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Practical Strategies

Phase 1: Building Motivation for Change

Motivational counseling can be divided into two major phases: building motivation for change and strengthening commitment to change (Miller and Rollnick 1991). The early phase of MET focuses on developing clients' motivation to make a change in their drinking. 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 phase may be thought of as tipping the motivational balance (Janis and Mann 1977; Miller 1989; Miller et al. 1988). One side of the seesaw favors status quo (i.e., continued drinking as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drinking and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's drinking and feared consequences of continuing unchanged. Your task is to shift the balance in favor of change. Eight strategies toward this end (Miller and Rollnick 1991) are outlined in this section.

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—more so, 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 alcoholic and you have to stop drinking" 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.

The positive side of the coin 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—

- Being open to input about drinking.
- Acknowledging real or potential problems related to drinking.
- Expressing a need, desire, or willingness to 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 drinking. Tell me about those.
- Tell me a little about your drinking. What do you like about drinking? What's positive about drinking for you? And what's the other side? What are your worries about drinking?
- Tell me what you've noticed about your drinking. 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 drinking? What are other people worried about? (If a spouse or significant other is present, this can be asked directly.)
- What makes you think that perhaps you need to make a change in your drinking?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?," and so forth. If it bogs down, you can inventory general areas such as—

- *Tolerance*—does the client seem to be able to drink more than other people without showing as much effect?
- *Memory*—has the client had periods of not remembering what happened while drinking or other memory problems?
- *Relationships*—has drinking affected relationships with spouse, family, or friends?
- *Health*—is the client aware of any health problems related to using alcohol?
- *Legal*—have there been any arrests or other brushes with the law because of behavior while drinking?
- *Financial*—has drinking contributed to money problems?

Information from the pretreatment assessment (to be used as feedback later) may also suggest some areas to explore.

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 drinking. 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 drinking is really *important* to you. Tell me about that.
- What is it about drinking 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 drinking.
- Tell me what it has cost you.
- Tell me why you think you might need to make a change.

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.

Empathy is commonly thought of as "feeling with" people, 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 last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the client has said and ignoring 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 drinking?

CLIENT: Well, I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking 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 have trouble remembering things.

T: And you wonder if that might be because you're drinking 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 drinking, sometimes I mix things up, and I wonder about that.

T: Wonder if . . .

C: If alcohol's pickling my brain, I guess.

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

C: Well, can't it? I've heard that alcohol kills brain cells.

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

C: But I don't think I'm an alcoholic 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. Easily 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 and Jackson 1985.)

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

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

- 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 an alcoholic.

- 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 drinking, what am I supposed to do for friends?

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

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 that selective reflection can backfire. For a client who is ambivalent, reflection of one side of the dilemma ("So you can see that drinking is 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 alcohol is harming you seriously now, and at the same time you *are* concerned that it might get out of hand for you later.
- You really enjoy drinking and would hate to give it up, and you can also see that it is causing serious problems for your family and your job.

Questioning

The MET style also includes questioning as an important therapist response. Rather than *telling* clients how they should feel or what to do, the therapist *asks* clients about their own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing (see below).

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. Go through the PFR step by step, explaining each item of information, pointing out the client's score and comparing it with normative data. The specific protocol used in Project MATCH is provided in appendix A along with suggestions for developing alternative batteries.

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 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. Examples:

CLIENT: Wow! I'm drinking a lot more than I realized.
THERAPIST: It looks awfully high to you.

CLIENT: I can't believe it. I don't see how my drinking can be affecting me that much.
THERAPIST: This isn't what you expected to hear.

CLIENT: No, I don't really drink that much more than other people.
THERAPIST: So this is confusing to you. It seems like you drink about the same amount as your friends, yet here are the results. Maybe you think there's something wrong with the tests.

CLIENT: More bad news!
THERAPIST: This is pretty difficult for you to hear.

CLIENT: This gives me a lot to think about.
THERAPIST: 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 thought he was drinking too much.
THERAPIST: You've been worried about him for quite a while.

HUSBAND: (weeping) I've *told* you to quit drinking!
THERAPIST: You really care about her a lot. It's hard to sit there and hear these results.

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

FRIEND: I never really thought he drank that much!
THERAPIST: This is taking you by surprise. (To client:) How about you? Does this surprise you, too?

WIFE: I've been trying to tell you all along that you were drinking too much. 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 quite familiar with the assessment battery and its interpretation. In Project MATCH, additional interpretive information is provided for the client to take home.

In the training videotape, "Motivational Interviewing," developed by and available from Dr. William Miller, this style of presenting assessment feedback to a resistant problem drinker is demonstrated.

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 in staying 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.

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, open 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, showing unwillingness to change, alleged impunity, pessimism

What too few therapists realize, however, is the extent to which such client resistance during treatment is powerfully affected by the therapist's own style. Miller, Benefield, and Tonigan (in press) 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 alcoholics are resistant because of pernicious personality characteristics that are part of their condition. Denial is often regarded as a trait of alcoholics. In fact, extensive research has revealed few or no consistent personality characteristics among alcoholics, and studies of defense mechanisms have found that alcoholics show no different pattern from nonalcoholics (Miller 1985). In sum, people with alcohol problems do not, in general, walk through 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.

An important goal in MET, then, is to avoid evoking client resistance (antimotivational 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 antimotivational statements from the client (Gordon 1970; Miller and Jackson 1985). 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.
- Using 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 antimotivational position and leave you in the logical position of counterargument. *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 it may evoke the opposite. Here are several strategies for deflecting resistance (Miller and 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 an alcoholic, or anything like that.

  THERAPIST: You don't want to be labeled.

  C: No. I don't think I have a drinking problem.

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

C: Well, I wouldn't say that.

T: Oh! So you do think sometimes your drinking has caused problems, but you just don't like the idea of being called an alcoholic.

- *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).

C: But I can't quit drinking. I mean, all of my friends drink!

T: You can't imagine how you could not drink 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.

C: But I can't quit drinking. I mean, all of my friends drink!

T: You're getting way ahead of things. I'm not talking about your quitting drinking here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here—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.

C: But I can't quit drinking. I mean, all of my friends drink!

T: And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It may be too difficult to make a change. That will be up to you.

Reframing

Reframing is a strategy whereby therapists invite clients to examine their 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 drinking problems, a wife's reaction of "I knew it" 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."

The phenomenon of tolerance provides an excellent example for possible reframing (Miller and Rollnick 1991). Clients will often admit, even boast of, being able to "hold their liquor"—to drink more than other people without looking or feeling as intoxicated. This can be reframed (quite accurately) as a risk factor, the absence of a built-in warning system that tells people when they have had enough. Given high tolerance, people continue to drink to high levels of intoxication that can damage the body but fail to realize it because they do not look or feel intoxicated. Thus, what seemed good news ("I can hold it") becomes bad news ("I'm especially at risk").

Reframing can be used to help motivate the client and SO to deal with the drinking behavior. 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 drinking. Some examples of reframes that can be utilized with problem drinkers are:

- *Drinking 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 going on a binge.

- *Drinking 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 drinking, as a way of trying not to burden your family." The implication here is that the problem drinker has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides drinking.

- *Drinking as an adaptive function.* "Your drinking can be viewed as a means of avoiding conflict or tension in your marriage. Your drinking tends to keep the status quo, to keep things as they are. It seems like you have been drinking to keep your marriage intact. Yet both of you seem uncomfortable with this arrangement." The implication is that the client cares about the marriage 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.

Summarizing

It is useful to summarize periodically during a session, 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 clients to hear their 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 what you've noticed about your drinking, and you told me several things. You said that your drinking has increased over the years, and you also notice that you have a high tolerance for alcohol—when you drink a lot, you don't feel it as much. You've also had some memory blackouts, which I mentioned can be a worrisome sign. There have been some problems and fights in the family that you think are related to your drinking. On the feedback, you were surprised to learn that you are drinking more than 95 percent of the U.S. adult population and that your drinking must be getting you to fairly high blood alcohol levels even though you're not feeling it. There were some signs that alcohol is starting to damage you physically and that you are becoming dependent on alcohol. That fits with your concerns that it would be very hard for you to give up drinking. And I remember that you were worried that you might be labeled as an alcoholic, and you didn't like that idea. I appreciate how open you have been to this feedback, though, and I can see you have some real concerns now about your drinking. 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 may be damaging your health by drinking too much and that sometimes you may not be as good a parent to your children as you'd like because of your drinking. 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 and 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 determination stage, 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 and 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 drinking." "If I wanted to change my drinking, 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).

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

- 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, and so forth?

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

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

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

- 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 drinking and change. It is also wise to delay any decisionmaking 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, Phase 1 strategies are no longer needed. 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.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (building motivation) to negotiating a *plan* for change. Clients may initiate this by stating a need or desire to change or by asking what they could do. Alternatively, the therapist may signal this shift (and test the water) by asking a transitional question such as:

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

Your goal during this phase is to elicit from the client (and SO) some ideas and ultimately a plan for what to do about the client's drinking. It is not your task 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 drinking, 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?" 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 drinking for you. Only you can do it.
- You can decide to go on drinking just as you were or to change.

Consequences of Action and Inaction

A useful strategy is to ask the client (and SO) to anticipate the result if the client continues drinking as before. What would be 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

stopping drinking, for example? What are the advantages of continuing to drink 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 write down) the pros and cons of change options. What are the positive and negative aspects of continuing with drinking as before? What are the possible benefits and costs of making a change in drinking?

Information and Advice

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

- Do alcohol problems run in families?
- Does the fact that I can hold my liquor mean I'm addicted?
- How does drinking damage the brain?
- What's a safe level of drinking?
- If I quit drinking, will these problems improve?
- Could my sleep problems be due to my drinking?

The number of possible questions is too large to plan specific answers here. In general, however, you should provide accurate, specific information that is requested by clients and SOs. It is often helpful afterward to ask for the client's response to this information: 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 drinking (e.g., "I think you need to quit drinking altogether").
- 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 sobriety (e.g., find new ways to spend time that don't involve drinking).

With regard to specific "how to's," however, you should *not* prescribe specific strategies or attempt to train specific skills. This challenge is turned 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 drinking. 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 not 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.

Emphasizing Abstinence

Every client should be given, at some point during MET, a rationale for abstinence from alcohol. Avoid communications that seem to coerce or impose a goal, since this is inconsistent with the style of MET. Within this style, it is not up to you to "permit" or "let" or "allow" clients to make choices. The choice is theirs. You should, however, commend (not prescribe) abstinence and offer the following points in all cases:

- Successful abstinence is a safe choice. If you don't drink, you can be sure that you won't have problems because of your drinking.

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

- No one can guarantee a safe level of drinking that will cause you no harm.

In certain cases, you have an additional responsibility to advise against a goal of moderation if the client appears to be deciding in that 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 goal of moderation are (Miller and Caddy 1977)—

- Medical conditions (e.g., liver disease) that contraindicate any drinking.

- Psychological problems likely to be exacerbated by any drinking.

- A diagnosis of idiosyncratic intoxication (DSM–III–R 291.40).

- Strong external demands on the client to abstain.

- Pregnancy.

- Use/abuse of medications that are hazardous in combination with alcohol.

- A history of severe alcohol problems and dependence.

The data in table 2 may be useful in determining cases in which moderation should be more strongly opposed. They are derived from long-term followups (3 to 8 years) of problem drinkers attempting to moderate their drinking (Miller et al. 1992). "Abstainers" are those who had been continuously abstinent for at least 12 months at followup; "asymptomatic drinkers" had been drinking moderately without problems for this same period. The "improved but impaired" group showed reduction in drinking and related problems but continued to show some symptoms of alcohol abuse or dependence. The AB:AS column shows the ratio, within each of four client ranges, of successful abstainers to successful asymptomatic drinkers.

In addition to the commendation of abstinence given in all cases, clients falling into ranges 3 or 4 should receive further counsel if they are entertaining a moderation goal. They can be advised that in a study

Table 2. Relationship of severity measures to types of treatment outcome

Severity		Treatment Outcome				
Range	Scores	Total abstainers *n* %	Asymptomatic drinkers *n* %	Improved but impaired *n* %	Not improved *n* %	Ratio AB:AS
Michigan Alcoholism Screening Test (MAST)						
1	0–10	3 14 %	5 23 %	8 36 %	6 27 %	3:5
2	11–18	7 21	7 21	6 18	14 41	1:1
3	19–28	10 40	2 8	4 16	9 36	5:1
4	29+	4 29	0 0	4 29	6 43	4:0
	Median	19.5	12.0	15.0	18.0	
	Mean	19.0	13.2	18.0	18.6	
	SD	7.6	6.2	12.5	9.1	
Alcohol Dependence Scale (ADS) Lifetime Accumulation of Symptoms						
1	0–14	2 8 %	6 24 %	9 36 %	8 32 %	1:3
2	15–20	4 14	4 14	4 14	16 57	1:1
3	21–27	11 35	6 19	5 16	9 29	11:6
4	28+	6 75	0 0	2 25	0 0	6:0
	Median	22.5	19.0	15.0	16.5	
	Mean	27.2	16.6	17.1	18.0	
	SD	14.5	7.8	7.7	5.4	

Source: Data from Miller et al. 1992.
NOTE: Asymptomatic = Drinking moderately with no evidence of problems
Improved = Drinking less, but still showing alcohol-related problems
AB/AS Ratio = Ratio of successful abstainers to asymptomatic drinkers

of problem drinkers attempting to moderate their drinking, people with severity scores resembling theirs were much more likely to succeed with abstinence. Those falling in range 4 can further be advised that in this same study, no one with scores like theirs managed to maintain problem-free drinking. 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, or tapering off of drinking toward an ultimate goal of abstention (Miller and Page 1991).

Dealing With 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 drinking 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 drinking 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 dialog 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 the 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 convenient for MET therapists. Carbonless copy forms are recommended so 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 and Rollnick 1991). This may include a repetition of the reasons for concern uncovered in 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. Last time, we reviewed the reasons why you and your husband have been concerned about your drinking. There were a number of these. You were both concerned that your drinking has contributed to problems in the family, both between you and with the children. You were worried, too, about the test results you received indicating that alcohol has been damaging your health. Your drinking seems to have been increasing slowly over the years, and with it, your dependence on alcohol. The accident that you had helped you realize that it was time to do something about your drinking, 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 AA, and you thought you'd just cut down on your drinking and try to avoid drinking when you are alone. 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 drinking pattern you've had for so many years, you'd probably slip back into drinking too much and forget what we've discussed here. You agreed that that would be a risk and could imagine talking yourself into drinking alone or drinking to feel high. You didn't like the idea of AA, 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 drinking at all, for 3 months at least, to see how it goes and how you feel. Your husband likes this idea, too, and has agreed to spend more time with you so you can 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 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 key question (not necessarily in these words) is:

- Are you ready to commit yourself to doing this?

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

- Clarify what, exactly, the client plans to do. Give the client the completed Change Plan Worksheet and discuss it.
- Reinforce what the client (and SO) perceive to be likely benefits of making a change, as well as the consequences of inaction.
- Ask what concerns, fears, or doubts the client (and SO) may have that might interfere with carrying out the plan.
- Ask what other obstacles might be encountered that could divert the client from the plan. Ask the client (and SO) to suggest how they could deal with these.
- Clarify the SO's role in helping the client to make the desired change.
- Remind the client (and SO) that you will be seeing the client for followthrough visits (scheduled at weeks 6 and 12) to see how he/she is 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. When clients remain ambivalent or hesitant about making a written or verbal commitment to deal with the alcohol problem, you may ask them to defer the decision until later. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing clients the opportunity to postpone such decisionmaking 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, clients may feel coerced into making a commitment before they are ready to take action.

In this case, clients may withdraw prematurely from treatment, rather than "lose 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 very 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 clients' ambivalence as well as confidence in their ability to resolve the dilemma.

Involving a Significant Other

When skillfully handled by the therapist, the involvement of a significant other (spouse, family member, friend) can enhance motivational discrepancy and commitment to change. Whenever possible, clients in MET will be strongly urged to bring an SO to the first two MET sessions. At these meetings, the SO is actively engaged in the treatment process. Emphasis is placed on the need for the client and SO to work collaboratively on the drinking problem.

The MET approach recognizes the importance of the significant other in affecting the client's decision to change drinking behavior. This emphasis is based upon recent findings from a variety of alcohol 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).

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

Goals for Significant Other Involvement

The following are general goals for the two SO-involved sessions:

- Establish rapport between the SO and the counselor.
- Raise the awareness of the SO about the extent and severity of the alcohol problem.
- Strengthen the SO's commitment to help the client overcome the drinking problem.
- Strengthen the SO's belief in the importance of his or her own contribution in changing the client's drinking patterns.
- Elicit feedback from the SO that might help motivate the problem drinker to change the drinking behavior. For example, a spouse might be asked to share concerns about the client's past, present, and future drinking. Having the spouse "deliver the message" can be valuable in negotiating suitable treatment goals.
- Promote higher levels of marital/family cohesiveness and satisfaction.

MET does not include intensive marital/family therapy. The main principle here is to elicit from client and SO those aspects of their relationship which are seen as most positive and to explore how they can work together in overcoming the drinking 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. The counselor should *not* allow the client and SO 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 will be accompanied by an SO at the first session. The invitation to the SO should be made for the first session only, allowing you the flexibility to include or not include the SO in a second session. In the beginning of the session, the counselor should comment favorably on the SO's willingness to attend sessions with the problem drinker. The rationale is then presented for having the SO attend:

- The SO cares about the client, and changes will have direct impact on both their lives.
- The SO's input will be valuable in setting treatment goals and developing strategies.

- The SO may be directly helpful by working with the client to resolve the drinking problem.

Emphasize that ultimate responsibility for change remains with the client but that the SO can be very helpful. It is useful here to explore tentatively, with both the SO and the client, how the SO might be supportive in resolving the drinking problem. 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 drinking?

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

It is also important to remember that your role does *not* include prescribing specific tasks, offering spouse training, or conducting marital therapy. The MET approach provides the SO an opportunity to demonstrate support, verbally and behaviorally, and encourages the SO and client to generate their own solutions.

The Significant Other in Phase 1

In the first conjoint session, an important goal is to establish rapport—to create an environment in which the SO can feel comfortable about openly sharing concerns and disclosing information that may help promote change. The SO could also be expected to identify potential problems or issues that might arise which could interfere with attaining these objectives. To begin with, the counselor should attempt to "join" with the SO by asking about her or his own (past and present) experiences with the alcohol problem.

- What has it been like for you?
- What have you noticed about [client's] drinking?
- 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—should be discussed and reframed as *normative*, that is, events that are common in families with an alcohol problem. Such a perspective should be communicated

to the family member in the interview. The counselor might compare the SO'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).

Any concerns that the SO may have about the amount or type of treatment should be explored. Again, concerns expressed by family members or SOs should be responded to in an accepting, reflective, reassuring manner. SOs who express concern about the brevity of MET can be told about the findings of previous research (see table 1), namely, that people can and do overcome their drinking problems given even briefer treatment than this, and that making a firm commitment is the key.

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

- How has the drinking affected you?
- What is different now that makes you more concerned about the drinking?
- What do you think will happen if the drinking continues as it has been?

Feedback provided by the SO 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 drinking problem for family members, an SO may cause the client to experience emotional conflict (discrepancy) about drinking. Thus, the client may be confronted with a dilemma in which it is not possible both to continue drinking and to have a happy family. In this way, the decisional balance can be further tipped in favor of changing the drinking. One client became more conflicted about his drinking after his wife described the negative impact it was having on their children. He subsequently decided to give up drinking rather than to experience himself as a harmful parent.

At the same time, there is a danger of overwhelming the client if the feedback given by the SO is new, extremely negative, or presented in a hostile manner. Negative information presented by both the SO and

the counselor may result in the client's feeling "ganged up on" in the session and could result in treatment dropout. The MET approach relies primarily upon instilling intrinsic motivation for change in the client rather than using external motivators such as pressure from SOs.

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

- What are the things you like most about [client] when he/she is not drinking?
- What positive signs of change have you noticed that indicate [client] really wants to make a change?
- What are the things that give you hope that things can change for the better?

Supportive and affirming statements from the counselor and SO 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 SO has offered. You might ask, for example:

- Of these things your husband has mentioned, which concern you most?
- How important do you think it is for you to deal with these concerns that your wife has raised?

Feedback provided from the assessment battery is also presented and discussed during SO-involved sessions. SOs can be asked for their own comments and reactions to the material being presented.

- What do you think about this? Is this consistent with what you have been thinking about [client's] drinking? Does any of this surprise you?

Such questions may help to confirm the SO's own perceptions about the severity of the alcohol problem as well as to clarify 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 SO as well. Once an agreement is reached about the seriousness of the problem, the counselor should explore how the SO might be helpful and supportive in dealing with the problem. Remember that MET is not a skill-training approach; the primary mechanism here is to elicit ideas from the SO and client about what could be done. In raising the awareness of the spouse about the client's drinking and related issues, the counselor mainly seeks to *motivate* the SO 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. An SO can play a positive role in instigating and sustaining change, particularly in situations where interpersonal commitment is high. The SO can be involved in a number of ways.

Eliciting Feedback From the SO

The SO might provide further examples of the negative effects of drinking on the family, such as not showing up for meals, missing family celebrations such as birthday parties, embarrassing the family by being intoxicated, or alienating children and relatives. This is an extension of the SO's role in Phase 1.

Eliciting Support

The SO can comment favorably on the positive steps undertaken by the client to make a change in drinking, and you should encourage such expression of support. The SO may also agree to join with the client in change efforts (e.g., spending time in nondrinking settings).

Eliciting Self-Motivational Statements From the SO

This strategy should be employed in the second SO-involved session, after the client and SO have had a chance to reflect upon the information presented earlier. Clients may become less resistant after they have had more time to think about drinking and related issues (see "Asking for Commitment"). If, in the second interview, the client still appears to be hesitant or reluctant about dealing with the drinking and related matters, then an attempt should be made to acknowledge the feelings of frustration and helplessness experienced by the SO and to examine alternative ways 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's/wife's] attitude about drinking—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 drinking. What do you think about this third option? What things could you do to keep from being involved in drinking situations yourself and to develop a more rewarding life away from drinking?

In response to this question, one spouse determined that she would no longer accompany her spouse to the neighborhood tavern. Another went a step further and indicated that he would not be involved in any drinking-related activities with his wife. By eliciting such self-motivational statements and plans from SOs, it is possible to tip the client's balance further in favor of change (cf. Sisson and Azrin 1986).

Addressing the SO's Expectations

When goals and strategies for change are being discussed, SOs are invited to express their own views and to contribute to generating options. Any discrepancy between the client and SO with respect to future alcohol use should be addressed. Information from the pretreatment assessment may be used here to reach a consensus between client and SO (e.g., severity of alcohol problems, consumption pattern). If agreement cannot be reached, a decision may be delayed, allowing further opportunity to consider the issues (see "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 alcohol problems.

Handling SO Disruptiveness

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

- Comments are made by the SO that appear to exacerbate an already strained relationship and to evoke further resistance from the client. Your efforts at eliciting verbal support from the SO are met with resistance. Your own efforts to elicit self-motivational statements from the client are hindered by SO remarks that foster client defensiveness.

- Comments made by the SO suggest an indifferent or hostile attitude toward the client. The SO demonstrates a lack of con-

cern about whether the client makes a commitment or is attempting to resolve the drinking problem. The involvement of the SO appears to have little or no beneficial impact on eliciting self-motivational statements from the client. When the client does make self-motivational statements, the SO offers no support.

- The SO seems unwilling or unable to make changes requested by the client that might facilitate an improvement in the drinking pattern or their relationship. For example, despite strong requests from the client (and perhaps from you) to place a moratorium on negative communication patterns, the SO continues to harass the client about past drinking habits.

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) to acknowledge and highlight the problematic interactions. If usual MET strategies do not result in a decrease in SO disruptiveness, intervene directly to stop the pattern. The following are potentially useful strategies for minimizing SO 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."

- Limit the amount of involvement of the SO in sessions. You might explicitly limit SO involvement to (1) providing collateral information about the extent and pattern of drinking and (2) acquiring knowledge and understanding about the severity of the alcohol problem and the type of treatment being offered. Your interactions with the SO can be limited to clarifying factual information and ensuring that the SO has a good understanding of the client's alcohol 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?"

- 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 drinking needs priority and that other concerns are best dealt with after the client has competed the MET program. Then direct the discussion to the client's concerns.

- Limit the SO's involvement in decisionmaking activities. If SO participation is problematic, allow the SO to be a witness to change, without requesting his or her direct involvement inside or outside of sessions. Avoid requesting input from the SO in

formulating change goals and developing the plan of action. Do not request or expect SO affirmation of decisions made by the client with regard to drinking and change.

Remember that it is not necessary to invite the SO back for a second session. This is easiest if your initial invitation did not mention two sessions. Also, remember that the maximum number of sessions that may be attended by any SO is two (not including emergency sessions).

Phase 3: Followthrough 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 followthrough. This may occur as early as the second session, depending on the client's progress. Three processes are involved in followthrough: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment.

Reviewing Progress

Begin a followthrough 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 can be used again to renew motivation for change. The extent of this renewal depends on your judgment of the client's current commitment to change. This may be assessed by asking clients what they remember as the most important reasons for changing their drinking.

Redoing Commitment

The Phase 2 processes can also be continued during followthrough. 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.