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# The Structure of MET Sessions

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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.

## Followthrough Sessions

### The Second Session

The second session is scheduled 1 to 2 weeks after session 1 and should begin with a brief summary of what transpired during the first session. Then proceed with the MET process, picking up where you left off. Continue with the client's personal feedback from assessment if this was not completed during the first session, and give the client the PFR and a copy of "Understanding Your Personal Feedback Report" (see appendix A) to take home. Proceed toward Phase 2 strategies and commitment to change if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with followthrough procedures.

At the end of the second session, in all cases, offer a closing summary of the client's reasons for concern, the main themes of the feedback, and the plan that has been negotiated (see "Recapitulation"). This is the closing of the second session. If no commitment to change has been made, indicate that you will see how the client is doing at the followup in 4 weeks and will continue the discussion at that point. In any event, remind the client of the third session at week 6. When a spouse or SO has been involved in the first two sessions, thank the SO for participating in those sessions and explain that the next two sessions will be with the client alone. If the SO was not involved in both of the initial sessions, he or she may return for the third session. (The SO's involvement is not to exceed two sessions.)

### Sessions 3 and 4

Sessions 3 and 4 are to be scheduled for weeks 6 and 12, respectively. They are important as "booster" sessions to reinforce the motivational processes begun in the initial sessions. As before, the therapist does not offer skill training or prescribe a specific course of action. Rather, the same motivational principles are applied throughout MET. Specific use is made in each session of the followthrough strategies outlined earlier: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment. Sessions 3 and 4 do *not* include the SO, unless the SO has not already attended two sessions.

Because several weeks normally lapse between sessions 2 and 3 and between sessions 3 and 4, you should send the client a handwritten note or telephone the client a few days before the scheduled appointment. This serves as a reminder and also expresses continued active interest in your client.

Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where the client is at present, eliciting the client's perceptions of what steps should be

taken next. The prior plan for change can be reviewed, revised, and (if previously written down) rewritten.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the client is still ambivalent and to continue using the motivation-building strategies of Phase 1 as well as the commitment-strengthening strategies of Phase 2.

There should be a clear sense of continuity of care. The four sessions of MET should be presented as progressive consultations and as continuous with the research protocol's schedule of followup sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions serve as periodic checkups of progress toward change.

It can be helpful during sessions 3 and 4 to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored:

- Situations in which the client drank
- Situations in which the client did not drink

### **Drinking Situations**

If the client drank since the last session, discuss how it occurred. Remember to remain empathic and to avoid a judgmental tone or stance. Consistent with the MET style, do not prescribe coping strategies for the client. Rather, use this discussion to renew motivation, eliciting from the client further self-motivational statements by asking for the clients thoughts, feelings, reactions, and realizations. Key questions can be used to renew commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?")

### **Nondrinking Situations**

Clients may also find it helpful and rewarding to review situations in which they might have drunk previously or in which they were tempted to drink but did not do so. Reinforce self-efficacy by asking clients to clarify what they did to cope successfully in these situations. Praise clients for small steps, little successes, even minor progress.

## **Termination**

Formal termination should be acknowledged and discussed at the end of the fourth session. This is generally accomplished by a final recapitulation of the client's situation and progress through the MET sessions. Your final summary should include these elements:

- Review the most important factors motivating the client for change, and reconfirm these self-motivational themes.
- Summarize the commitments and changes that have been made thus far.
- Affirm and reinforce the client for commitments and changes that have been made.
- Explore additional areas for change that the client wants to accomplish in the future.
- Elicit self-motivational statements for the maintenance of change and for further changes.
- Support client self-efficacy, emphasizing the client's ability to change.
- Deal with any special problems that are evident (see below).
- Remind the client of continuing followup sessions, emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

Review, in session 4, the major points that have come up in the prior three sessions. It may be useful to ask clients about the worst things that could happen if they went back to drinking as before. Help clients look to the immediate future, to anticipate upcoming events or potential obstacles to continued sobriety.

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# Dealing With Special Problems

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Special problems can arise during any treatment. The following are general troubleshooting procedures for handling some of the situations that may arise in delivering therapy in general as well as within a research context.

## Treatment Dissatisfaction

Clients may report thinking that the assigned treatment is not going to help or wanting a different treatment. Under these circumstances, you should first reinforce clients for being honest about their feelings (e.g., "I'm glad you expressed your concerns to me right away."). You should also confirm that clients have the right to quit treatment at any time, seek help elsewhere, or decide to work on the problem on their own. In any event, you should explore the client's feelings further (e.g., "Whatever you decide is up to you, but it might be helpful for us to talk about why you're concerned"). Concerns of this kind that arise during the first session are probably reservations about an approach they have not yet tried. Typically, in randomized studies of multiple treatments, it is appropriate to assure the client that all of the treatments in the study are expected to succeed equally and that you will be offering all the help you can. No one can guarantee that any particular treatment will work, but you can encourage the client to give it a good try for the planned period and see what happens. You can add that should the problem continue or worsen, you will discuss other possible approaches.

If a client expresses reservations after two or three sessions, consider whether there have been new developments. Have new problems arisen? Did the plan for change that was previously developed with the client fail to work, and if so, why? Was it properly implemented? Was it tried long enough? Is there input or pressure from someone else for a change in approaches or for discontinuation of treatment? Is the client discouraged?

If the client's drinking problem has shown improvement but new problems, not previously identified, have appeared, these new problems can be discussed, following (and not departing from) the treatment procedures outlined above. The discussion of new problems and concerns, or a review of how prior implementation failed, can set the stage

for continuation in treatment. You can suggest that it may be too early to judge how well this approach will work and that the client should continue for the 12-week duration. After that, if the client still feels a need for additional treatment, he or she could certainly obtain it.

If other parties are concerned about this treatment and are pressuring the client, you can explore this problem by following the treatment guidelines outlined above. It is also permissible for you to telephone the concerned party (with written consent from the client) to discuss the concerns and provide assurances, along the same lines as those outlined above for similar client concerns.

In Project MATCH, a limit of no more than two additional “emergency” sessions may be provided at the therapist’s discretion. These must remain consistent with the MET guidelines provided in this manual and can be viewed as an extension or intensification of MET. The SO may be included in these sessions if appropriate, but the SO may never be seen alone. All sessions, including any emergency sessions, must be completed within 12 weeks of the first session. After that date, therapists are no longer permitted to see the client for any session, even if MET has not been completed.

A plan to provide a specific referral and help the client make contact was devised in Project MATCH in case all attempts to keep the client in treatment fail. Additional treatment may not be provided by any project therapist. Referral is made to an outside agency or to a therapist within the same agency who has no involvement in Project MATCH. A good procedure for accomplishing the referral is to telephone the agency or professional while the client is still in your office and make a specific appointment. For Project MATCH, this is discussed with the project coordinator or project director, because it has implications for the client’s continuation in the study. In any event, the client is urged to participate in followup interviews as originally planned.

## Missed Appointments

When a client misses a scheduled appointment, respond immediately. First try to reach the client by telephone, and when you do, cover these basic points:

- Clarify the reasons for the missed appointment.
- Affirm the client—reinforce for having come.
- Express your eagerness to see the client again.
- Briefly mention serious concerns that emerged and your appreciation (as appropriate) that the client is exploring these.
- Express your optimism about the prospects for change.

- Reschedule the appointment.

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the client whether the missed appointment might reflect any of the following:

- Uncertainty about whether or not treatment is needed (e.g., “I don’t really have that much of a problem”)
- Ambivalence about making a change
- Frustration or anger about having to participate in treatment (particularly with clients coerced by others into entering the program)

Handle such concerns in a manner consistent with MET (e.g., with reflective listening, reframing). Indicate that it is not surprising, in the beginning phase of consultation, for people to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the client to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase 1 strategies to handle any resistance that is encountered. Affirm the client for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the client in this regard. Reschedule the appointment.

In all cases, unless you regard it as a duplication of the telephone contact that might offend the client, *also* send a personal, individualized handwritten note with these essential points. This should be done within 2 days of the missed appointment. Research indicates that a prompt note and telephone call of this kind significantly increase the likelihood that the client will return (Nirenberg et al. 1980; Panepinto and Higgins 1969). Place a copy of this note in the clinical file.

This procedure should be used when any of the four appointments is missed. Three attempts (new appointments) should be made to reschedule a missed session.

## Telephone Consultation

Some clients and their SOs will contact you by telephone between sessions for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client’s file. An attempt should be made to keep such contacts brief, rather than providing additional sessions by telephone. All telephone contacts must also comply with the basic procedures of MET. Specific change strategies should not be prescribed. Rather, your approach emphasizes elicitation and reflection.

Early in a telephone contact, you should comment positively on the client's openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that are expressed with regard to goals or strategies discussed in a previous session. It can be helpful to "normalize" ambivalence and concerns; for example: "What you're feeling is not at all unusual. It's really quite common, especially in these early stages. Of *course* you're feeling confused. You're still quite attached to drinking, and you're thinking about changing a pattern that has developed over many years. Give yourself some time." Also, reinforce any self-motivational statements and indications of willingness to change. Reassurance can also be in order during these brief contacts, e.g., that people really do change their drinking, often with a few consultations.

## Crisis Intervention

The Project MATCH protocol provides guidelines on actions to be taken if the therapist is contacted by the client or SO in a condition of crisis. Others using this manual can adopt these guidelines as needed for their own protocols. These guidelines permit offering up to two special emergency sessions with the client (and SO) within the 12-week treatment period.

If at any time, in the therapist's opinion, the immediate welfare and safety of the client or another person is in jeopardy (e.g., impending relapse, client is acutely suicidal or violent), the protocol instructs the therapist to intervene immediately and appropriately for the protection of those involved, with appropriate consultation from the therapy program supervisor. This may include your own immediate crisis intervention as well as appropriate referral. In Project MATCH, the therapist's involvement in crisis interventions cannot exceed two sessions above and beyond those prescribed by the treatment condition. If a client's urgent needs require more additional treatment than this, referral is arranged.

Cases where there appears to be a worsening of the drinking problems or evidence of other new and serious difficulties (e.g., suicidal thoughts, psychotic behavior, violence) are referred to the onsite Project MATCH study coordinator for further evaluation and consultation. Based on his/her own evaluation and the defined procedures of the study, the coordinator determines what action is warranted and whether the client should be continued in the study. If alternative treatments are warranted, the coordinator is involved in making this determination.