Motivation and Treatment

Interventions

NIAAA Social Work Education
Module 6

(revised 3/04)
Outline

- Treatment Adherence
- Motivational Interviewing
- Brief Interventions
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Relationship Enhancement Therapy (RET)
- Limitations, Matching
- Pharmacological Interventions
- Future and Issues
Treatment Adherence

Moving from assessment to treatment requires addressing the sources of adherence problems

- Client beliefs and perceptions about the problem
  - Perceptions about treatment
  - Ambivalence about change
  - Expectancies about treatment outcomes
Treatment Adherence (continued)

Individuals who do not believe that they have problems that need changing, and are placed in a treatment that they do not believe will help, are susceptible to adherence problems.

- Level of self-efficacy
- Barriers
- Previous negative treatment experiences
- Practitioner outcome expectancies
- Stigma
• Client blaming and negative labeling impede adherence
• Shift to interactional perspective
• Root treatment approaches in readiness to change/motivation processes (e.g. MI)
Motivational Interviewing (MI)

Adherence improves treatment outcomes
Motivational Interviewing (MI) ensures participation in treatment by:
- Modifying unrealistic treatment expectations
- Resolving client ambivalence
- Enhancing client self-efficacy
Motivational Interviewing (MI)

- Motivational is a critical element in facilitating treatment adherence and positive outcomes
- MI is a style, not a specific technique
- MI can be a stand alone approach or an add-on to other forms of treatment
Motivational Interviewing (continued)

- Interviewing style elements:
  - Ask open-ended questions
  - Conduct empathetic assessments
  - Discover client’s beliefs
  - Reflective listening
Motivational Interviewing (continued)

• Motivating strategies:
  - Normalize client doubts
  - Amplify client doubts
  - Deploy discrepancy
  - Support self-efficacy
  - Review past treatment experiences
Motivational Interviewing (continued)

• Motivating strategies (continued):
  - Provide relevant feedback
  - Summarize sources of non-adherence
  - Negotiate proximal goals
  - Discover potential barriers
  - Display optimism
  - Involve supportive significant others
Motivational Interviewing (continued)

- Treatment is negotiated
- Incorporates:
  - Client perceptions of needs
  - Client preferences
  - Client outcome expectancies
- Requires:
  - Assessment
  - Assessment feedback
Motivational Interviewing (continued)

- Present menu of options
- Client choice based on need and capacities
- Possibly employ incremental approach
- Make long-term goals into “doable” units
- Discuss “setback” issues
Brief Interventions

- Intended for at-risk drinkers or those in early stages
- Applied in a broad array of settings outside traditional alcohol treatment systems (non-specialized treatment settings)
- Effective and cost effective
Brief Interventions (continued)

- Time-limited, structured
- Self-help
- Prevention strategy
- Negotiated reduction in alcohol use
- Not teaching specific skills
- Not changing social environment
Brief Interventions (continued)

Steps:
- Screening
- Assessment
- Advice giving
- Assessing motivation for change
- Establishing drinking goals
- Conducting follow-up
Brief Interventions: Screening

“On average, how many days a week do you drink?”
“On a day when you drink alcohol, how many drinks do you have?”
“What is the maximum number of drinks you consumed on any given occasion during the past month?”

• Positive screen = Women >7/week or >3/occasion, Men >14/week or >4/occasion
Brief Interventions: Assessment

- Perform with anyone who drinks above established cut-offs
- Assess potential alcohol-related problems
- Assess for symptoms of dependence
- Refer to specialist practitioner if evidence of alcohol dependence
Brief Interventions: Advice Giving

• Express concerns about the alcohol use pattern

• Provide personalized feedback about how alcohol affects person

• Advise about need to change the drinking behavior
Brief Interventions: Assessing Motivation to Change

1. Not interested (precontemplation)
2. Considering change (contemplation)
3. Ready for action (preparation)
4. Initiating action (action)
5. Already acting (maintenance)
Brief Interventions: Establishing Drinking Goals

- Negotiate specific drinking amounts
- Establish specific dates
- Develop a written contract
- Offer resources, materials, information, workbook, exercises, drinking diary
**Brief Interventions: Conducting Follow-up**

- Review drinking goals
- Assess ongoing problems
- Support ongoing efforts to change
- Assess new problems that might emerge
• Most trials found a greater reduction in alcohol use among intervention groups compared to controls
• Methodological limitations exist
Motivational Enhancement Therapy (MET)

Derived from the FRAMES model
Feedback
Responsibility
Advice
Menu
Empathy
Self-efficacy

Source: Miller & Sanchez, 1994
**MET (continued)**

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy
- Ensure client choice
- Convey optimism

@2002 Microsoft Corporation
MET (continued)

• Phase I:
  - Establish rapport
  - Provide personal feedback
  - Build motivation

• Phase II:
  - Strengthen motivation
  - Develop specific change plan
  - Commitment
  - Move to action
• Evidence suggests that MET is effective
• Evidence indicates that MET is cost-efficient
Client/Treatment Matching
• Matching treatment to
  - Client characteristics
  - Readiness to change to improve adherence
• For clients with high anger levels, MET was superior to
  - Cognitive Behavioral Therapy (CBT)
  - Twelve-Step Facilitation (TSF)
Cognitive Behavioral Therapy (CBT)

- Skills building (not motivation) interventions
- Targets a wide range of objectives:
  - To improve social skills
  - To reduce psychiatric symptoms
  - To reduce anger
  - To increase social support
  - To facilitate job finding
CBT (continued)

20-20-20 rule
CBT (continued)

• Effective when delivered as part of comprehensive program, not as a stand-alone
• Most effective at changing social environment context
• More effective than other treatments when added to pharmacotherapy
Client/Treatment Matching:
• Aftercare with low alcohol dependence… Cognitive Behavioral Therapy better than Twelve-Step Facilitation
• More alcohol dependence symptoms… Twelve-Step Facilitation better
• Higher degree of psychiatric severity… Cognitive Behavioral Therapy better than interactional therapy
• High drinking support environment… Cognitive Behavioral Therapy better than Relationship Enhancement Therapy
Relationship Enhancement Therapy (RET)

- Promotion and active involvement of supportive significant others (SSO)
- SSO may be child, parent, friend, clergy, self-help group member
- Examples: marital or family therapy mutual help opportunities
Benefits

• Increase awareness about problem
• Enable acceptance of responsibility for change
• Buttress motivational readiness
• Improve interaction patterns that promote and reinforce sobriety
• Reduce interaction patterns that trigger or reward problem drinking
• Increase social networking
• Common goals include:
  - Compliance, motivation, promote sobriety, emotional ties, abstinence networks, coping capacities, spirituality
• Ideal SSOs:
  - Support sobriety, support is valued by client, not experiencing alcohol-related hardship
RET (continued)

• RET is superior to control groups on several outcome measures:
  - Drinking
  - Marital stability
  - Motivation
  - Compliance
Limitations

- Research requires “purity” for comparison; reality requires blending and variability due to the differential needs and capacities of heterogeneous populations.
- Need better, more comprehensive theory of client-treatment matching.
Matching

Phase Model of Matching
• How to deliver treatments over time?
• Change is a dynamic, contextualized process
• Client-treatment matching effects are short-lived unless therapeutic ingredients interact with circumstances, conditions

Use of Decision Trees
• Link specific modules to stated preferences and assessed needs/capacities
• Flexible model with real-world applicability
• Clinical research tests the principles underlying
Pharmacological Interventions

Important and revolutionary advances in pharmacological agents for treating alcohol problems

*Naltrexone* = opioid antagonist, dealing with pleasure areas of brain activity

*Acamprosate* = glutamate antagonist, dealing with negative areas of brain activity

Combinations
FUTURE: Combining Treatments

- Pharmacology alone is not an answer
- As individuals start to feel better medically they need other social and psychological treatments to support them
- Extend benefits beyond 3-month drug therapy period with other treatments
- Medications can enhance efficacy of other treatments (e.g., Naltrexone + CBT)
## Combining Treatments (continued)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medication</th>
<th>Psychosocial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance motivation</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Improve coping</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Enhance network support</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Leisure-time counseling</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Cravings, urges</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
Combining Treatments (continued)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medication</th>
<th>Psychosocial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic alliance</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Priorities setting</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Facilitate compliance</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>(treatment, medication)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overcoming obstacles</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Changing beliefs</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Improving attitudes</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
Non-Treatment?

- Change may or may not require professional treatment to occur
- Natural history and process of change is consistent either way
- Treatment may support natural change efforts
Appendix

Addressing Treatment Adherence Problems
Addressing Adherence

For Problem Acceptance:

• Risk from client misperceptions, misunderstandings, uncertainties about beliefs and/or problem seriousness
• Use empathic reflection, awareness building, deploy discrepancies, normalize unclarities, use open-ended questions, elicit “change talk”, amplify doubts
Addressing Adherence

For Treatment Acceptance:
• Risk from previous negative treatment experiences, misperceptions about need, negative therapist or treatment outcome expectancies, barriers to care, ambivalence about change, low self-efficacy
• Use information, support self-efficacy, display optimism, decisional balancing, explore and address barriers, negotiate proximal goals, involve SSO
Addressing Adherence (continued)

• Phase I: Assess and understand why the client may be unable or unwilling to participate in treatment
• Phase II: Aim at helping the client to develop an adherence plan that is appropriate to his/her capacities, resources, and treatment
Addressing Adherence (continued)

Phase I

- Conduct an empathic assessment
- Review chain of events leading to program
- Discuss importance of events to change
- Detect early warning signs of nonadherence
- Communicate understanding about nonparticipation
- Help make client aware of, and sort out reasons for, nonadherence
Phase I (continued)

• Review past and current treatment experiences related to nonadherence
• Ask about and re-discuss goals, therapist style factors, outcome expectancies
• Make client sensitive to ongoing pattern of nonadherence
Phase II

• Log negative feelings about the treatment process
• Identify and involve significant others for support
• Break down large goals into manageable tasks
• Present a menu of options
Phase II (continued)
• Review the pros/cons of options
• Address decisional balance
• Do not negotiate with doubts or if conditions indicate you should
• State concerns about nonparticipation
• Obtain agreement before opinion
• Summarize and plan for anticipated sources of nonadherence
• Communicate non-perfection message
Appendix:

Using Reflective Strategies
Reflection

Reflection is not a passive process, it is a highly selective process involving:

- Direction (to draw attention)
- Reinforcement (to strengthen and build up)
- Exaggeration (to elicit correction from the client)
- Amplification (to heighten effect)
- Increase awareness (linking pieces of information)
Reflection

Multiple levels of reflection exist:
- Simple reflection
- Amplified reflection
- Double-sided reflection
- Reflection of expressed or inferred feelings or affect
- Reflection of meaning