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Q: What is motivational enhancement therapy?

A: Motivational enhancement therapy (MET) is a time-limited, manualized treatment that employs motivational interviewing (MI) principles with assessment feedback to encourage mobilization of the patient's own resources in order to elicit behavioral change (Miller, Zweben, DiClemente, & Rychtarik, 1992). In MET, the goal of the therapist is to evoke from the patient statements of problem perception and a need for change. Similar to MI, MET is a patient-centered and directive treatment approach that seeks to increase intrinsic motivation to change through expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 1991; Miller et al., 1992). Unlike cognitive behavioral therapy (CBT), MET does not include skills training but focuses instead on the patient's own natural change processes, and on resources which often include the patient's spouse or significant other. MET and CBT can be used together as complementary approaches to treat cannabis use disorder (CUD).

Q: What is the treatment model underlying MET for CUD?

A: Research on the marijuana amotivational syndrome indicates that cannabis use is associated with reductions in motivation-related constructs such as general self-efficacy (Lac & Luk, 2018). MET focuses on enhancing motivation and supporting self-efficacy and targets key areas that may interfere with behavioral change among cannabis users. In addition, behavioral changes associated with MET can be understood within the transtheoretical model of change (Prochaska & DiClemente, 1984), in which motivation is conceptualized as an important predictor and mechanism of change (DiClemente, Corno, Graydon, Wiprovnick & Knoblach, 2017). A hallmark of both MI and MET is recognizing that patients may feel ambivalent about change (Moos, 2007). A unique feature of MET is the help it provides to resolve ambivalence and facilitate movement from the earlier stages of change (e.g., precontemplation and contemplation) to the later stages of change (e.g., preparation, action, and maintenance; Miller & Rollnick, 1991).

Q: Is MET recommended as a treatment for CUD in the Military Health System (MHS)?

A: Yes. The *2021 VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* gives a "weak for" recommendation for MET in the treatment of patients with CUD.

The MHS relies on the VA/DoD clinical practice guidelines (CPGs) to inform best clinical practices. The CPGs are developed under the purview of clinical experts and are derived through a transparent and systematic approach that includes, but is not limited to, systematic reviews of the literature on a given topic and development of recommendations using a graded system that takes into account the overall quality of the evidence and the magnitude of the net benefit of the recommendation. A further description of this process and CPGs on specific topics can be found on the VA clinical practice guidelines website.

Q: Do other authoritative reviews recommend MET as a treatment for CUD?

A: Yes. Other authoritative reviews have substantiated the use of MET as a treatment for CUD.

Several other recognized organizations conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the Agency for Healthcare Research and Quality (AHRQ) and Cochrane.

- AHRQ: No reports on MET for CUD were identified.
- Cochrane: A 2016 systematic review of psychosocial interventions for CUD found evidence supporting MET, particularly in combination with CBT, for lowering the frequency of cannabis use at early follow-up (median, four months; Gates, Sabioni, Copeland, Le Foll, & Gowing, 2016).

Q: What conclusions can be drawn about the use of MET as a treatment for CUD in the MHS?

A: The *2021 VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* suggests MET, CBT, or combined CBT/MET for treatment of CUD with a "weak for" strength of recommendation. Much of the research on CBT and MET for CUD comprises studies using components of both treatments, and a 2016 Cochrane systematic review found that combined MET and CBT was most consistently supported for CUD (Gates et al., 2016). Clinicians should consider several factors (e.g., readiness for change, cognitive-behavioral skill levels) when choosing a front-line treatment with their patient. Treatment decisions should take into account practical considerations such as treatment availability and patient preference that might influence treatment engagement and retention.

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