affect the client's relationships with loved ones and friends?

Job: Work and School - How does drug use affect the person's school or employment?

Key People - What do key people in the client's life think about his or her drug use?

Loving Relationships and Sexuality - How does drug use impact the client's physical attractiveness, sexual drive, sexual relationships, safe sex practices, etc.?

Mental Abilities - Has drug use affected the person's memory, ability to concentrate, learning?

Information from pretreatment assessment (to be used as feedback later) may also suggest some areas to explore during this open-ended motivational interviewing phase.

If you encounter difficulties in eliciting client concerns, still another strategy is to employ gentle paradox to evoke self-motivational statements. In this table-turning approach, you subtly take on the voice of the client's "resistance," evoking from the client the opposite side. Some examples:

You haven't convinced me yet that you are seriously concerned. You've come down here and gone through several hours of assessment. Is that *all* you're concerned about?

I'll tell you one concern I have. This program is one that requires a fair amount of motivation from people, and frankly I'm not sure from what you've told me so far that you're motivated enough to carry through with it. Do you think we should go ahead?

I'm not sure how much you are interested in changing, or even in taking a careful look at your drug use. It sounds like you might be happier just going on as before.

Particularly in the presence of a significant other, such statements may elicit new self-motivational material. Similarly, a client may back down from a position if you state it more extremely, even in the form of a question. For example:

So drugs are really *important* to you. Tell me about that.
What is it about drugs that you really need to hang onto, that you can't let go of?

In general, however, the best opening strategy for eliciting self-motivational statements is to ask for them:

Tell me what concerns you about your drug use.
Tell me what it has cost you.
Tell me why you think you might need to make a change.

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to clients' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is an optimal response within MET.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke client resistance; (2) it encourages the client to keep talking and exploring the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the client means; and (5) it can be used to reinforce ideas expressed by the client.

This latter characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the client has said, and passing over others. In this way, clients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the client to elaborate the reflected statement. Here is an example of this process.

THERAPIST: What else concerns you about your drug use?

CLIENT: Well, I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm using too much.

T: Too much for . . .

C: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

T: It messes up your thinking, your concentration.

C: Yes, and sometimes I do stupid things.

T: And you wonder if that might be because you're using too much.

C: Well, I know it is sometimes.

T: You're pretty sure about that. But maybe there's more.

C: Yeah - even when I'm not using, sometimes I get things mixed things up, and I can't think right, and I wonder about that.

T: Wonder if . . .

C: If drugs are frying my brain, I guess.

T: You think that can happen to people, maybe to you.

C: Well can't it? I've heard that drugs can mess up your brain.

T: Um hmm. I can see why that would worry you.

C: But I don't think I'm an addict or anything.

T: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

C: Yeah.

T: Kind of a scary thought. What else worries you?

This therapist is responding primarily with reflective listening. This is not, by any means, the *only* strategy used in MET, but it is an important one. Neither is this an easy skill. Readily parodied or done poorly, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favor of continued exploration of the client's own processes. (For more detail, see Egan, 1982; Miller & Jackson, 1995).

It may be of further help to contrast reflective with other kinds of possible therapist responses to some client statements:

CLIENT: I guess I do use too much sometimes, but I don't think I have a *problem* with drugs.

> CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .
>
> QUESTION: Why do you think you don't have a problem?
>
> REFLECTION: So on the one hand you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

CLIENT: My wife is always telling me that I'm a junkie.

> JUDGING: What's wrong with that? She probably has some good reasons for thinking so.
>
> QUESTION: Why does she think that?
>
> REFLECTION: And that really annoys you.

CLIENT: If I quit using drugs, what am I supposed to do for friends?

> ADVICE: I guess you'll have to get yourself some new ones.
>
> SUGGESTION: Well, you could just tell your friends that you don't use anymore, but you still want to see them.
>
> REFLECTION: It's hard for you to imagine living without drugs.

This style of reflective listening is to be used throughout MET. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to client statements. As the following sections indicate, however, the ME therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a client who is ambivalent, reflection of one side of the dilemma ("So you can see that drugs are causing you some problems.") may evoke the other side from the client ("Well, I don't think I have a *problem* really."). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the client's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favor the latter to highlight the ambivalence:

DOUBLE-SIDED REFLECTIONS

You don't think that drugs are harming you seriously now, and at the same time you *are* concerned that they might get out of hand for you later.

You really enjoy using drugs and would hate to give that up, and you can also see that they are causing serious problems for your family and your job.

3. Questioning

The MET style does include some purposeful questioning as an important therapist response. Rather than *telling* the client how he/she should feel, or what to do, the therapist *asks* the client about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing (see below).

4. Presenting Personal Feedback

The first MET session should always include feedback to the client from the pretreatment assessment. This is done in a structured way, providing clients with a written report of their results ("Personal Feedback Report"), and comparing these with normative ranges.

To initiate this phase, give the client (and significant other, if attending) the Personal Feedback Report (PFR), retaining a copy for your own reference and the client's file. Go through the PFR step by step, explaining each item of information, pointing out the client's score, and comparing it with the normative data provided. The details of this feedback process are provided in the Appendix.

A very important part of this process is your own monitoring of and responding to the client during the feedback. Observe the client as you provide personal feedback. Allow time spaces for the client (and significant other) to respond verbally. Use reflective listening to reinforce self-

motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

Here are several different examples:

> CLIENT: Wow! This says that I'm using a lot more drugs than most people.
> THERAPIST: And that doesn't seem right to you.
>
> C: I don't see how my drug use can be affecting me that much.
> T: This isn't what you expected to hear.
>
> C: No, I don't really use much more than other people.
> T: So this is confusing to you. It seems like you use about the same amount as your friends, yet here are the results. Maybe you wonder if there's something wrong with the tests, or if I'm not being honest with you.
>
> C: More bad news!
> T: This is pretty difficult for you to hear.
>
> C: This gives me a lot to think about.
> T: A lot of reasons to think about making a change.

The same style of responding can be used with the client's significant other (SO). In this case, it is often helpful to reframe or emphasize the caring aspects behind what the SO is saying:

> WIFE: I always knew he was using too much.
> THERAPIST: You've been worried about him for quite a while.
>
> HUSBAND: (weeping) I've *told* you to quit doing drugs!
> THERAPIST: You really care about her a lot. It's hard to sit there and listen to this.

After reflecting an SO statement, it is often wise to ask for the client's perceptions, and to reflect self-motivational elements:

> FRIEND: I never really thought he used that much!
> THERAPIST: This is taking you by surprise.
> (Then to client:) How about you? Does this surprise you, too?
>
> WIFE: I've been trying to tell you all along that you drugs were no good for you. Now maybe you'll believe me.
> THERAPIST: You've been worrying about this for a long time, and I guess you're hoping now he'll see why you've been so concerned. (To client:) What *are* you thinking about all this? You're getting a lot of input here.

Often a client will respond *nonverbally*, and it is possible also to reflect these reactions. A sigh, a frown, a slow sad shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback. You can respond to these with a reflection of the apparent feeling.

If the client is not volunteering reactions, it is wise to pause periodically during the feedback process to ask:

What do you make of this?
Does this make sense to you?
Does this surprise you?
What do you think about this?
Do you understand? Am I being clear here?

Clients will have questions about their feedback and the tests on which their results are based. For this reason, you need to be thoroughly familiar with the assessment battery and its interpretation. Some additional interpretive information is provided on the PFR, which the client takes home.

The training videotape "Motivational Interviewing" offers one demonstration of this style of presenting assessment feedback to a resistant problem drinker [See Demonstration Videotapes list at the end of this section.]

5. Affirming the Client

You should also seek opportunities to affirm, compliment, and reinforce the client sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting client self-esteem. Some examples:

I appreciate your hanging in there through this feedback, which must be pretty rough for you.

I think it's great that you're strong enough to recognize the risk here, and that you want to do something before it gets more serious.

You've been through a lot together, and I admire the kind of love and commitment you've had to stay together through all this.

You really have some good ideas for how you might change.

Thanks for listening so carefully today.

You've taken a big step today, and I really respect you for it.

6. Handling Resistance

Client resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some client behaviors that have been found to be predictive of poor treatment outcome:

Interrupting - cutting off or talking over the therapist

Arguing - challenging the therapist, discounting the therapist's views, disagreeing, hostility

Sidetracking - changing the subject, not responding, not paying attention

Defensiveness - minimizing or denying the problem, excusing one's own behavior, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

What too few therapists realize, however, is that the extent to which such client "resistance" occurs during treatment is powerfully affected by the therapist's own style. Miller, Benefield and Tonigan (1993) found that when problem drinkers were randomly assigned to two different therapist styles (given by the same therapists), one confrontational-directive and one motivational-reflective, those in the former group showed substantially higher levels of resistance, and were much less likely to acknowledge their problems and need to change. These client resistance patterns were, in turn, predictive of less long-term change. Similarly, Patterson and Forgatch (1985) had family therapists switch back and forth between these two styles within the *same* therapy sessions, and demonstrated that client resistance and noncompliance went up and down markedly with therapist behaviors. The picture that emerges is one in which the therapist dramatically influences client defensiveness, which in turn predicts the degree to which the client will change.

This is in contrast with the common view that drug addicts are resistant because of pernicious personality characteristics that are part of their condition. Denial is often regarded to be a trait of "chemical dependency." In fact, extensive research has revealed relatively few consistent personality characteristics among drug users, nor do studies of defense mechanisms suggest any unique pattern associated with addictive behavior (cf. Miller, 1985). This suggests that people with drug problems do not, in general, walk though the therapist's door already possessing high levels of denial and resistance. These important client behaviors are more a function of the interpersonal interactions that occur during treatment, although they may result in part from the context in which therapeutic contact occurs (e.g., mandate by the courts).

An important goal in MET, then, is to *avoid* evoking client resistance (anti-motivational statements). Said more bluntly, *client resistance is a therapist problem*. How you *respond* to resistant behaviors is one of the defining characteristics of MET.

A first rule of thumb is *never meet resistance head-on*. Certain kinds of reactions are likely to exacerbate resistance, back the client further into a corner, and elicit anti-motivational statements from the client (Gordon, 1970; Miller & Jackson, 1995). These therapist responses include:

Arguing, disagreeing, challenging
Judging, criticizing, blaming
Warning of negative consequences
Seeking to persuade with logic or evidence
Interpreting or analyzing the "reasons" for resistance
Confronting with authority
Sarcasm or incredulity

Even direct questions as to *why* the client is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the client further defense of the anti-motivational position, and leave you in the logical position of counter argument. *If you find yourself in the position of arguing with the client to acknowledge a problem and the need for change, shift strategies*.

Remember that you want the *client* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the client. Here are several strategies for deflecting resistance (Miller & Rollnick, 1991):

Simple reflection. One strategy is simply to reflect what the client is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.

Reflection with amplification. A modification is to reflect, but exaggerate or amplify what the client is saying to the point where the client is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.

CLIENT: But I'm not addicted, or anything like that.

THERAPIST: You don't want to be labelled.

CLIENT: No. I just don't think I have a drug problem.

THERAPIST: So as far as you can see, there really haven't been any problems or harm because of your drug use.

CLIENT: Well, I wouldn't say that exactly.

THERAPIST: Oh! So you do think sometimes your drug use has caused problems, but you just don't like the idea of being called an addict.

Double-Sided Reflection. The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a client offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: You can't imagine how you could not use with your friends, and at the same time you're worried about how it's affecting you.

Shifting Focus. Another strategy is to defuse resistance by shifting attention away from the problematic issue.

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: You're getting way ahead of things. I'm not talking about your quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your feedback - and later on we can worry about what, if anything, you want to do about it.

Rolling With. Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

CLIENT: But I can't just quit drugs. I mean, all of my friends use!

THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to keep on using as you have been. It may be too difficult to make a change. That will be up to you.

7. Reframing

Reframing is a strategy whereby the therapist invites the client to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said. When a client is receiving feedback that confirms drug problems, a wife's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the client and SO to deal with drug use. In placing current problems in a more positive or optimistic frame, the counselor hopes to communicate that the problem is solvable and changeable (Bergaman, 1985; Fisch et al., 1982). In developing the

reframe it is important to use the client's own views, words, and perceptions about drug use. Some examples of interpretive reframes that can be utilized with drug abusers are:

> *Drugs as reward*. "You may have a need to reward yourself on the weekends for successfully handling a stressful and difficult job during the week." (The implication here is that there are alternative ways of rewarding oneself without using drugs.)
>
> *Drug use as a protective function*. "You don't want to impose additional stress on your family by openly sharing concerns or difficulties in your life [give examples]. As a result, you carry all this yourself, and absorb tension and stress by using drugs, as a way of trying not to burden your family." (The implication here is that the user has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides using drugs.)
>
> *Drug use as an adaptive function*. "Your drug use can be viewed as a means of avoiding conflict or tension in your relationship. Your drug use tends to keep the *status quo*, to keep things as they are. It seems like you have been using drugs to keep your relationship intact. Yet both of you seem uncomfortable with this arrangement." (The implication is that the client cares about the relationship and has been trying to keep it together, but needs to find more effective ways to do this.)

The general idea in reframing is to place the problem behavior in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the client has said. It is especially useful to repeat and summarize the client's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the client. Such a summary serves the function of allowing the client to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Here is an example of how you might offer a summary to a client at the end of a first session:

> Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your drug use, and you told me several things. You said that your cocaine use has been increasing rapidly, and you notice that you have a high tolerance for it - it's taking more for you to get the high that you want. You've been spending a lot of money on cocaine, and you're worried that you could lose your job and your house. There have been some real problems and fights in the family about your drug use, and you're concerned about how all of this is affecting your son. On the feedback, you were somewhat surprised to learn that your drug use in general is very high compared to

> American adults - that very few people use drugs they way you do. You have seen some signs that your drug use is starting to damage you physically. And though you don't want to think of yourself as an addict, you are quickly becoming dependent on cocaine, and you feel scared that it would be very hard for you to give it up. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your drug use. Is that a pretty good summary? Did I miss anything?

Along the way during a session, shorter "progress" summaries can be given:

> So thus far you've told me that you are concerned you're setting a bad example for your kids by using drugs, and that sometimes you may not be able to be as good a parent to your children as you'd like because of your drug use. What else concerns you?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the client's decisional balance in favor of change. A second major process in MET is to consolidate the client's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente model, this is the stage of *determination*, when the balance of contemplation has tipped in favor of change, and the client is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the client's decision.

There are no universal signs of crossing over into the determination stage. These are some changes you might observe (Miller & Rollnick, 1991):

- The client stops resisting and raising objections
- The client asks fewer questions
- The client appears more settled, resolved, unburdened, or peaceful
- The client makes self-motivational statements indicating a decision (or openness) to change ["I guess I need to do something about my drug use." "If I wanted to kick this, what could I do?"]
- The client begins imagining how life might be after a change

Here is a checklist of issues to assist you in determining a client's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment (Zweben et al., 1988):

1. Has the client missed previous appointments or canceled prior sessions without rescheduling?

2. If the client was coerced into treatment (e.g., for a drunk driving offense), has the client discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?

3. Does the client show a certain amount of indecisiveness or hesitancy about scheduling future sessions?

4. Is the treatment being offered quite different from what the client has experienced or expected in the past; and if so, have these differences and the client's reactions been discussed?

5. Does the client seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?

6. Does the client perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the client's uncertainties and ambivalence about drug use and change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many clients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the client has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment. The following strategies are useful once the initial phase has been passed, and the client is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

What do you make of all this?
Where does this leave you in terms of your drug use?
What's your plan? What are you thinking you will do?
I wonder what you're thinking about your drug use at this point.
Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The critical shift for the therapist is from focusing on *reasons* for change (Phase 1; building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). The client may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the client (and SO) some ideas and ultimately a plan for what to do about the client's drug use. It is not your task at this point to prescribe a plan for *how* the client should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your drug use, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?" and to the SO, "How do you think you might help him/her?" Reflecting and summarizing continue to be good therapeutic responses as more self-motivational statements and ideas are generated.

Communicating Free Choice

An important and consistent message throughout MET is the client's responsibility and freedom of choice. Reminders of this theme should be included during the commitment-strengthening process:

It's up to you what you do about this.
No one can decide this for you.
No one can change your drug use for you. Only you can do it.
You can decide to go on using just as you have been, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the client (and SO) to anticipate what the result would be if the client continued using as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the client (and SO).

For a more complete picture, you could also discuss what the client *fears* about changing. What might be the negative consequences of giving up drugs, for example? What are the advantages of continuing to use as before? Reflection, summarizing, and reframing are appropriate therapist responses.

One possibility here is to construct a formal "decisional balance" sheet, by having the client generate (and writing down) the pros and cons of change options. What are the positive and negative aspects of continuing to use drugs as before? What are the possible benefits and costs of making a change?

Information and Advice

Often clients (and SOs) will ask for key information, as important input for their decisional process. Such questions might include:

What is likely to happen to me if I quit cold turkey?
Do drug problems run in families?
How addicted am I?
Does marijuana damage the brain?
What's a safe level of use?
If I quit using, will these problems improve?
Could my sleep problems be due to my drug use?

The number of possible questions is too large to plan specific answers here. In general, however, you should feel free to provide accurate, specific information that is requested by clients and SOs. It is often helpful to ask for the client's response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Clients and SOs may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree. For example:

If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.

> I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

> I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life. I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

Within this general set, feel free to give the client your best advice as to what change should be made, specifically with regard to:

> What change should be made in the client's drug use
> The need for the client and SO to work together
> General kinds of changes that the client might need to make in order to support changes in drug use (e.g., find new ways to spend time that don't involve drugs)

When it comes to "how to's," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the client (and SO):

> How do you think you might be able to do that?
> What might stand in your way?
> You'd have to be pretty creative [strong, clever, resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a drug that you can take once a day and it keeps you from using. How does it work?"). Accurate and specific information can be provided in such cases.

A client may well ask for information that you do not have. Do not feel obliged to know all the answers. It is fine to say that you do now know, but will find out. You can offer to research a question and get back to the client at the next session, or by telephone.

Abstinence and Harm Reduction

Not all clients choose, as their goal, to abstain totally from all psychotropic drugs. The goal of change is, in fact, a choice that each client must and does make. Within an MET style, it is not up to you to "permit" or "let" or "allow" clients to make choices. The choice is theirs to make, and you cannot make it for them.

There are, of course, some persuasive reasons to consider drug abstention:

1. Successful abstinence is a safe choice. If you don't use drugs, you can be sure that you won't have problems (e.g., legal violations, AIDS risk, health damage) because of your drug use.

2. There are good reasons to at least *try* a period of abstinence (e.g., to find out what it's like to live without drugs, and how you feel; to learn the ways you have become dependent on drugs; to break your old habits; to experience a change and build some confidence; to please your spouse, etc.)

3. No one can guarantee a "safe" level of drug use (including alcohol use) that will cause you no harm.

At the same time many clients, at least initially, find a goal of complete abstention unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective in drug abuse treatment: basically, that any step in the right direction is a step in the right direction. A change from needle sharing to using clean needles is an important risk reduction. A change from intravenous use to oral or nasal administration further reduces risk. A shift from more dangerous to less dangerous drugs is an improvement. A reduction in frequency and quantity of use represents progress.

What goals, then, can be considered as harm reduction, short of immediate, permanent cold turkey cessation of all drug use? The more specific question here is: What kind of change(s) is the client willing to pursue with which drugs? Some "warm turkey" options include: (1) a trial period of abstention, (2) a gradual tapering of use toward abstention, and (3) a trial period of reduced use (Miller & Page, 1991). Shifting from more to less hazardous drugs or use patterns is also a feasible goal.

It is important to be clear, here, that you are not *advocating* continued use of illicit substances. Your overall goal in counseling is to help the user move away from harmful drug use, including illegal drug use.

In certain cases, you may feel particular responsibility to encourage abstinence, if the client appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MET. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . ."). Among the reasons for advising against a non-abstinence goal are:

* legal risks involved in the use of illicit substances
* medical conditions that contraindicate any use
* psychological problems likely to be exacerbated by use
* strong external demands on the client to abstain
* pregnancy

* use/abuse of medications that are hazardous in combination
* a history of severe problems and dependence

Clients who are unwilling to discuss immediate and long-term abstinence as a goal might be more responsive to intermediate options, such as a short-term (e.g., 3-month) trial abstinence period.

Handling Resistance

The same principles used for defusing resistance in the first phase of MET also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MET. One form of such statements is permission to continue unchanged:

> Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

> I wonder if it's really possible for you to keep using and still have your marriage, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the client's action plan. You can use it as a format for taking notes as the client's plan emerges. Do not *start* Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide, to ensure that you have covered these aspects of the client's plan:

The changes I want to make are... In what ways or areas does the client want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors).

The most important reasons why I want to make these changes are... What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the client?

The steps I plan to take in changing are... How does the client plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies

described, what are some specific, concrete first steps that the client can take? When, where, and how will these steps be taken?

The ways other people can help me are... In what ways could other people (including the significant other, if present) help the client in taking these steps toward change? How will the client arrange for such support?

I will know that my plan is working if... What does the client hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are... Help the client to anticipate situations or changes that could undermine the plan. What could go wrong? How could the client stick with the plan despite these problems or setbacks?

Preprinted Change Plan Worksheet forms are available for use by MET therapists. These are carbonless copy forms, so that you can write or print on the original and automatically have a copy to keep in the client's file. Give the original to the client, and retain the copy for the file.

CHANGE PLAN WORKSHEET

The changes I want to make are:

The most important reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

Person	Possible ways to help

I will know that my plan is working if:

Some things that could interfere with my plan are:

Recapitulating

Toward the end of the commitment process, as you sense that the client is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired (Miller & Rollnick, 1991). This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the client's self-motivational statements, the SO's role, the client's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

> Let me see if I understand where you are, then. Last time we reviewed the reasons why you and your husband have been concerned about your cocaine use. There were a number of these. You were both concerned that your drug use has contributed to problems in the family, both between you and with the children. You were worried, too, about the amount of money you have been spending, and the fact that your use seems to be getting out of control. The accident that you had helped you to realize that it was time to do something about your drug use, but I think you were still surprised when I gave you your feedback, just how much in danger you were. We've talked about what you might do about this, and you and your husband had different ideas at first. He thought you should go to C.A., and you thought you'd just cut down on your use on your own. We talked about what the results might be if you tried different approaches. Your husband was concerned that if you didn't make a sharp break with this drug habit, you'd probably slip right back into regular use, and forget what we've discussed here. You agreed that that would be a risk, and could imagine just blowing it all away to feel high. You didn't like the idea of C.A. because you were concerned that people would see you there, even though, as we discussed, there is a strong principle of anonymity. Where you seem to be headed now is toward trying out a period of not using at all, for three months at least, to see how it goes and how you feel. If that seems too rough at first, you might want some medication to help you get through the early weeks. Your husband likes this idea, too, and has agreed to spend more time with you, so you can go and do things together in the evening or on weekends. You also thought you would get involved again in some of the community activities you used to enjoy during the day, or maybe look for a job to keep you busy. Do I have it right? What have I missed?

If the client offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the client's situation, as above, and responded to additional points and concerns raised by the client (and SO), move toward getting a formal commitment to change. In essence, the client is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

1. Clarify what, exactly, the client plans to do. Give the client the completed Change Plan Worksheet, and discuss it.

2. Reinforce what the client (and SO) perceive to be likely benefits of making a change, as well as the consequences of inaction.

3. Ask what concerns, fears, or doubts the client (and SO) may have, which might interfere with carrying out the plan.

4. Ask what other obstacles might be encountered, which could divert the client from the plan. Ask the client (and SO) to suggest how they could deal with these.

5. Clarify the SO's role in helping the client to make the desired change.

6. Determine what additional help the client would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the client (and SO) that there will be a follow-up interview to see how they are doing.

If the client is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the client the signed original, retaining a copy for your file.

Some clients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the drug problem, you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing clients the opportunity to postpone such decision-making, is that the motivational processes will act more favorably on them over time (Goldstein et al., 1966). Such flexibility provides clients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the client may feel coerced into making a commitment before she or he is ready to take action. In this case, a client may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's perfectly understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next visit, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I'm sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of the client's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Involving the Significant Other in MET

When skillfully handled by the therapist, the involvement of a concerned significant other (CSO) can enhance motivational discrepancy and commitment to change. The CSO should be encouraged to participate and be actively engaged in treatment whenever possible. Emphasis is placed on the need for the client and CSO to work collaboratively on resolving the drug problem.

The MET approach recognizes the importance of the spouse, family member, close friend, or significant other in affecting the client's decision to change his or her drug use. This emphasis is based upon recent findings from a variety of treatment studies. For example, alcoholics seen in an outpatient setting were found more likely to remain in a spouse-involved treatment than in an individual approach (Zweben et al., 1983). Similarly, clients maintaining positive ties with family members fared better in a relationship enhancement therapy than in an intervention focused primarily on the psychological functioning of the client (Longabaugh et al., in press). Szapocznik and his colleagues (1983, 1986) have shown the efficacy of family therapy as an engagement strategy in the treatment of drug abuse.

Involvement of a CSO in the treatment process offers several advantages. It provides the SO an opportunity for first-hand understanding of the problem. It permits the CSO to provide input and feedback in the development and implementation of treatment goals. The client and CSO can also work collaboratively on issues and problems that might interfere with the attainment of treatment goals.

Goals for Spouse/SO Involvement

The following are general goals for the CSO's involvement in MET:

1. to establish a working rapport among the client or identified patient (IP), the CSO and the counselor

2. to raise the awareness, by the IP and CSO, of the CSO's concerns about the extent and severity of drug problems

3. to strengthen the CSO's commitment to help the client overcome the drug problem

4. to strengthen the CSO's belief in the importance of his or her own contribution in changing the client's drug use patterns

5. to elicit feedback from the CSO that might help motivate the drug user to change. For example, a spouse might be asked to share his or her concerns about the client's past, present, and future drug use. Having the spouse "deliver the message" can be valuable in negotiating suitable treatment goals.

6. to promote higher levels of cohesiveness and satisfaction in the relationship between the IP and CSO.

MET does not include intensive marital/family therapy. The main principle here is to elicit from client and CSO those aspects of their relationship which are seen as most positive, and to explore how they can work together in overcoming the drug problem. Both client and SO can be asked to describe the other's strengths and positive attributes. Issues raised during SO-involved sessions can be moved toward the adoption of specific change goals. Do *not* allow the client and CSO to spend significant portions of a session complaining, denigrating, or criticizing. Such communications tend to be destructive, and do not favor an atmosphere that motivates change.

Explaining the Significant Other's Role

Ideally, a client and CSO will come together to the client's first session. In the beginning of the session, comment favorably on the willingness of both to come for consultation, and the caring that it reflects. Then explain the CSO's role in treatment sessions. The major points are that:

1. the CSO cares about the client, and changes will directly impact both their lives

2. the CSO's input will be valuable in setting treatment goals and developing strategies

3. the CSO may be directly helpful to the client by working together to resolve any drug problems

The Significant Other in Phase 1.

In the first conjoint session, an important goal is to establish rapport, to create an environment in which both the client and the CSO can feel comfortable about openly sharing concerns and disclosing information that may help promote change. During the course of Phase 1, ask the CSO about her or his own (past and present) experiences with the client's drug use and problems.

What has it been like for you?
What have you noticed about [client's] drug use?
What things have concerned you the most?
What has discouraged you from trying to help in the past?
What do you see that is encouraging?

Emphasis should be placed on positive attempts to deal with the problem. At the same time, negative experiences - stress, family disorganization, job and employment difficulties, etc. - should be discussed and reframed (where appropriate) as *normative;* that is, as events which are common in families with drug problems. Such a perspective should be communicated in the interview. The counselor might compare the CSO's experiences to the personal stress experienced by families confronted with other chronic mental health or physical disorders such as heart disease, diabetes, and depression (without going into depth about such experiences).

The CSO can often play an important role in helping the client to resolve uncertainties or ambivalence about drug use and change during Phase 1. The CSO can be asked to elaborate on the risks and costs of continued drug use. For example, one CSO revealed during counseling that she was becoming increasingly alienated from her partner as a result of the negative impact that the drug use was having on her children. These questions, asked of the CSO in the presence of the client, can be helpful in eliciting such concerns:

1. How has the drug use affected you?
2. What is different now, that makes you more concerned about the drug use?
3. What do you think will happen if the drug use continues as it has been?

Feedback provided by the CSO can often be more meaningful to a client than information presented by the counselor. It can help the client mobilize commitment to change (Pearlman et al., 1989). In sharing information about the potential consequences of the drug problem for family members, a CSO may cause the client to experience emotional conflict (discrepancy) regarding his or her drug use. Thus, the client may be confronted with a dilemma in which it is not possible both to continue drug use and to have a happy family. In this way the decisional balance can be further tipped in favor of changing the drug use. One client became more conflicted about his drug use after his wife described the negative impact it was having on their children. He subsequently decided to quit using drugs, rather than to experience himself as a harmful parent.

At the same time, there is a danger here of overwhelming the client, if the feedback given by the CSO is new, extremely negative, or presented in a hostile manner. Negative information presented by both the CSO and the counselor may result in the client feeling "ganged up on" in the session, and could result in treatment drop-out. The MET approach relies primarily upon instilling intrinsic motivation for change in the client, rather than using external motivators such as pressure from CSOs.

Therefore, when involving the CSO in a session, it may be useful to "go slow" in presenting material to the client. You may gauge the mood or state of the client by allowing him or her the opportunity to respond to specific items before soliciting further comments from the CSO. You may ask whether the client is ready to examine the consequences (i.e., both personal and family concerns) that have followed from drug use. If the feedback provided seems to be particularly aversive to the client, then it is important to intersperse affirmations of the client. The CSO can be asked questions to elicit supportive and affirming comments:

1. What are the things you like most about [client] when he/she is not using?

2. What positive signs of change have you noticed, that indicate [client] really wants to make a change?

3. What are the things that give you hope that things can change here for the better?

Supportive and affirming statements from the counselor and CSO can further enhance commitment to change.

The client-centered nature of MET can be further emphasized by focusing on the client's responses to what the CSO has offered. You might ask, for example:

Of these things which your husband has mentioned, which are of the most concern to you?

How important do you think it is for you to deal with these concerns that your brother has raised?

CSOs can be asked for their own comments and reactions to the material being presented during feedback from pretreatment assessment:

What do you think about this? Is this consistent with what you have been thinking about [client's] drug use? Is any of this surprising to you?

Such questions may help to confirm the CSO's own perceptions about the severity of the drug problem as well as clarifying any misunderstandings about the problems being dealt with in treatment sessions. The same strategies used to evoke client self-motivational statements can be applied with the CSO as well. Once an agreement is reached about the seriousness of the problem, the counselor should explore with the SO how he or she might be helpful and supportive in dealing with the problem. Remember that MET is not itself a skill-training approach; the primary mechanism here is to elicit ideas from the CSO and client about what could be done. In raising the awareness of the CSO about the client's drug use and related issues, seek mainly to *motivate* the CSO to play an active role in dealing with the problem.

The Significant Other in Phase 2

A spouse or other significant person who is attending sessions may be engaged in a helpful way in the commitment process of Phase 2. A CSO can play a positive role in instigating and sustaining change, particularly in situations where interpersonal commitment is high. The CSO can be involved in a number of ways:

Eliciting feedback from the CSO. The CSO might provide further examples of the negative effects of the IP's drug use on the family, such as not showing up for meals, missing family

celebrations like birthday parties, embarrassing the family by being impaired, alienating children and relatives, etc. This is an extension of the CSO's role in Phase 1.

Eliciting support. The CSO can comment favorably on the positive steps undertaken by the client to make a change in drug use, and you should encourage such expression of support. The CSO may also agree to join with the client in change efforts (e.g., spending time in non-using settings). Emphasize that ultimate responsibility for change remains with the client, but that the CSO can be very helpful. It is useful here to explore tentatively, with both the CSO and the client, how the CSO might be supportive in changing drug use. You might ask the following:

> To SO: In what ways do you think you could be helpful to _____?
>
> To SO: What has been helpful to _____ in the past?
>
> To Client: How do you think _____ might be supportive to you now, as you're taking a look at your drug use?

Be careful not to "jump the gun" at this point. Asking such questions may elicit defensiveness and resistance if the client is not fully ready to consider change.

Eliciting self-motivational statements from the CSO. This strategy should be employed in the second CSO-involved session, after the client and SO have had a chance to reflect upon the information presented earlier. It is possible that the client has become less resistant after he or she has had more time to think about drug use and related issues (see section on *Asking for Commitment*). If, in the second interview, the client still appears to be hesitant or reluctant about dealing with the drug use and related matters, then an attempt should be made to acknowledge the feelings of frustration and helplessness experienced by the CSO while at the same time allowing him or her the opportunity to examine alternatives in order to handle these frustrations:

> I know that you both want to do what's best for the family. However, there are times when there are differences in what the two of you want. It can be frustrating when you can't seem to agree about what to do. (Turning to the spouse). In this case, you have a number of options. You can try to change your [husband/wife's] attitude about drug use - I think you've tried that in the past without much success, right? Or you could do nothing and just wait. But that still leaves you feeling frustrated or helpless, maybe even hopeless, and that's no good. Or you can concentrate your energies on yourself and other members of your family, and focus on developing a lifestyle for yourself that will take you away from the drug use. What do you think about this third option? What things could you do to keep from being involved in drug use situations yourself, and to develop a more rewarding life away from drugs?

In response to this question, one spouse determined that she would no longer accompany her spouse to the homes of friends who use drugs. Another went a step further and indicated that he would not be involved in any drug-related activities with his wife. By eliciting such self-

motivational statements and plans from CSOs, it is possible to tip the client's balance further in favor of change (cf. Sisson & Azrin, 1986).

Addressing the CSO's expectations. When goals and strategies for change are being discussed, the CSO is invited to express his or her own views, and to contribute to generating options. Any discrepancy between the client and SO with respect to future drug use should be addressed. Information from the pretreatment assessment may be used here to reach a consensus between client and CSO (e.g., severity of problems, consumption pattern, etc.). If agreement cannot be reached, a decision may be delayed, allowing further opportunity to consider the issues (see section on *Asking for Commitment*). The objective is to establish goals that are mutually satisfactory. This can further reinforce commitment to the relationship, as well as the resolution of drug problems.

Handling CSO Disruptiveness

In some cases, CSO involvement could become an obstacle in motivating the client to change, and could even lead to a worsening of the drug problem. It is important to identify these potentially problematic situations and to deal with them. The following scenarios are provided to illustrate circumstances where CSO involvement might have a negative impact on MET:

> Comments are made by the CSO that appear to exacerbate an already strained relationship and to evoke further resistance from the client. Your efforts at eliciting verbal support from the CSO are met with resistance. Your own efforts to elicit self-motivational statements from the client are hindered by CSO remarks that foster client defensiveness.
>
> Comments made by the CSO suggest an indifferent or hostile attitude toward the client. The CSO demonstrates a lack of concern about whether the client makes a commitment or is attempting to resolve the drug problem. The involvement of the CSO appears to have little or no beneficial impact to elicit self-motivational statements from the client. When the client does make self-motivational statements, the CSO offers no support.
>
> The CSO seems unwilling or unable to make changes requested by the client, which might facilitate an improvement in the drug problems or their relationship. For example, despite strong requests from the client (and perhaps from you) to place a moratorium on negative communication patterns, the CSO continues to harass the client about past drug use.

In these or other ways, involvement of the SO may prove more disruptive than helpful to treatment. The first approach in this case is to use MET procedures (reflection, reframing, etc.) to acknowledge and highlight the problematic interactions. If usual MET strategies do not result in a decrease in CSO disruptiveness, intervene directly to stop the pattern. The following are potentially useful strategies for minimizing CSO interference with the attainment of treatment goals, and are consistent with the general MET approach. Note that these are departures from the usual procedures for MET spouse involvement, and are implemented for "damage control."

1. Limit the amount of involvement of the CSO in sessions. You might explicitly limit CSO involvement to (1) providing collateral information about the extent and pattern of drug use, and (2) acquiring knowledge and understanding about the severity of the drug problem and the type of treatment being offered. Your interactions with the CSO can be limited to clarifying factual information and ensuring that the CSO has a good understanding of the client's drug problem and the plan for change. Typical structuring questions of this kind would be, "Do you understand what has been presented thus far?" "Do you have any questions about the material we have discussed so far?"

2. Focus the session(s) on the client. You can announce that the focus of discussion should be on the client in terms of helping to resolve the concerns that brought him or her to treatment. Indicate that the drug use needs priority of attention, and that other concerns are best dealt with after the client has competed this phase of treatment. Then direct the discussion to the client's concerns.

3. Limit the CSO's involvement in decision-making activities. If CSO participation is problematic, allow the CSO to be a witness to change, without requesting his or her direct involvement inside or outside of sessions. Avoid requesting input from the CSO in formulating change goals and developing the plan of action. Do not request or expect CSO affirmation of decisions made by the client with regard to drug use and change.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the client's commitment to change (Phase 2), MET focuses on follow-through. This may occur as early as the second session, depending upon the client's pace of progress. Three processes are involved in follow-through: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment. It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the client what commitment and plans were made, and explore what progress the client has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the

client's current commitment to change. This may be assessed by asking the client what he/she remembers as the most important reasons for making a change in drug use.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the client has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the client's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the client may decide that he or she would like specific additional treatment to help in pursuing goals. The important Phase 3 task here is to clarify with the client what goals are to be achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

[Within the CRAFT format it is acceptable for the therapist to continue to provide such additional treatment for up to a total (including MET) of 12 sessions. Referral to a range of community services is also possible, though their cost is not covered by this grant.]

THE STRUCTURE OF MET SESSIONS

The preceding sections outlined the basic flow of MET from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MET sessions.

The Initial Session

Preparing for the First Session

In Project CRAFT, for which this manual was originally developed, treatment was preceded by an extensive battery of assessment instruments, some of which were used as the basis for personal feedback in the first session. It is not necessary to use these *particular* instruments. The general intent is to provide the client with objective feedback regarding his or her drug use and related problems.

When you contact the client to make your first appointment, stress the importance of bringing along to this session his/her CSO. If not already identified, this typically would be the spouse, a family member, or a close friend, who can be supportive through the treatment process. The critical criteria are that the CSO is considered to be an "important person" to the client, and that the CSO ordinarily spends a significant amount of time with the client. If no such person is initially identified, explore further during the first session whether an CSO can be designated.

Also explain that the client must come to this session clean and sober, that a breath test will be administered, and that any significant alcohol in the breath or other evidence of drug impairment will require rescheduling. All MET sessions are preceded by a breath alcohol test, to ensure sobriety. The client's BAC must be no higher than .05 (50 mg%) in order to proceed. Otherwise, the session must be rescheduled. If there is disagreement as to whether a client is impaired by other drugs at the time of interview, it is acceptable to request an additional urine sample.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

> Before we begin, let me just explain a little about how we will be working together. You have already spent several hours completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today.
>
> I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to

> you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?
>
> After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together for up to a total of 12 sessions. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing?

After this introduction, start the first session with a brief structuring of the first session and, if applicable, the CSO's role in this process (refer to the section on "Involving a Significant Other"). Tell the client (and CSO) that you will be giving them feedback from the pretreatment questionnaires and interviews, but first you want to understand better how they see the client's situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Client," "Handling Resistance," and "Reframing" are also quite appropriate here. [See the "Motivational Interviewing" videotape by Dr. Miller, demonstrating this early phase of MET.]

When you sense that you have elicited the major themes of concern from the client (and CSO), offer a summary statement (see "Summarizing"). If this seems acceptable to the client (and CSO), indicate that the next step is for you to provide feedback from the client's initial assessment. Give the client a copy of the Personal Feedback Report (PFR), and review it step by step (see "Presenting Personal Feedback"). Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session, and *take back the client's copy of the PFR* for use in your second session, indicating that you will give it back to keep after you have completed reviewing the feedback next week.

Whenever you do complete the feedback process, ask for the client's (and CSO's) overall response. One possible query would be:

> I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MET.

After obtaining the client's (and CSO's) responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MET: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the client and CSO [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the client (and CSO) what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the client. The basic client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MET sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the client's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the client [and CSO]. Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a client may drop out of treatment rather than "go back on" the agreement.

Ending the First Session

Always end the first session by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the first session presenting feedback and dealing with concerns or resistance. In other cases, the client will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the first session. The speed with which this session proceeds will depend upon the client's current stage of change. Where possible, it is desirable to elicit some client self-motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the client will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a client toward change before he or she is ready will evoke resistance and undermine the MET process.

At the end of the first session, it is acceptable to provide the client with a copy of suitable reading material. If feedback has been completed, also give the client the Personal Feedback Report and a copy of "Understanding Your Personal Feedback Report."

The Follow-up Note

After the first session, prepare a handwritten note to be mailed to the client. This is *not* to be a "form letter," but rather a personalized message in your own handwriting. [If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.]

There are several elements which can be included in this note, and which are personalized to the individual:

1. A "joining message" ["I was glad to see you" or "I felt happy for you and your wife after we spoke today," etc.]

2. Affirmations of the client (and SO)

3. A reflection of the seriousness of the problem

4. A brief summary of highlights of the first session, especially self-motivational statements that emerged

5. A statement of optimism and hope

6. A reminder of the next session.

Be mindful, of course, of the central importance of protecting client confidentiality in sending this letter. Here is an example of what such a note might say:

Dear Mr. Robertson:

This is just a note to say that I'm glad you came in today. I agree with you that there are some serious concerns for you to deal with, and I appreciate how openly you are exploring them. You are already seeing some ways in which you might make a healthy change, and your wife seems very caring and willing to help. I think that together you will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Place a photocopy of this note in the client's clinical file.

Missed Appointments

When a client misses a scheduled appointment, respond immediately. First try to reach the client by telephone, and when you do, cover these basic points:

1. Clarify the reasons for the missed appointment

2. Affirm the client - reinforce for having come

3. Express your eagerness to see the client again, and encouragement to continue

4. Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the client is exploring these

5. Express your optimism about the prospects for change, and for benefit to the client and CSO

6. Ask whether there are any questions that you can answer for the client

7. Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the client whether the missed appointment might reflect any of the following:

* uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)

* ambivalence about making a change

* frustration or anger about having to participate in treatment (particularly with clients coerced into entering the program)

Handle such concerns in a manner consistent with MET (e.g., with reflective listening, reframing). Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the client to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the client for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the client in this regard. Reschedule the appointment.

In all cases, unless you regard it a confidentiality risk or a duplication of the telephone contact that might offend the client, *also* send a personal, individualized handwritten note with these essential points. This should be done within two days of the missed appointment. Research indicates that a prompt note and telephone call of this kind significantly increases the likelihood that the client will return (Nirenberg, Sobell & Sobell, 1980; Panepinto & Higgins, 1969). Place a copy of this note in the clinical file.

This procedure should be used when any of the four appointments is missed. At least three attempts (new appointments) should be made to reschedule a missed session.

Follow-Through MET Sessions

The second session may be scheduled during the same week as Session 1, and in general should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MET process, picking up where you left off. Continue with the client's personal feedback from assessment, if this was not completed during the first session, and give the client the PFR and a copy of "Understanding your Personal Feedback Report" to take home. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress; (2) renewing motivation, and (3) redoing commitment. Complete each session with a summary of where the client is at present (e.g., the client's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the client's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten.

During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the client is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care. MET sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change.

It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored:

1. Situations in which the client used drugs

2. Situations in which the client didn't use drugs.

Drug Use Situations. If the client used since the last session, discuss how it occurred. Remember to remain empathic, and to avoid a judgmental tone or stance. During the MET phase of treatment, use this discussion to renew motivation, eliciting from the client further self-motivational statements by asking for the clients thoughts, feelings, reactions, and realizations. Key questions can be used to redo commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?"

Non-use Situations. Clients may also find it helpful and rewarding to review situations in which they might have used previously, or in which they were tempted to use, but did not do so. Reinforce self-efficacy by asking the client to clarify what he/she did to cope successfully in these situations. Encourage the client for small steps, little successes, even minor progress.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the client would like to have in support of change. If you are personally able to provide some or all of the desired treatment, proceed [up to a total of 12 sessions, including the MET sessions]. If not, help the client to identify the appropriate treatment resources and make the referral. Whenever possible, make the referral call personally from your office while the client is present, and make a specific appointment for the client.

Termination

Formal termination of the MET phase is generally accomplished by a final recapitulation of the client's situation and progress through the MET sessions. Your final summary should include these elements:

1. Reviewing the most important factors motivating the client for change, and reconfirming these self-motivational themes.

2. Summarizing the commitments and changes that have been made thus far.

3. Affirming and reinforcing the client (and CSO) for commitments and changes that have been made.

4. Exploring additional areas for change that the client wants to accomplish in the future.

5. Eliciting self-motivational statements for the maintenance of change, and for further changes.

6. Supporting client self-efficacy, emphasizing the client's ability to change.

7. Dealing with any special problems that are evident (see below).

8. Reminding the client of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the client (and CSO) what would be the worst things that could happen if he/she went back to using as before. Help the client look to the

immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

Time and Session Limits

In Project CRAFT, a total of twelve sessions may be provided, as a combination of MET and further indicated treatment. Up to two additional emergency sessions may be provided, at your discretion. All sessions, including any emergency sessions, must be completed within three months of the date of the first session. After that date, you may no longer see the client for any session.

Telephone Consultation

Some clients and their CSOs will contact you by telephone between sessions, for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client's file. An attempt should be made to keep such contacts brief, rather than providing additional sessions by telephone.

Early in a telephone contact, you should comment positively on the client's openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that are expressed with regard to goals or strategies discussed in a previous session. It can be helpful to normalize ambivalence and concerns; for example: "What you're feeling is not at all unusual. It's really quite common, especially in these early stages. Of *course* you're feeling confused. You're still quite attached to the drugs you've been using, and you're thinking about changing a pattern that has developed over many years. Give yourself some time." Also reinforce any self-motivational statements and indications of willingness to change. Reassurance can also be in order during these brief contacts; e.g., that people really do make changes in their drug problems, often with a few consultations.

Crisis Intervention

In certain circumstances, you may be contacted by the client or CSO in a condition of crisis. As described earlier, it is permissible to offer up to two special emergency sessions with the client (and CSO) within the 12-week treatment period.

If at any time, in your opinion, the immediate welfare and safety of the client or another person is in jeopardy (e.g., impending relapse, client is acutely suicidal or violent), you should intervene immediately and appropriately for the protection of those involved, with appropriate consultation from your supervisor. This may include your own immediate crisis intervention as well as appropriate referral. If a client's urgent needs require more additional treatment than you can provide, referral should be arranged.

RECOMMENDED READING AND ADDITIONAL RESOURCES

Clinical Descriptions

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van Bilsen, H. P. J. G., & van Emst, A. J. (1986). Heroin addiction: Motivational milieu therapy. International Journal of the Addictions, 21, 707-713.

Demonstration Videotapes

Miller, W. R. (1989). Motivational interviewing. [Albuquerque: University of New Mexico. Available from William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM, USA 87131-1161. European format videotape available from the National Drug and Alcohol Research Centre, P. O. Box 1, University of New South Wales, Kensington, NSW 2033, Australia.]

Motivation and change (1990). [Set of two training videotapes available from the Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada.]

Rollnick, S. & Killick, S. (1989). I want it but I don't want it: An introduction to motivational interviewing. [Mind's Eye Video. European format only. Available from the Department of Psychology, Whitchurch Hospital, Cardiff, Wales, United Kingdom, CF4 7XB.

van Bilsen, H. P. J. G., & Bennett, G. (1987). Motivational interviewing in the addictive behaviours. [East Dorset Health Authority & Matakena Video Productions. Contact Gerald A. Bennett, Ph.D., 20 Newstead Road, Bournemouth, Dorset, United Kingdom BH6 3HJ.]

van Emst, A. J., van Bilsen, H. P. J. G., & Schippers, G. M. (1986). Motivation: A demonstration videotape on motivational interviewing. Part I: Problem drinking; Part 2: Heroin addiction. [Audi-Visuele dienst A-faculteiten, Catholic University, Nijmegen, the Netherlands.]

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APPENDIX A

Motivational Enhancement Therapy
Therapist Manual Supplement
Assessment Feedback Procedures

Preface

The instructions contained in Appendix A pertain to the assessment feedback components of Motivational Enhancement Therapy, as practiced in Project CRAFT. It is not necessary, however, to use exactly the same assessment instruments as were employed in Project CRAFT. The basic idea is to assess a range of dimensions, with particular emphasis on those likely to reflect early problems or risk. If you wish to replicate the exact procedures used in CRAFT, information is provided at the end of this appendix for obtaining the needed instruments. You may, however, construct your own assessment battery and design a corresponding Personal Feedback Report (PFR) based on normative data for the instruments you have chosen.

In general, your assessment battery should sample a variety of potential problem and risk domains. Here is a brief list of pertinent domains, with examples of appropriate assessment approaches for each.

Interpreting the PFR to Clients

This information is to help you in interpreting the Personal Feedback Report to your clients. Following general therapeutic guidelines in the MET manual, you should provide a clear explanation of the client's feedback in understandable language. The general therapeutic style in giving MET feedback is demonstrated in the second half of Dr. Miller's "Motivational Interviewing" videotape provided to each site.

Give the original copy of the PFR to your client, and retain a copy for the file. The PFR consists of three pages of data from interviews and questionnaires. When you have finished presenting the feedback, the client may take home the PFR plus a copy of "Understanding Your Personal Feedback Report." If you end a session partway through the feedback process, however, you should retain the original PFR, sending it home with the client only after you have completed your review of feedback at the next session.

You should be thoroughly familiar with each of the scales included on the PFR. "Understanding Your Personal Feedback Report" provides basic information for the client. Here is some additional information to help you in interpreting findings to clients:

1. DRUG USE

Here the client's personal use of drugs in several categories is being compared with national norms, as established by the household survey of the National Institute on Drug Abuse. The survey is conducted quite carefully, with full confidentiality, and proper measures are taken to sample households representatively (e.g., not only those with telephones).

Explain what the percentile (%) scores mean that have been written on this first sheet. A **95** in this column, for example, means that the client's use of this drug is greater than 95 out of 100 American adults (over the age of 12). Said another way, fewer than 5% of adults use this drug as much as the client does.

Circled on this sheet are **decile** ranges. Thus a score of **75** will result in circling of decile **8**. This is just another way of showing how the client's use compares with that of the general population.

Sources:

National Household Survey on Drug Abuse: Population Estimates (1990). National Institute on Drug Abuse.

Eighth Special Report to the U.S. Congress on Alcohol and Health (1994). National Institute on Alcohol Abuse and Alcoholism

Date from the 1990 National Alcohol Survey, Alcohol Research Group, Berkeley, courtesy of Dr. Robin Room

2. Lifetime Negative Consequences of Drug Use

The client's *lifetime* scores from the Inventory of Drug Use Consequences (InDUC) are shown on page 2 of the PFR. The client's raw scores for the total scale and for five specific subscales are printed in the boxes at the bottom of the profile form (note that there are separate norms for men and women). These same raw scores are circled in the column corresponding to each scale, to show the client's elevation relative to *individuals currently seeking treatment for substance abuse*. Be sure to point out that the normative reference group has changed from page 1, where drug use was being compared with the general population. Here a "low" score is low relatively to people being treatment for substance abuse, which may still be a high score in the general population. (This is the only normative base currently available, and actually comes from Project MATCH and a companion instrument focusing on alcohol use only. The InDUC was modified to ask about other drugs as well, and specific norms for the InDUC are not yet available.)

Explain that this shows the extent to which the client has experienced negative consequences (problems) related to his or her drug use, in comparison with people who are being treated for such problems.

Here is some basic information to help you interpret the subscales. This information is also on the client's form, *Understanding Your Personal Feedback Report*.

Physical	This score reflects unpleasant physical effects of drug use such as hangovers, sleeping problems, and sickness; harm to health, appearance, eating habits, and sexuality; and injury while drinking or using other drugs
Intrapersonal	These are personal, private negative effects such as feeling bad, unhappy or guilty because of drug use; experiencing a personality change for the worse; interfering with personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.
Social Responsibility	These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations.
Interpersonal	These are negative effects of drug use on important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or parenting abilities; concern about drinking expressed by family or friends; damage to reputation; and cruel or embarrassing actions while drinking or using other drugs.
Impulse Control	This is a group of other negative consequences of drug use that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

3. General Functioning

The third section of the report gives an indication of how the client has been doing more generally in six life areas. These are ratings given by the RA who conducted the Addiction Severity Index interview. A low score (0, 1,2 or 3) indicates that the interviewer observed no real problem in this area. A high score (6, 7, 8, or 9) says that the interviewer observed a serious problem in need of treatment. Scores in between (4 or 5) reflect a less serious problem, but one that might still need to be treated. The six areas are:

Medical	General physical health as judged from what the client said during the interview

Employment/ Support The client's general state of financial support, including work, benefits, and support from friends and family

Drug/Alcohol The interviewer's rating of the seriousness of the client's overall alcohol/drug problems and need for treatment

Legal Trouble with the law

Family/Social Problems in the family, or in relationships with others more generally

Psychological Problems with mood, anxiety, thinking, self-control, etc.

4. Level of Depression

Section 4 shows a single score from the Beck Depression Inventory, a scale commonly used to screen for depression. This is one specific area of psychological adjustment. High scores on this scale (19 and above) indicate possibly severe depression, which would benefit from treatment. The client's score here is compared with American adults in general.

Source: Beck, A. T., & Steer, R. A. (1987). Beck Depression Inventory manual. San Antonio: Psychological Corporation.

5. Motivation for Change

Where was the client in readiness to make a change in drug use? Section 5 shows the client's scores on five scales of motivation for change, derived from the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES-D). Here the client's score is again compared with people being considered for treatment for alcohol/drug problems. Here is what the scales mean:

Precontemplation A high score on this scale indicates a person who is not really ready to make a change, and who sees no real problem in need of treatment

Contemplation A high score on this scale indicates a person who is unsure whether or not he/she has problems with drugs and needs treatment.

Determination A high score on this scale indicates a person who recognizes that he or she has problems with drugs and is ready to make a change

Action A high score here indicates a person who not only recognizes a problem, but is already trying to change

Maintenance	A high score on this scale indicates a person who has already made changes in his or her drug use, and is working to hold onto that change and not slip back to old patterns

Various combinations of scale elevations are possible. These scores offer an opportunity to discuss with the client his or her perceptions (at the time of initial assessment) of a problem and need for change.

INSTRUCTIONS FOR PREPARING A PERSONAL FEEDBACK REPORT (PFR)

Section I: Drug Use

All of the data for this section are derived from the client's Form 90-DI pretreatment interview. From the 90-day period reconstructed by 90-DI, determine the *number of days of use* for each of the following drug classes. You will find these numbers in the "Total Days" column of the Use Pattern Chart on page 8 of Form 90-DI. Then convert the client's use pattern into a percentile score for each of the drug classes using the following rules:

Alcohol

To determine the appropriate percentile score for alcohol use, you need to use the number of days of Level 1, Level 2, and Level 3 use as shown on the Use Pattern Chart.

Multiply Days of Level 1 use by 1

Multiply Days of Level 2 use by 2

Multiply Days of Level 3 use by 3

Then add these three numbers together to calculate the client's QF score.

Finally, use the chart below to determine the client's percentile score, and print it on the Chemical Health Check-up Personal Feedback Report (PFR).

QF Score	Men	Women
0	0	0
1-40	32	53
41-90	70	89
91-135	79	94
136-159	82	95
160-180	88	96
181-200	90	98
201-270	95	99

Tobacco

For tobacco, as for many other drug classes below, we currently have only percentile scores for the presence or absence of any use. If the client is a nonsmoker, enter a zero (0) in the % column on the PFR. If the client is a smoker, enter:

70 if the client is a male
75 if the client is a female

Marijuana

Compare the client's total days of use in this 90-day period to determine the appropriate percentile score for marijuana.

Days Use	Men	Women
0	0	0
1-2	88	92
3-11	94	97
12-59	96	99
60 or more	99	99.5

Tranquilizers

If the client reported no abuse of tranquilizers, enter zero (0). Any illicit use of tranquilizers results in a percentile score of 99 for both men and women.

Sedatives/Downers

If the client reported no abuse of sedative/downers, enter zero (0). Any illicit use of sedative/downers results in a percentile score of 99 for both men and women.

[No normative data are currently available for Steroids]

Stimulants/Uppers

If the client reported no abuse of stimulant/uppers, enter zero (0). Any illicit use of stimulant/uppers results in a percentile score of 99 for both men and women.

Cocaine

Use the total days of use in this 90-day period to determine the client's appropriate percentile score:

Days Use	Men	Women
0	0	0
1-2	96	98
3-11	99	99
12 or more	99.6	99.8

EXCEPT that:

If the client reported any use of crack, enter
99.6 for males 99.9 for females

Hallucinogens

If the client reported no use of hallucinogens, enter zero (0). Any use of hallucinogens results in a percentile score of
99.6 for men 99.8 for women.

Opiates

If the client reported no use of opiates, enter zero (0). Any illicit use of opiates results in a percentile score of
99.5 for men 99.8 for women

Inhalants

If the client reported no use of opiates, enter zero (0). Any use of inhalants results in a percentile score of:
99 for men 99.6 for women

Finally, for all drug categories, circle the decile score that corresponds to each percentile score. Thus, for a percentile score of **75** you would circle decile **8**. (There is no need to connect the circled numbers with lines.)

Section 2: Lifetime Negative Consequences of Drug Use

These data are derived wholly from the *lifetime* version of the Inventory of Drug Use Consequences (InDUC-2L). [Be careful not to use form 2R, which is for more recent consequences.] Using the InDUC scoring form, copy the client's responses onto the proper lines, then sum down the columns to calculate the five scale scores. Record these raw scores in the boxes at the bottom of the profile form on page 2, noting that there are separate forms for men (above) and women (below). Sum the five scale scores to calculate the Total Score, and record it in the proper box. Then for each of the six scores, circle the corresponding range or number in the column immediately above it. This shows the elevation (in deciles) of each score.

Section 3: Interviewer Ratings of General Functioning

From the *interviewer ratings* section of the Addiction Severity Index (ASI), determine the rating (on a 0-9 scale) given by the ADI interviewer on each of the six scales shown, and *circle* that rating for each scale.

Section 4: Level of Depression

Score the Beck Depression Inventory (CDI) and print the total score in the box underneath the range into which it falls.

Section 5: Motivation for Change

To score the SOCRATES questionnaire, copy the client's responses onto the proper lines of the SOCRATES scoring form, then sum down the columns to calculate the five scale scores. Record these raw scores in the boxes at the bottom of the profile form on page 3 of the PFR. Then for each of the six scores, circle the corresponding range or number in the column immediately above it. This shows the elevation (in deciles) of each score.

On the following pages you will find the text of "Understanding your Personal Feedback Report," which is to be given to a client with the completed PFR sheet.

CASAA Research Division
3/95

Understanding Your Personal Feedback Report

Your Personal Feedback Report gives you information from your Chemical Health Check-up. It tells you where you stand, relative to other people, on several aspects of drug use and related problems.

1. DRUG USE

The first section compares your own use of different drugs with all adults in the United States. For each drug group, your report shows the percentage of days on which you use the drug(s). This information comes from the interview in which a calendar was used to help you describe your use of drugs.

The number written in the "%" column indicates how your drug use compares with that of American adults in general. A "95" in this column would mean that you use this drug more often than 95 percent of all Americans, or that only 5 percent of Americans use this drug as often as you do. This is also shown by circling a number on a scale of 1 to 10 comparing your use with
American adults in general. A low number (1-5) means that your use (or non-use) falls within the normal range for American adults, at least in terms of *how often* you use that drug. A higher number means that you have been using this drug more often than is typical for American adults. A ten (10), for example, means that relatively few Americans use the drug as often as you do.

These numbers tell you nothing about *how much* of a drug you use - only *how often* you use it. It is possible, for example, that a person could drink alcohol only a few days a month (within the normal range), but drink 12 beers on those days (far beyond the normal range).

2. NEGATIVE CONSEQUENCES

This section summarizes the negative consequences of your drug use - the harmful effects it has had in your life. Here your own personal scores are being compared *with other people who are already in treatment for alcohol and other drug problems*. Thus a "medium" score on these scales means that your score is typical for people who have already had enough trouble to seek treatment. A "medium" score here would be a very high score for Americans in general.

The first column shows you your total problem score, relative to people receiving treatment. Then there are five more specific scales that show the level of problems you reported in five areas:

Physical This score reflects unpleasant physical effects of drug use such as hangovers, sleeping problems, and sickness; harm to your health, appearance, eating habits, and sexuality; and injury while drinking or using other drugs

Intrapersonal These are personal, private negative effects such as feeling bad, unhappy or guilty because of drug use; experiencing a personality change for the worse; interfering with your personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.

Social Responsibility These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations of you.

Interpersonal These are negative effects of drug use on your important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or your parenting abilities; concern about drinking expressed by your family or friends; damage to your reputation; and cruel or embarrassing actions while drinking or using other drugs.

Impulse Control This is a group of other negative consequences of drug use that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

These scores all reflect drug-related problems that you have *ever* had in your lifetime.

3. GENERAL FUNCTIONING

The third section of the report gives an indication of how you are doing more generally in six life areas. These are ratings given by the person who interviewed you. A low score (0, 1,2 or 3) indicates that the interviewer observed no real problem in this area. A high score (6, 7, 8, or 9) says that the interviewer observed a serious problem in need of treatment. Scores in between (4 or 5) reflect a less serious problem, but one that might still need to be treated. The six areas are:

Medical	Your general physical health as judged from what you said during the interview
Employment/ Support	Your general state of financial support, including work, benefits, and support from friends and family
Drug/Alcohol	This is the interviewer's rating of the seriousness of your alcohol/drug problems and need for treatment
Legal	Trouble with the law
Family/Social	Problems in the family, or in your relationships with others more generally
Psychological	Problems with mood, anxiety, thinking, self-control, etc.

4. LEVEL OF DEPRESSION

Section 4 shows a single score from the Beck Depression Inventory, a scale commonly used to screen for depression. This is one specific area of psychological adjustment. High scores on this scale (19 and above) indicate possibly severe depression, which would benefit from treatment. Your score here is compared with American adults in general.

5. MOTIVATION FOR CHANGE

Where were you in readiness to make a change in your drug use? Section 5 shows your scores on five scales of motivation for change. Here your score is compared with people being considered for treatment for alcohol/drug problems. Here is what the scales mean:

Precontemplation A high score on this scale indicates a person who is not really ready to make a change, and who sees no real problem in need of treatment

Contemplation A high score on this scale indicates a person who is unsure whether or not he/she has problems with drugs and needs treatment.

Determination A high score on this scale indicates a person who recognizes that he or she has problems with drugs and is ready to make a change

Action A high score here indicates a person who not only recognizes a problem, but is already trying to change

Maintenance A high score on this scale indicates a person who has already made changes in his or her drug use, and is working to hold onto that change and not slip back to old patterns