Motivation and Treatment Interventions

NIAAA Social Work Education
Module 6

(revised 3/04)

NIAAA

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

Treatment Adherence (continued)

- 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

Adherence improves treatment outcomes

Motivational Interviewing (MI)

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

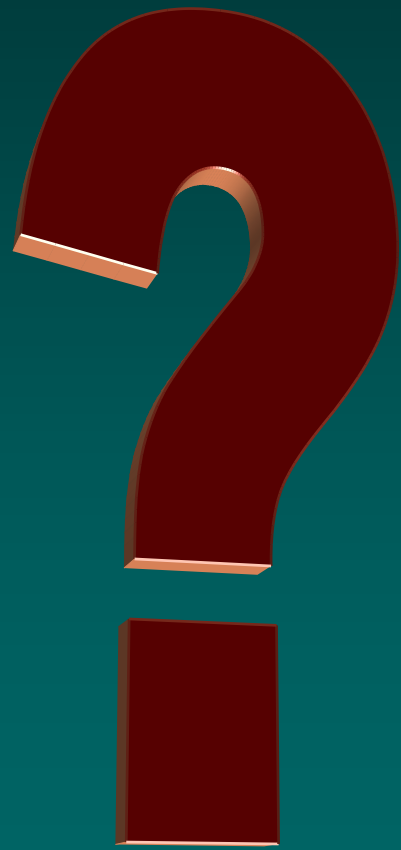
Motivational Interviewing (MI)

- *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*



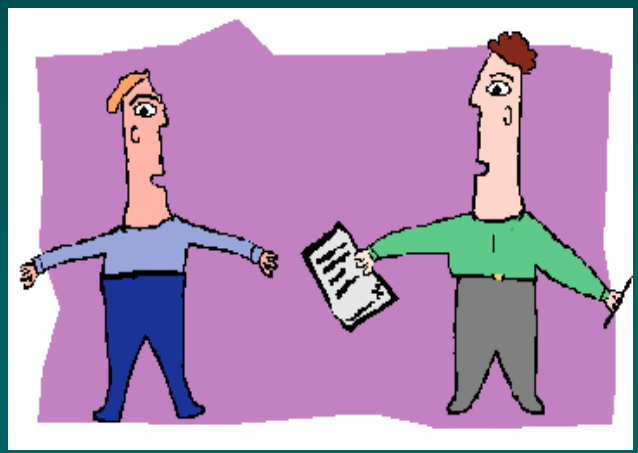
Motivational Interviewing (continued)

- *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

Brief Interventions (continued)

- Most trials found a greater reduction in alcohol use among intervention groups compared to controls
- Methodological limitations exist

Motivational Enhancement Therapy (MET)

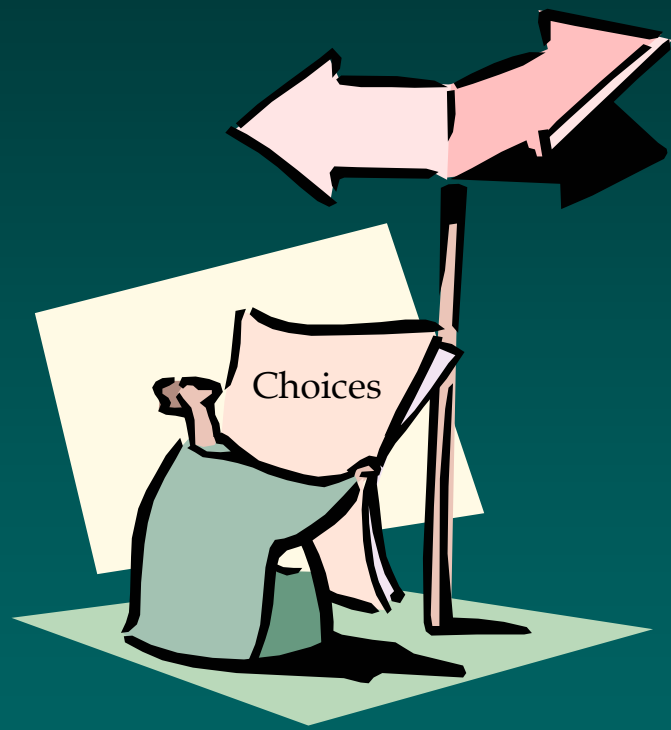
Derived from the FRAMES model

- 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

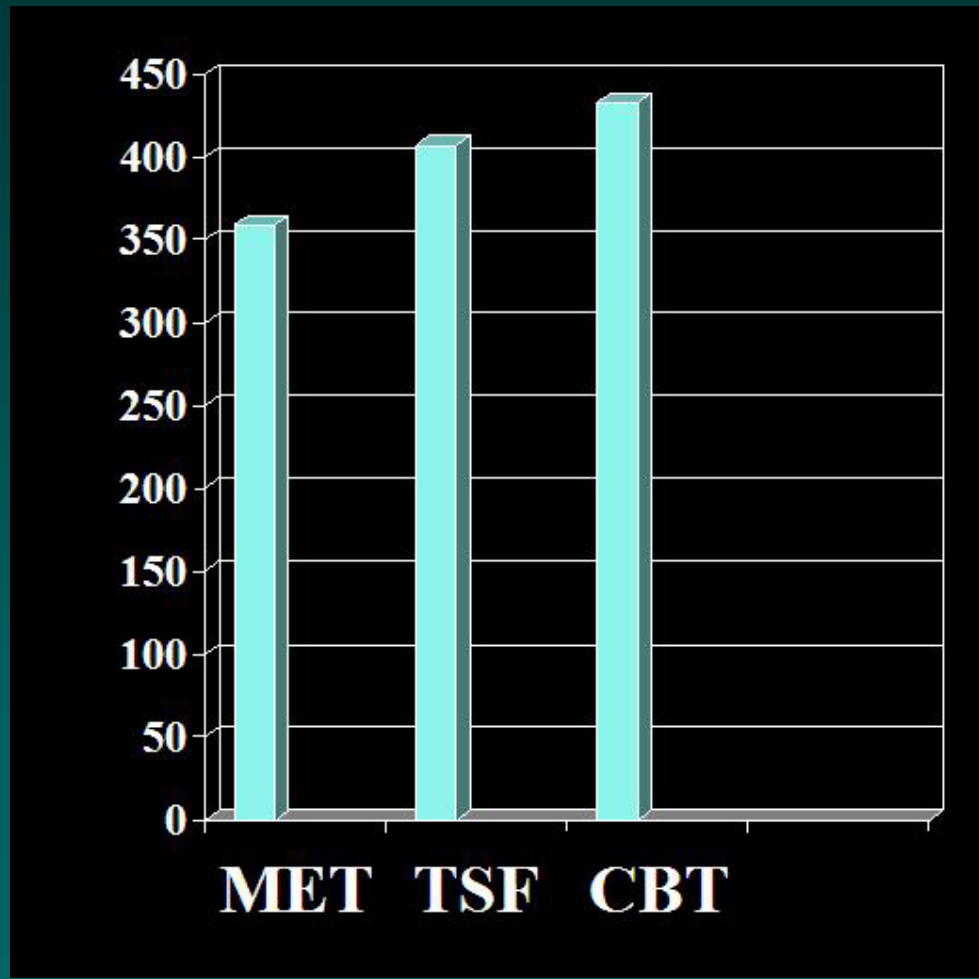


MET (continued)

- Phase I:
  - Establish rapport
  - Provide personal feedback
  - Build motivation
- Phase II:
  - Strengthen motivation
  - Develop specific change plan
  - Commitment
  - Move to action

MET (continued)

- Evidence suggests that MET is effective
- Evidence indicates that MET is cost-efficient



MET (continued)

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)

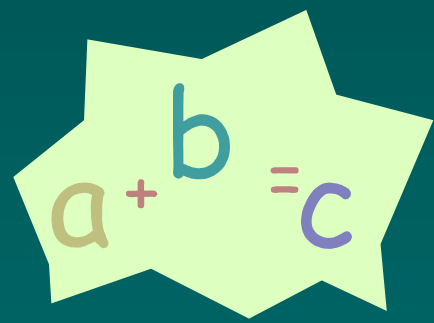
Cognitive Behavioral Therapy (CBT)

- 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)

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



CBT (continued)

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

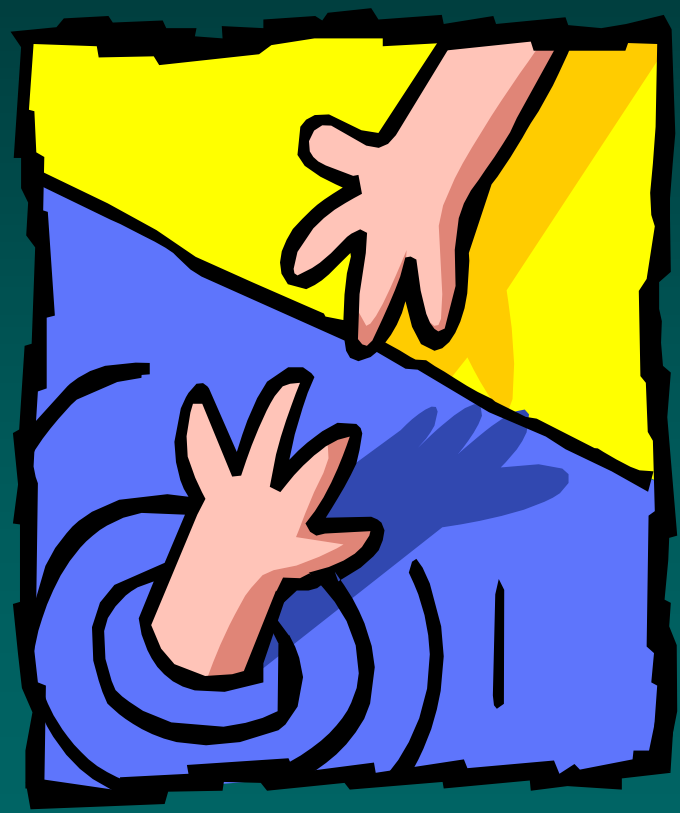
RET (continued)

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

RET (continued)

- 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

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)

Benefits	Medication	Psychosocial
Enhance motivation	√	√
Improve coping		√
Enhance network support		√
Leisure-time counseling		√
Cravings, urges	√	√

Combining Treatments (continued)

Benefits	Medication	Psychosocial
Therapeutic alliance	√	√
Priorities setting		√
Facilitate compliance (treatment, medication)	√	√
Overcoming obstacles		√
Changing beliefs	√	√
Improving attitudes	√	√

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

Addressing Adherence (continued)

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

Addressing Adherence (continued)

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

Addressing Adherence (continued)

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