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.

The Structure of MET Sessions

The preceding sections outline the basic flow of MET from Phase 1 through Phase 3. This section addresses issues involved in planning and conducting the four specific sessions.

The Initial Session

Preparation for the First Session

Before treatment begins, clients are given an extensive battery of assessment instruments; the results are used as the basis for personal feedback in the first session. Appendix A discusses the instruments used in Project MATCH and various alternatives.

When you contact clients to make your first appointment, stress the importance of bringing along to this session their spouse or, if unmarried, someone else to whom they are close and who could be supportive. Typically, this would be a family member or a close friend. The critical criteria are that the SO is considered to be an "important person" to the client and that the SO ordinarily spends a significant amount of time with the client. Those designated as significant others are asked to participate in assessment and also to attend two (and only two) treatment sessions. If no such person is initially identified, explore further during the first session whether an SO can be designated. The intended support person is contacted either by the client or by the therapist (whichever is desired by the client) and invited to participate in the client's treatment. Again, the initial invitation should be for one visit only, to allow flexibility regarding a second session.

Also explain that the client must come to this session sober, that a breath test will be administered, and that any significant alcohol in the breath will require rescheduling. All MET sessions are preceded by a breath alcohol test to ensure sobriety. The client's blood alcohol concentration must be no higher than .05 (50 mg%) in order to proceed. Otherwise, the session must be rescheduled.

Presenting the Rationale and Limits of Treatment

The MET approach may be surprising for some clients, who come with an expectation of being led step by step through an intensive process of therapist-directed change (Edwards and Orford 1977). For this reason, you must be prepared to give a clear and persuasive explanation of the rationale for this approach. The timing of this rationale is a matter for your own judgment. It may not be necessary at the outset of MET. At least *some* structuring of what to expect, however, should be given to the client at the beginning of the first session. Here is an example of what you might say:

> Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the tests that we need, and we appreciate the effort you put into that process. We'll make good use of the information from those tests today. This is the first of four sessions that we will be spending together, during which we'll take a close look together at your situation. I hope that you'll find these four 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 four sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

Many clients will find this a very comfortable and compatible approach. Some, in fact, will express relief, having feared being castigated or coerced. Other clients or their significant others, however, may be uneasy with this approach and may need additional explanation and assurance. Here are several lines of followup discussion in such cases:

- Even with very extensive kinds of treatment, it is still the person who, in the end, decides what happens. *You* will determine what happens with your drinking.

- Longer and shorter treatment programs don't seem to produce different results. People in longer or more intensive programs don't do any better, overall, than those getting good consultation like this. Again, no one can "do it to you." In fact, many people change their drinking or quit smoking without any formal treatment at all.

- You are not alone. We will be keeping in touch with you to see how you are doing. If at followup visits, you still need more help, this can be arranged.

- You can call if you need to. I'm available here by telephone.

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

After this introduction, start with a brief structuring of the first session and, if applicable, the SO's role in this process (refer to the section on "Involving a Significant Other"). Tell the client (and SO) that you will be giving them feedback from the assessment instruments they completed, but first you want to understand better how they see the client's situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening With Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Client," "Handling Resistance," and "Reframing" are also quite appropriate here. (The "Motivational Interviewing" videotape by Dr. Miller demonstrates this early phase of MET.)

When you sense that you have elicited the major themes of concern from the client (and SO), offer a summary statement (see "Summarizing"). If this seems acceptable to the client (and SO), indicate that the next step is for you to provide feedback from the client's initial assessment. Give the client a copy of the Personal Feedback Report and review it step by step (see "Presenting Personal Feedback"). Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session, and *take back the client's copy of the PFR* for use in your second session, indicating that you will give it back to keep after you have completed reviewing the feedback next week.

If you do complete the feedback process, ask for the client's (and SO's) overall response. One possible query would be:

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

Both the feedback and this query will often elicit self-motivational statements that can be reflected and used as a bridge to the next phase of MET.

After obtaining the client's (and SO's) responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MET: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the client and SO (see "Recognizing Change Readiness"), begin eliciting thoughts, ideas, and plans for what might be done to address the problem (see "Discussing a Plan"). During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the client (and SO) what are perceived to be the possible benefits of action and the likely negative consequences of inaction (see "Consequences of Action"). These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to change) and given to the client. The standard commendation of abstinence is to be included during this phase at an appropriate time. If a high-severity client (range 3 or 4 in table 2) appears to be headed toward a moderation goal, this is also the time to employ the abstinence advice procedure outlined in "Emphasizing Abstinence." The basic client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly is to be maintained throughout this and all MET sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard (see "Asking for Commitment"). It can be helpful to write down the client's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the client (and SO). Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a client may drop out of treatment rather than renege on the agreement.

Ending the First Session

Always end the first session by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the first session presenting feedback and dealing with concerns or resistance. In other cases, the client will be well along toward determination, and you may be into Phase 2 (strengthening commitment) strategies by the end of the first session. The speed with which this session proceeds will depend upon the client's current stage of change. Where possible, it is desirable to elicit some client self-motivational statements about change within the first session and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the client will do and what changes will be made (if any) between the first and second sessions. Do not hesitate

to move toward commitment to change in the first session if this seems appropriate. On the other hand, do not feel pressed to do so. Premature commitment is ephemeral, and pressuring clients toward change before they are ready will evoke resistance and undermine the MET process.

At the end of the first session, always provide the client with a copy of *Alcohol and You* (Miller 1991) or other suitable reading material. If feedback has been completed, also give the client the Personal Feedback Report and a copy of "Understanding Your Personal Feedback Report."

The Followup Note

After the first session, prepare a handwritten note to be mailed to the client. This is *not* to be a form letter, but rather a personalized message in your own handwriting. (If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.)

Several personalized elements can be included in this note:

- A "joining message" ("I was glad to see you" or "I felt happy for you and your wife after we spoke today")
- Affirmations of the client (and SO)
- 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 and hope
- A reminder of the next session

Here is an example of what such a note might say:

> Dear Mr. Robertson:
>
> 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 are already seeing some ways in which you might make a healthy change, and your wife seems very caring and willing to help. I think that together you will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Keep a copy of the note for your records.