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Introduction

Overview

Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change in problem drinkers. 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.

Treatment is preceded by an extensive assessment battery (appendix A) requiring approximately 7–8 hours. Each treatment session is preceded by a breath test to ensure sobriety, and a positive breath alcohol reading is cause for rescheduling the session.

As offered in Project MATCH, MET consists of four carefully planned and individualized treatment sessions. Whenever possible, the client's spouse or another "significant other" is included in the first two of these four sessions. The first treatment session (week 1) focuses on (1) providing structured feedback from the initial assessment regarding problems associated with drinking, level of consumption and related symptoms, decisional considerations, and future plans and (2) building client motivation to initiate or continue change. The second session (week 2) continues the motivation enhancement process, working toward consolidating commitment to change. In two followthrough sessions, at week 6 and week 12, the therapist continues to monitor and encourage progress. All therapy is completed within 90 days.

MET is not intended to be a minimal or control treatment condition. MET is, in its own right, an effective outpatient treatment strategy which, by virtue of its rationale and content, requires fewer therapist-directed sessions than some alternatives. It may, therefore, be particularly useful in situations where contact with problem drinkers is limited to few or infrequent sessions (e.g., in general medical practice or in employee assistance programs). Treatment outcome research strongly supports MET strategies as effective in producing change in problem drinkers.

The initial presentation of MET in this manual is written from the perspective of outpatient treatment. These procedures can also be

applied in aftercare, however, and such adaptation is addressed in appendix B.

Research Basis for MET

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

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 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 (in press) 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 problem drinkers for change (Miller 1985; Miller and Rollnick 1991).

Therapeutic interventions containing some or all of these motivational elements have been demonstrated to be effective in initiating treatment and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking. Table 1 summarizes this research. It is noteworthy that, in a number of these studies, the

Table 1. Specific FRAMES components of evaluated brief interventions

Author	Feedback	Response	Advice	Menu	Empathy	Self-Efficacy	Outcome
*Anderson and Scott 1992	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Babor and Grant 1991	Yes	Yes	Yes	Manual	Yes	Yes	Brief > No counseling
*Bien 1991	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Brown and Miller 1992	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Carpenter et al. 1985	Yes	No	Yes	No	No	No	Brief = Extended counseling
*Chapman and Huygens 1988	Yes	Yes	Yes	Yes	No	Yes	Brief = IPT = OPT treatment
*Chick et al. 1985	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Chick et al. 1988	No	Yes	Yes	No	No	No	Brief < Extended motiv cnslg
Daniels et al. 1992	Yes	No	Yes	Manual	No	No	Advice + Manual = No advice
Drummond et al. 1992	Yes	No	Yes	No	No	No	Brief = OPT treatment
Edwards et al. 1977	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT/IPT treatment
Elvy et al. 1988	Yes	No	Yes	No	No	No	Brief > No counseling
*Harris and Miller 1990	No	Yes	Yes	Manual	Yes	Yes	Brief = Extended > No treatment
*Heather et al. 1986	Yes	Yes	Manual	Manual	No	No	Manual > No manual
*Heather et al. 1987	Yes	Yes	Yes	Manual	No	No	Brief = No counseling
*Heather et al. 1990	Yes	Yes	Yes	Manual	No	No	Manual > No manual
*Kristenson et al. 1983	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
Kuchipudi et al. 1990	Yes	No	Yes	Yes	No	No	Brief = No counseling
Maheswaran et al. 1990	Yes	No	Yes	No	No	No	Brief > No counseling
*Miller and Taylor 1980	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1980	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1981	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1988	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Miller et al. 1991	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Persson and Magnusson 1989	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Robertson et al. 1986	Yes	Yes	Yes	Yes	Yes	Yes	Brief < Behavioral counseling
*Romelsjo et al. 1989	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT treatment
*Sannibale 1989	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT treatment
*Scott and Anderson 1990	Yes	Yes	Yes	Yes	Yes	Yes	Brief = No counseling
*Skutle and Berg 1987	No	Yes	Yes	Yes+Man	Yes	Yes	Brief = Behavioral counseling
*Wallace et al. 1988	Yes	Yes	Yes	Manual	Yes	Yes	Brief > No counseling
*Zweben et al. 1988	Yes	Yes	Yes	Yes	No	Yes	Brief = Conjoint therapy
Percent Yes	81	81	100	59	63	69	

Source: Bien, Miller, and Tonigan 1992.
NOTE: Components listed are characteristics of the *brief* intervention in each study.
* Additional information obtained from the study's authors.
Manual = Manual-guided therapy; IPT = Inpatient treatment setting; OPT = Outpatient treatment setting

motivational intervention yielded comparable outcomes even when compared with longer, more intensive alternative approaches.

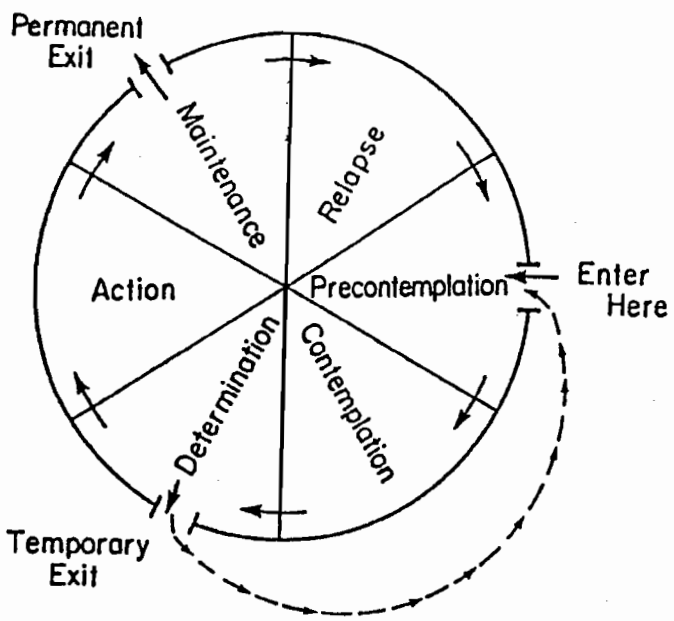
Further evidence supports the efficacy of the therapeutic *style* that forms the core of MET. The therapist characteristic of "accurate empathy," as defined by Carl Rogers and his students (e.g., Rogers 1957, 1959; Truax and Carkhuff 1967), has been shown to be a powerful predictor of therapeutic success with problem drinkers, even when treatment is guided by another (e.g., behavioral) rationale (Miller et al. 1980; Valle 1981). Miller, Benefield, and Tonigan (in press) reported that the degree to which therapists engaged in direct confrontation (conceptually opposite to an empathic style) was predictive of continued client drinking 1 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 were identified in this model (Prochaska and DiClemente 1984, 1986).

Figure 1. A Stage Model of the Process of Change

Prochaska and DiClemente



People who are not considering change in their problem behavior are described as PRECONTEMPLATORS. The CONTEMPLATION stage entails individuals' beginning to consider both that they have a problem and the feasibility and costs of changing that behavior. As individuals progress, they move on to the DETERMINATION stage, where the decision is made to take action and change. Once individuals begin to modify the problem behavior, they enter the ACTION stage, which normally continues for 3–6 months. After successfully negotiating the action stage, individuals move to MAINTENANCE or sustained change. If these efforts fail, a RELAPSE occurs, and the individual begins another cycle (see figure 1).

The ideal path is directly from one stage to the next until maintenance is achieved. For most people with serious problems related

to drinking, 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 often needed to learn how to maintain change successfully.

From a stages-of-change perspective, the MET approach addresses where the client currently is 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 seriously consider two basic issues. The first is how much of a problem their drinking behavior poses for them and how their drinking is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drinking toward change is essential for movement from contemplation to determination. Second, the client in contemplation assesses the possibility and the costs/benefits of changing the problem behavior. Clients consider whether they will be able to make a change and how that change will affect 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 drinking behavior 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.

In sum, MET is well grounded in theory and research on the successful resolution of alcohol problems. 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. A summary of alcohol treatment outcome research reveals that a motivational approach of this kind is strongly supported by clinical trials: 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).