**Psychologist Treatment Manual: Integrated Stepped Care for Unhealthy Alcohol Use in HIV (STEP Trial)**

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**Introduction to the Study**

The major purpose of this randomized clinical trial is to examine the role of integrated care for unhealthy alcohol use in patients with HIV. This manual is designed to guide psychologists in the delivery of the motivational enhancement interventions. The manual will be enriched with actual clinical material so that it evolves to a detailed practical guide to administer the interventions as they are intended to be as reliably as possible.

Context of Intervention Delivery

Before describing the intervention it will be useful to provide some context for the study. As a general overview of the study, men and women 21 years of age or older with HIV-infection who present for primary care appointments for medical reasons are invited to participate in a brief screening regarding health-related habits. Those who are screened as eligible for participation in the project are invited to participate in the baseline assessment. Upon completion of the baseline assessment, subjects who remain eligible for the study according to the assessment are invited to participate in a study of modification of drinking patterns. Individuals who give their consent are randomly assigned to one of the two intervention conditions – Treatment as usual or Integrated Stepped Care. The Motivational Enhancement intervention includes follow-up sessions, 2 and 4, and 6 weeks after the initial session, respectively.

Patient Recruitment Sites

Patients for the clinical trial are recruited from four HIV primary care clinics at the four VA Medical Centers in Atlanta, Houston, Manhattan, Dallas and Washington, D.C.

Criteria for Patient Participation in the Study

In order for patients to be eligible to participate in this study they must meet several criteria of inclusion and exclusion. The inclusion criteria are as follows:

1. Be HIV-infected.

2. Meet one of the following criteria for unhealthy alcohol use:

• **At-risk Drinking Study**- greater than 14 drinks per week or greater than 4 drinks per occasion in men and greater than 7 drinks per week or greater than 3 drinks per occasion in women and those over 65.

• **Alcohol Abuse or Dependence Study -** Meet DSM-IV TR criteria for alcohol abuse or dependence, not in remission.

• **Moderate Alcohol + Liver Disease Study** - Report alcohol consumption in the past month, are HCV co-infected, confirmed by HCV viral load or have liver fibrosis - Fib-4 (>1.45). Do not meet criteria for at-risk drinking, alcohol abuse or dependence.

3. Be able to understand English and provide informed consent.

***Exclusion criteria:*** No subject may:

1. Be acutely suicidal, or with a psychiatric condition that affected their ability to provide informed consent or participate in counseling interventions (e.g. psychotic, dementia, delusional).

2. Be enrolled in formal treatment for alcohol at baseline (excluding self-help, e.g. Alcoholics Anonymous).

3. Have medical conditions that would preclude completing or be of harm during the course of the study.

**Introduction to Motivational Enhancement (ME) Intervention**

This ME condition is derived directly from the Miller et al. (1992) treatment manual. In this regard, as part of their training all psychologists have thoroughly reviewed that manual, as well as other reading materials (such as Miller & Rollnick, 1991) and three audiovisual training tapes created by Dr. Miller and other experts on motivational interviewing. This manual focuses on a summary of the major points about ME and on the specific application of ME principles. As such, this manual assumes a good degree of familiarity with those principles and methods. In this clinical trial, ME is presented as an individual intervention in four sessions. The initial session lasts 30 minutes to 45 minutes. There also are three follow-up sessions that occur 2, 4 weeks and 6 weeks after the initial session, respectively, and that last 20 minutes to 30 minutes each. Because of these parameters, considerable adaptation of the Miller et al. (1992) Project MATCH intervention is required, since that version of ME covered 4 sessions over 3 months time and followed a far more extensive baseline assessment protocol than what is used in this study.

Major General Points about ME

The bases of ME are the work of US psychologist William R. Miller and began to appear in the research and clinical literature over 30 years ago. This foundation of ME is an integration of concepts from motivational psychology, social psychology, and the theory and practice of psychotherapy. Here the bases of ME may be distilled into four major points:

1. Individuals have the inner resources to change their own behavior.

2. Change can be initiated and sustained successfully by the individual if he or she becomes aware of the benefits of changing and of the disadvantages of not changing (i.e., if the individual becomes "motivated" to change).

3. The process of changing a behavior may be described by Prochaska and DiClemente's stage of change model. The present version of the model includes five main stages, in the following sequence from not motivated to change to engaging in and sustaining change activities: precontemplation -- contemplation -- determination (or preparation) -- action -- maintenance. When individuals are in the precontemplation or contemplation stages regarding changing a problem behavior, the idea is to "bring" them to the determination or action stages, where their inner resources will take over and drive whatever behavior changes are required to meet the individual's goals.

4. ME may be thought of as a collection of techniques to initiate and accelerate the individual's progress from precontemplation or contemplation status to the determination or action stage.

ME also is organized around general techniques and principles that have been hypothesized to explain the effectiveness of brief interventions for changing patterns of alcohol consumption. They have been summarized by the acronym **FRAMES**. "**F**" refers to giving the individual objective **f**eedback about his or her behavior in order to make salient to him or her the possible risks of continuing to engage in that behavior. "**R**" refers to **r**esponsibility, or to making it clear to the individual that it is his or her choice of whether to make a change and, if that choice is made, that the responsibility for change lies with the individual. "**A**" refers to **a**dvice, or to direct counseling about whether a change would be in the individual's best interests and, if so, what degree of change. "**M**" stands for **m**enu, which means that several options to make changes should be presented to the individual, and not just one. "**E**" refers to **e**mpathy, which refers loosely to the capacity to put oneself in another's place, resulting in being sensitive to his or her thoughts and feelings. The technical application of empathy in ME is discussed in detail below. Finally, "**S**" stands for **s**elf-efficacy, or the instilling in the individual the belief that he or she has the capacity to make the changes that are desired.

ME is a "brief" (relative to the duration of traditional alcohol treatment) intervention that in the Project MATCH version consists of four sessions with a patient. In that format that first two sessions cover the main content of the intervention, and the remaining two session are considered "booster" sessions. The main content of the intervention consists of two phases, (a) building motivation to change, followed by (b) strengthening commitment to change.

**Phase I: Building Motivation to Change in ME**

This first phase is designed to shift the balance from maintaining the status quo to making changes. Essentially, the idea is to make salient to the individual the advantages of changing and the disadvantages of not changing, as opposed to the advantages of maintaining the status quo and the disadvantages of changing. In ME the shift in the individual's perception of incentive to change is accomplished by the use of eight techniques.

Eliciting Self-Motivational Statements

This first technique refers simply to *having patients generate the statements themselves* that lead toward change. This may involve, for example, being open to information about the risks of heavy alcohol consumption and expression of a need or desire to change. In essence, the idea is to get people to "tell themselves" that change makes sense for them, rather than having therapists or other professionals tell them. The words are viewed as being more persuasive to the individual if they come from him or her than from somebody else.

Several techniques have been suggested to help elicit self-motivational statements from individuals who present for treatment of problem drinking. However, in this study patients did not initially present to their clinic setting for alcohol problems per se, but ostensibly because of their need for HIV care. Therefore, it may be useful to begin eliciting self-motivational statements from patients by use of general questions, such as, "I assume that since you are here that you have some concerns or questions about your use of alcohol and your HIV care in general". "Could you tell me what some of your concerns are?" Another possibility is, "What is the biggest risk to you about your drinking and health?"

An important note in applying this technique is that patients may at first be slow to generate self-motivational statements. In such cases it may be helpful for psychologist to give specific cues relevant to alcohol and risk, particularly regarding health (HIV, HCV, other). Of course, this must be done in a way that does not result in further inhibiting the patient. For example, the psychologist might say, "Alcohol is known to affect the body in a lot of ways. For example, our liver, other parts of our digestive system, our heart, our ability to adhere to medications such as antiretrovirals, and our thinking can be affected in the long run by alcohol. Do any of your concerns having something to do with these or other effects of alcohol that can affect our physical or psychological health?"

Listening with Empathy

The elicitation of self-motivational statements, and other responses from patients, likely will be more effective if psychologists listen empathically to what patients are saying. In ME this therapeutic skill also is called reflection, active listening, or understanding. In this context, empathic listening goes beyond the dictionary meaning; it involves listening to what the patient says, and "reflecting" it back to him or her, often in a modified or reframed form. Many times the reflection includes acknowledgement of the patient's feelings. The reader may recognize the influence of the work of Carl Rogers on the use of reflective listening to build motivation.

An important aspect of reflection is that the *therapist may reflect selectively, reinforcing certain thoughts or feelings the patient has expressed*. Therefore, patients hear themselves say a motivational statement, and immediately hear the therapist say that it was said. In addition, reflective responding often encourages the patient to elaborate on the self-motivational statement. Some examples of reflective responding follow.

Psychologist: What concerns you about your drinking?

Patient: I'm not too concerned, but sometimes I wonder if drinking might have something to do with my feeling dragged out all the time.

I: Dragged out?

P: Yeah, like finding it hard to get going in the morning the day after I drink, feeling tired during the day, that sort of thing.

I: So you think that your lack of energy might have something to do with how much you're drinking.

P: Yeah, maybe it does, at least sometimes.

Notice that in this (contrived) example that the psychologist uses information that the patient has expressed, and through summarizing the content and feelings back to the patient has encouraged him or her to elaborate further. *Also notice that the psychologist gives no direct advice, and asks no direct "why" or similar questions*. Another example of reflective listening follows.

P: I like alcohol, but sometimes I wonder about it.

I: You wonder about it?

P: Yeah, that maybe it's not always worth the fun that you have with it.

I: You think that alcohol may not always be just fun.

P: That's right, like it might cause arguments.

I: You think that arguments may happen while drinking that might not take place if you weren't using alcohol.

It is important to note that reflective listening may appear simple, but to do it well takes an psychologist with specific skills. He or she must be an alert listener who is attuned to his or her patient, who is able to respond quickly to capture the most compelling thoughts and feelings that the patient is expressing at the moment, and able to summarize them back to the patient in a way that is meaningful to him or her and that encourages elaboration. Accordingly, the psychologist makes use of the patient's nonverbal as well as verbal cues in formulating reflections back to him or her. Notice again that true reflection does **not** involve giving advice, agreement or disagreement, teaching, or suggestions. Instead, the psychologist responds to the patient in a way to encourage elaboration of the patient's own thoughts and feelings. To repeat, reflective listening seems easy but takes considerable skill to do well.

Of course, reflection also may involve the psychologist's inferring a bit what the patient is feeling. For example,

P: If I stop drinking I'll lose all my friends.

I: It's hard for you to imaging having any social life if you stop using alcohol.

Actually, capturing patient fears such as that expressed in this example and reflecting them back cogently is crucial in making ME effective.

Another point about reflection is that patients may express ambivalence, or may "counterpoint" your reflection to take the other side of view. For example, in the case of ambivalence, the patient might say,

P: I know that drinking less makes sense, but life just wouldn't be the same.

I: You think it's smart to drink less, but you're afraid life wouldn't be as much fun.

Here the psychologist is making an inference in part about what the patient is expressing and reflecting back his or her ambivalence, in a way that encourages the patient to go on with his or her thoughts. Notice again that the psychologist does not use the patient's statement as a cue to teach or instruct him or her that one can still have a good time without drinking or with drinking moderately.

As regards the pendulum of patient viewpoint swinging as a result of a psychologist reflection,

P: I'm worried about how much I drink.

I: So you think that you drink enough that it may be a problem for you.

P: Well, not really a *problem*.

I: There are things you like about drinking but you also have some concerns about it.

In this case the psychologist goes with the patient's counter-reaction to the first reflection with an attempt to restore "balance" by reflecting the patient's ambivalence.

One final point about reflective listening is that it is not a technique that has specific, circumscribed application in ME, but one that is used throughout its course. Although reflection is not the only way the psychologist responds to the patient, it is a predominant style of interacting with him or her in ME.

Questioning

This third technique is a style of psychologist response in ME that, like reflection, may be used throughout the course of ME. It refers to *asking* patients about their thoughts and feelings, rather than *telling* them. This style of interaction is based on the idea that the patient is the best source of information about what his or her internal workings are.

Presenting Personal Feedback

In ME a major way of making the risks of a patient's drinking salient to him or her is to present formal, written feedback regarding his or her alcohol use and its consequences. This feedback may take any form suitable to the context of an intervention. However, the format is standard: written feedback comparing what the patient does or how he or she performs on some standardized psychological test with some standard. Typically, the standard is one of "low risk" behavior. The goal of giving feedback to the patient is to identify clearly what he or she is doing to place him or her at higher risk for developing alcohol problems, or for developing more severe problems. Through such recognition, concerns arise in the patient about his or her drinking. And it is through raising these concerns that movement toward behavior change happens.

An important part of providing feedback again is how the psychologist responds to the patient's reactions to the information. Reflection plays a major part in this interaction. For example,

P: I never realized the chances I've been taking with the amount I drink.

I: This information surprises you.

Another example involves the psychologist reflecting both sides of the patient's reaction:

P: I drink as much as all of my friends do, but that amount may not be too safe.

I: You feel that you really haven't been doing anything too unusual, and yet drinking that much may not be the safest way for you.

It is possible that patients will have little to say, nor show much nonverbal reaction to the feedback. In that case it works well if the psychologist asks directly what the patient's reaction is. For example, questions such as, "What do you make of this?", "Does this surprise you?", and "What do you think about this?" help to further the change process. In this regard, to restate the major aim of providing feedback to patients, *it is away to make salient to them what risks they are incurring by engaging in a pattern of behavior, which may raise concerns in them that are expressed by them*. Such concerns are the bedrock of initiating behavior change.

Affirming the Patient

This fifth technique is another style of interacting with the patient that the psychologist uses throughout ME. It refers to genuine complimenting and reinforcing the patient for giving effort and time to considering and taking concrete steps to change a given behavior. According to Miller and colleagues, therapist affirmation may have several effects that further patient change: It strengthens the working relationship, enhances the patient's attitude of self-responsibility and empowerment, reinforces effort and self-motivational statements, and sustains and increases patient self-esteem. A few examples of psychologist affirmation statements are, "You've taken a big step in receiving this feedback today, and I respect you for it," and "You show a lot of strength going through this feedback and using the information to make some changes."

Handling Resistance

The problem of how to handle patient resistance has plagued addictions treatment for years. Resistance refers to patients' failure to comply with psychologist instructions and is further indicated by these patient behaviors: interrupting, cutting off, or taking over the psychologist; arguing with or challenging the psychologist, discounting her views, and showing hostility; sidetracking or changing the subject, not responding, not paying attention; and defensiveness, or minimizing or denying the problem, blaming others, rejecting the psychologist's opinion, and so forth.

Resistance may occur at any point in the course of an intervention, and how it is handled makes a difference. Studies have shown that how psychologists interact with patients influences the degree and frequency with which resistance occurs. This implies that resistance is at least as much a function of the psychologist as it is of the patient. This slant differs sharply from the common view, held especially in addictions treatment, that resistance is a product of a patient characteristic, such as "denial" of his or her problem behavior. With this alternative approach it follows that therapists can learn a style that typically results in a reduction of patient resistance behaviors. Such a style is a matter of *not* doing certain things, and of *doing* others.

The available research suggests that psychologists should *not*: argue with, disagree with, or challenge the patient; judge, criticize, or blame the patient; warn the patient of dire consequences of his or her behavior; try to persuade the patient by using logical argument or data; interpret the patient's resistance to him or her; confront the patient by pulling authority or "rank" (by virtue of the psychologist's expertise); or use sarcasm or disbelief.

Miller and Rollnick (1991) offer several suggestions about what psychologists can *do* to reduce resistance. First, our major tactic of reflection may be applied. If the resistance is reflected back to the patient, sometimes it results in eliciting the opposite (nonresistant) response from him or her. Next, the psychologist might try reflection with amplification. This is an extension of reflection and involves exaggerating what the patient is saying to the point that the patient is likely to adopt the opposite view. For example,

P: I may drink heavy once in a while and forget to take my medications, but so what? It happens all the time, and I haven’t died from it.

I: So you think what you're doing is perfectly safe.

P: Well, I wouldn't say that; what *is* perfectly safe after all?

I: Oh, so you think maybe there is some risk in drinking heavily and forgetting to take your medications.

As Miller and Rollnick say, using this tactic is somewhat risky for the psychologist, because if it is carried too far or timed poorly it may elicit further hostility from the patient.

Another strategy is to use double-sided reflection. This refers to reflecting back the resistant response along with its opposite. For example,

P: I don't want to think of life without alcohol! All the fun would be gone.

I: You think that stopping drinking would take the fun out of life, but at the same time you see that drinking can make your HIV disease worse.

Yet another way that has been proposed to handle resistance is to shift focus, which means that the psychologist shifts attention away from the issue that is causing the resistance.

P: I can't stop drinking, but that seems to be the only way.

I: I think you may be getting ahead of things here. No one said totally stopping drinking is the only way to lower your risk for problems. Let's finish going through this feedback, and later we'll talk about what you might do about things.

The final major method that has been suggested is to "roll" with the resistance, in contrast to opposing it. This method involves the psychologist's use of paradox to bring the patient back to the opposite side, as a way to "balance" the interaction.

P: But I can't cut down drinking that much. My life would change in too many ways.

I: I can see your concern, and you may decide when we're through with this that you want to continue drinking the way you are now. Change might be too hard on you. But the choice will be yours to make.

To remind the reader, the purpose of these tactics for handling resistance is to elicit self-motivational statements from patients.

Reframing

This technique was made popular by cognitive therapists and involves encouraging patients to examine their perceptions from a different slant or in a reorganized form. This often results in the patient discerning new meaning from what is said. Reframing may also result in putting behavior in a more positive light, which may give hope to the patient that a problem is solvable and that behavior change is possible.

P: Why is everyone always getting on me? My mother's always getting into my life about my drinking.

I: It sounds as if your mother cares about what happens to you.

Another example is,

P: Drinking is a way that my girlfriend and me have a good time. It keeps things relaxed.

I: You've been going along drinking with your girlfriend so that you can keep your relationship peaceful and satisfying. Most people like that kind of relationship. But at the same time it seems you're uncomfortable with drinking that much.

In this latter example note that the psychologist has placed heavy drinking in a positive light for the patient, but concurrently opens a door for the patient to express concerns about her drinking.

Summarizing

Part of ME is to summarize periodically during the course of a session, especially toward its end. Most important is to reflect back the patient's self-motivational statements, so they are heard yet another time. It also may be useful in summarizing to include some of the patient-expressed resistance, so as to prevent a counter-reaction from patients that could occur if they hear only a series of motivation to change statements.

**Summary of Phase I**

The goal of Phase I in ME, shifting of incentive from maintaining the status quo to change, is achieved through a variety of techniques. These techniques are designed to elicit from the patient an awareness of risk of and concerns about his or her drinking. Such concerns are the foundation of patients making a commitment to behavior change.

ME prescribes no number or frequency of use of the eight techniques outlined above. Rather, the use of the techniques is determined by the intervention context. The only constants are the goals of elicitation of patients' concerns and self-motivational statements, and of making risk more salient to them through feedback about the consequences of their drinking. Indeed, rather than a collection of discrete techniques, they together constitute a **therapeutic style** that defines ME and that, for the most part, permeate its course.

**Phase II: Strengthening Commitment to Change in ME**

Once sufficient motivation to change is achieved, the next step is to develop a plan for action (change). Typically, no clear "signal" goes off when this point is reached. Instead, the psychologist looks for different patient behaviors or comments that suggest he or she is ready for change. For example, the patient may stop making resistance statements, or may ask fewer questions. The patient may be direct about it as well, and say that he or she is ready for change. The important points here are, first, that when time for an action plan seems right it should be seized. Furthermore, the patient's making a commitment to change does not necessarily mean that he or she has no ambivalence about such change. The psychologist must always be prepared to use the techniques discussed in Phase I of ME to fortify the patient's motivation to change.

As in the discussion of Phase I of ME several techniques are highlighted for use in Phase II, once readiness for change has been identified.

Discussing a Plan

As is apparent, this involves developing a plan for change. The psychologist starts the process by making any of several remarks, such as, "What do you make of all this? What do you think you want to do about it?", or "Now that you've come this far, I wonder what you're thinking you'll do about your concerns." The major goal here is to get the patient started generating *his or her* ideas about what changes to make, and how to make them. **It is essential that the therapist not prescribe changes for the patient, or tell him or her how to make changes that are desired.** Rather, the major role of the therapist once again is to use reflection to generate solutions from patients.

Communicating Free Choice

This is a reiteration of a core feature of ME, the communication to the patient that, in the final analysis, it is his or her choice of whether to change, and of what changes to make. Psychologists communicate this message frequently in ME by making comments such as, "It's up to you what to do about your drinking, "No one can decide about this but you," and "You can decide to go on drinking the way you have been or to change."

Consequences of Action and Inaction

An excellent method for furthering commitment to change is to make a list of positives of changing, and the negatives of not changing. For balance, the negatives of changing and the plusses of maintaining the status quo may be listed as well. At this point the goal is to have the decision weighted on the side of change.

Information and Advice

Many patients regard knowledge as important to them in deciding whether to change. The giving of advice is a little trickier, given the philosophy of ME that has been articulated here so far. Patients tend to ask psychologists -- even demand from them at times -- advice about what to do. This is natural, in that the psychologist is viewed as an expert on the topic at hand. However, an essential feature of ME is that motivations and solutions come from patients and are not imposed by psychologists. This dilemma is resolved by the psychologist's offering her true opinion about a topic, but at the same time maintaining clearly that it is *only* her opinion and that the final choice stays with the patient. Moreover, it is suggested that the advice focus on a "whether" (e.g., "should I reduce my drinking?") and not on a "how" (e.g., "how should I go about cutting back on my drinking?") question. If patients ask a direct how question, the psychologist should put the question right back in the patient's court, such as by saying "How do you think you could do that?" In this way solutions are still coming from the patient. Another note here is that if a patient asks the psychologist for information on a topic and the psychologist does not know the answer, she should say so. Between that time and the next session the psychologist can find out the correct answer and tell the patient when they meet next, or the psychologist may phone the patient with the correct information.

Dealing with Resistance

As alluded to above, resistance signs may show up in the commitment phase of ME. As in Phase I the idea is to use reflection and reframing to meet resistance and not to "counter-resist" it. Paradox may also be used to get the patient back on track. For example, the psychologist might say, "You might decide that you want to keep on drinking heavily, even though you're aware of the risk in that." The idea is that such paradox will elicit an opposite reaction in the patient, i.e., that he or she does *not* want to continue drinking heavily.

The Change Plan Work Sheet

Part of ME as applied in Project MATCH is the formal development of a plan for change. This technique involves the patient's addressing 6 points with written answers. A work sheet, which appears in Appendix 1, is used for this exercise. Discussion of the patient's answers with the therapist follows. The 6 points are:

1. *The changes I want to make are...* In what ways does the patient want to change? (give specific answers). Miller et al. (1992) suggest using goals that are positive (things I want to do) as well as negative (things I want to stop doing).

2. *The most important reasons I want to make these changes are...* What are the likely consequences of action and inaction? What motivations for change seem most compelling to the patient?

3. *The steps I plan to take in changing are...* How does the patient plan to achieve his or her goals? How could the desired changes be accomplished? Within this overall goal, what are some specific, concrete first steps the patient can take? When, where, and how will these steps be taken?

4. *The ways other people can help me are...* In what ways could other people help the patient take these steps toward change? How will the patient arrange for such support?

5. *I will know my plan is working if...* What does the patient hope will happen as a result of this change plan? What benefits might be expected from this change?

6. *Some things that could interfere with my plan are...* Help patients anticipate situations or changes that could undermine their plans. What could go wrong? How can the patient stick with the plan in the face of obstacles or set backs?

Recapitulating

Toward the end of the commitment phase it is useful to bring together all that has transpired so far, to reinforce both self-motivational statements and a commitment to change. This general summary should include a repetition of reasons for concern discovered in Phase I, as well as new information revealed in Phase II. The basics to be covered include the patient's self-motivational statements, the patient's plans for change, and the perceived consequences of changing and not changing.

**Phase III: ME Booster Sessions**

As developed for Project MATCH, ME includes three booster sessions. According to the Miller et al. (1992) manual, three processes are involved in these sessions: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment.

Booster sessions begin with a **review** of what has happened since the last session. The psychologist discusses with the patient what commitments and plans were made, and explores with the patient what progress has been made toward these. Again, the psychologist responds with reflection, questioning, affirmation, and reframing. The psychologist determines the extent to which previously established goals and plans have been implemented.

The Phase I processes can be used again to **renew motivation** for change. How much renewal is needed is determined by the psychologist's judgment of the patient's current commitment to change. One way to evaluate this commitment is to ask patients what they remember as the most important reasons for changing their drinking.

Booster sessions also may be used to **redo the commitments** made earlier. In some cases, this may simply be a reaffirmation of the earlier plans. However, if the patient has met some problems or doubts in implementing his or her plans, it may be a time for re-evaluation of goals and plans and of developing new ones. It is important here that the psychologist reinforces the patient's sense of autonomy and self-efficacy -- the ability to carry out self-chosen goals and plans.

Application of ME Principles and Techniques to the Study

As has been noted several times, this Treatment Manual differs in major ways from Project MATCH in extensiveness of the assessment protocol and patient populations targeted. As such, we have had to take the basics of ME that have been summarized in the last three chapters of this manual and apply them to its research and clinical circumstances. The resulting ME is described in the next chapter.

**Structure of the ME in STEP Trial**

In this chapter the structure of the ME in STEP Trial is described. Again, in this project, there are four ME sessions. The first lasts from 30 to 45 minutes, and the remaining sessions last from 20 to 30 minutes each. The second, third and fourth sessions occur two, four and six weeks after the first session, respectively. All ME sessions begin with breath alcohol testing of the patient. If a positive blood alcohol is observed, then the patient's session must be rescheduled.

Session 1

Introduction and preliminaries (5 minutes). The session begins with any introductions of patient and psychologist that may not have already occurred. The psychologist answers any questions that the patient may have, and thanks him or her for agreeing to participate in this research. It then is useful to describe to the patient what will be happening, and to describe some general features about the ME approach. The following is adapted from the Miller et al. (1992) MATCH manual.

Before we begin, let me just explain a little how we will be working together. You already have spent time completing the tests we need, and we appreciate the effort you put in that process. We'll make good use of the information from those tests today. This is the first of three sessions that we will be spending together, during which we will take a close look at your situation. I hope that you'll find these three sessions interesting and helpful.

I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that after our three sessions together is completely up to you. I couldn't change you if I wanted to. The person who can decide whether and how you change is *you*. How does that sound to you?

Most patients accept this introduction and explanation of approach, and the intervention can then proceed. However, if the patient expresses some concerns, the psychologist should address them as well as she can. For example, again following the Miller et al. manual, she might say something like;

I understand your worries, and it's perfectly understandable that you would be unsure at this point. But let's just get started, and we'll see where we are after we've had a chance to work together.

Main content of Session 1 (15 minutes). With these preliminaries complete, the main content of the session can begin. This part of the session starts with the psychologist telling the patient that she will be giving him or her feedback from the (screening and baseline) assessments that the patient completed on \_\_\_\_\_ (dates of each of the assessments are stated). The psychologist then says that before she gets into the feedback she first wants to understand better how the patient sees his or her situation. For example,

I assume that since you agreed to participate in our study you have some concerns or questions about your use of alcohol, your HIV disease and your health in general. Could you tell me what some of these are?

Here the psychologist is attempting to hear the patient's viewpoint and in the process eliciting self-motivational statements from him or her. As such, methods for eliciting such statements described in discussion of Phase I of ME earlier in this manual should be applied here. In this regard, psychologists should remember here that if the patient is slow in expressing self-motivational statements, the psychologist could use direct questioning tactics (described earlier) that focus on the concerns about the relationship between heavy drinking, HIV and health problems. Given the patient population and recruitment sources of patients in this study, this is a broad area of concerns that virtually all participants should have in common.

It also is important to remind psychologists that use of reflection at this point in the intervention is critical, in order to have the patient expand and elaborate upon initial statements of concern. Other strategies described earlier that may be useful here are affirming the patient and handling resistance.

When the psychologist senses that major themes or concerns have been elicited from the patient, she offers a summary statement (see earlier description of "summarizing"). If the patient finds the summary acceptable, the psychologist's next step is to provide feedback from the initial assessments.

Provision of feedback (10 minutes). The psychologist gives the patient a copy of the Personal Feedback Form and reviews it step-by-step with the patient. After going through the feedback, the psychologist asks for the patient's overall response. The psychologist might say,

I've given you quite a bit of information here, and at this point I wonder what you're making of all of this and what you're thinking?

*Both the feedback and this question often elicit self-motivational statements that can be reflected and used as a bridge to the next phase of ME.* After the patient's response to the feedback (see earlier description of handling feedback) the psychologist offers one more brief summary, including concerns raised in the first eliciting process and information provided in the feedback (see earlier description of summarizing). This may be viewed as the transition point to Phase II of ME.

Phase II of ME (20 minutes). Using cues for the patient (see recognizing readiness to change), the psychologist starts to elicit from the patient thoughts, ideas, and plans for what might be done to address the problem. During this part of the session, it is important to use the techniques of communicating free choice and information, going through the consequences of action and inaction, and giving advice (selectively and as relevant), as described earlier. One point about free choice and advice is important here. If the patient has any of the contraindications to a moderation drinking goal (e.g. is in the moderate alcohol+liver disease group, or has know liver disease or is Hepatitis C infected) then the psychologist should point out such risks to the patient clearly and advise abstinence, if the patient seems to be leaning toward a moderation goal. Besides that consideration, however, here the usual ME posture of patient having freedom of choice of goals and solutions holds. Similarly, the basic ME client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly is maintained throughout Phase II of ME.

Phase II proceeds with working toward confirmation of a plan to change. In this regard, the psychologist seeks to get whatever commitment to change that she can from the patient. It is helpful here to have the patient record his or her goals, reasons for change, and so forth on the Change Plan Work Sheet (Appendix 1).

This point marks the end of the first ME session. If feedback has been completed the patient is given a copy of his or her feedback, along with a copy of "Understanding Your Feedback Report" (adapted from Project MATCH; see Appendix 2). In addition the patient is given access to web-based counseling. If the patient has completed a written action plan, then he or she takes that home as well. (The psychologist keeps a copy in the patient's research file.)

After the first session is completed, the procedure used in MATCH of the psychologist sending the patient a personal handwritten note is followed. It is essential that this note is handwritten, not typed, and not a form letter. The personalized elements in this note are: A "joining" message ("I was glad to see you," "I was happy to see you"); Affirmation of the patient; A reflection of the seriousness of the problem; A brief summary of highlights of the first session, especially self-motivational statements that emerged; A statement of optimism or hope; A reminder of the next session. An example from the Miller et al. (1992) manual,

Dear Mr. X,

This is just a note to say that I'm glad you came in today. I agree with you that there are some serious concerns for you to deal with, and I appreciate how openly you are exploring them. You already are seeing some ways in which you might make a healthy change. I think that you will be able to find a way through these problems. I look forward to seeing you again on Tuesday afternoon, August 1, at 2:00.

A copy of this note is kept in the patient's research file. In addition, the patient is contacted by telephone shortly before the second session to remind him or her of its scheduled time.

Session 2

Although this session is conceptualized as the first of three booster sessions, it is used to complete feedback provision and commitment to change techniques that were not accomplished in Session 1. If these latter procedures are completed in Session 2, then at the end of the session the patient is given a copy of his or her feedback report and a copy of the guide to its interpretation. Similarly, if a written action plan is completed in Session 2, then he or she receives a copy of that to keep at the end of the session.

If these latter procedures were completed in Session 1, then Session 2 is the first of three booster sessions. Whether or not feedback or goals have to be completed, Session 2 begins with a brief summary of what happened in the first session. As a booster session (this also applies to session 3 and 4, booster sessions only) Session 2 is used to reinforce the motivational processes that were begun in Session 1. As before, the psychologist does not offer training in coping skills, nor does she prescribe a course of action for the patient. Rather, the same motivational and commitment to action strengthening principles that were applied in Session 1 are applied in Sessions 2, 3 and 4. In addition, use of the follow through principles described earlier are used here, namely, reviewing progress, renewing motivation, and redoing commitment.

After review of what occurred in the previous session, the psychologist reviews with the patient what has happened since the last session. Complete each booster with a summary of where the patient is now, and with his or her perceptions of what steps should be taken next. The previous plan for change is reviewed, revised, and if previously written down, rewritten.

Part of booster sessions, as relevant, includes review of two types of drinking situations that may have occurred since the first session, those in which the patient drank more than was desired or than was safe, and those in which the patient adhered to desired and safe levels of alcohol use. For the first type of situation, the psychologist discusses how it occurred. In this process, the psychologist *remains empathic, avoids a judgmental posture, and does not prescribe solutions*. Instead, the psychologist uses the discussion to renew motivation, eliciting from the patient self-motivational statements by asking for the patient's thoughts, feelings, and reactions. In addition, key questions are used to renew commitment: "So what does this mean for the future?", "I wonder what you need to do differently next time?"

For the situations in which the patient drinks at desired and safe levels (including zero) the psychologist reinforces the patient's self-efficacy by asking patients to clarify what they did to cope successfully in these situations. In addition, the psychologist praises the patient for small steps, little successes, and even minor progress.

At the end of the second session the psychologist makes an appointment for session 3 with the patient. Between the second and third sessions, the psychologist again sends the patient a personal note, essentially to affirm the patient's working on his or her goals, expressing optimism for change, and reminding the patient of the next appointment. In addition, the patient is called on the phone shortly before the appointment for the third session to remind him or her of its scheduled time.

Termination

Termination is discussed at the end of the fourth session. As indicated in the MATCH manual, these points are covered:

1. Review the most important factors motivating the patient for change, and reconfirm these self-motivational themes.

2. Summarize the commitments and changes that have been made so far.

3. Affirm and reinforce the patient for commitments and changes that have been made.

4. Explore additional areas for change that the patient wants to accomplish in the future.

5. Elicit self-motivational statements for maintenance of change and for further changes.

6. Support patient self-efficacy, emphasizing the patient's ability to change.

7. Deal with any problems, such as obstacles to continued safe drinking, that the patient may anticipate.

8. Remind the patient of continued follow-up evaluations, and thank him or her for participating in the STEP Trial.

**Appendix 1. – Change Plan Worksheet**

1. *The changes I want to make are...*

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2. *The most important reasons I want to make these changes are...*

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3. *The steps I plan to take in changing are...*

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4. *The ways other people can help me are...*

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5. *I will know my plan is working if...*

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6. *Some things that could interfere with my plan are...*

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