

1  **Motivation and Treatment Interventions**
An Intro to Cognitive Behavioral Technique

2 

❖
❖COGITO ERGO SUM

3 

WE TREAT.....

BRAIN DISORDERS.....

.....NOT DRUGS!

4  **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

5  **Treatment Adherence**

6  **Treatment Adherence (continued)**

7  **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)

8  **Motivational Interviewing (MI)**

9  **Motivational Interviewing (continued)**

10  **Motivational Interviewing (MI)**











11  **Motivational Interviewing (continued)**

- ❖Interviewing style elements:
 - Ask open-ended questions
 - Conduct empathetic assessments
 - Discover client's beliefs
 - Reflective listening

12  **Motivational Interviewing (continued)**

13  **Motivational Interviewing (continued)**

14  **Motivational Interviewing (continued)**

- 15  **Motivational Interviewing (continued)**
- 16  **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
- 17  **Brief Interventions (continued)**
- ❖ Time-limited, structured
 - ❖ Self-help
 - ❖ Prevention strategy
 - ❖ Negotiated reduction in alcohol use
 - ❖ Not teaching specific skills
 - ❖ Not changing social environment
- 18  **Brief Interventions (continued)**
- 19  **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?"*
- 20  **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
- 21  **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
- 22  **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)
- 23  **Brief Interventions: Establishing Drinking Goals**
- ❖ Negotiate specific drinking amounts
 - ❖ Establish specific dates
 - ❖ Develop a written contract
 - ❖ Offer resources, materials, information, workbook, exercises, drinking diary
- 24  **Brief Interventions: Conducting Follow-up**
- ❖ Review drinking goals
 - ❖ Assess ongoing problems
 - ❖ Support ongoing efforts to change

- ❖ Assess new problems that might emerge

25  **Brief Interventions (continued)**

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

26  **Motivational Enhancement Therapy (MET)**

Derived from the FRAMES model

- Feedback
- Responsibility
- Advice
- Menu
- Empathy
- Self-efficacy

27  **MET (continued)**

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

28  **MET (continued)**

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

❖









29  **MET (continued)**

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

30  **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)

- 31  **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
- 32  **CBT (continued)**
- 33  **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
- 34  **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
- 35  **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
- 36  **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
- 37  **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
- 38  **RET (continued)**
- ❖ RET is superior to control groups on several outcome measures:

- Drinking
- Marital stability
- Motivation
- Compliance

39  **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

40  **Matching**

1. 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
2. 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

41  **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

42  **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)

43  **Combining Treatments (continued)**

44  **Combining Treatments (continued)**

45  **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
- ❖

46  **Appendix:**

47  **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 unclaritys, use open-ended questions, elicit "change talk", amplify doubts

48  **Addressing Adherence (continued)**

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

49  **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

50  **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

51  **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

52  **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

53  **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

54  **Appendix:**

55  **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)

56  **Reflection**

Multiple levels of reflection exist:

- Simple reflection
- Amplified reflection
- Double-sided reflection
- Reflection of expressed or inferred feelings or affect
- Reflection of meaning

57 

❖ <http://archives.drugabuse.gov/TXManuals/CBT/CBT5.html#202020>