Article Summary

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Motivational Interviewing began as a treatment for substance misuse and has strong practical support as an intervention for working with substance abuse and now has widespread applications. MI is often combined with other types of treatment when it is used for substance abuse, and one example is the COMBINE Research Project where an integration of MI and cognitive-behavioral strategies as well as several other approaches was examined.

Motivational Interviewing's empathic and evoking style has been joined to other interventions for problem drinking, including behavioral self-control (Graber and Miller, 1988), Harris and Miller, 1990) and (Miller, 1978) and personalized feedback (Walters, 2000) and (Walters et al., 2009). MI was developed as a focus on collaboration with clients to address motivation to change as a contrast to previous confrontational approaches common for drinkers. Finally, specific elements of MI were separated from the companion treatments with which it had regularly been paired allowing MI to be offered as a stand-alone treatment, thus MI was used in clinical trials with the results indicating effectiveness even without add-on treatments. Many studies have shown an even greater effect for MI when it is paired with more intensive interventions such as inpatient treatment.

Why Add MI to CBT?

The practice of blending MI with other interventions was strengthened due to Project MATCH beginning in 1997 when those designing the interventions for Project MATCH were tasked with blending three empirically supported treatments: MI, 12-step treatment, and cognitive-behavioral therapy (CBT). While a 12-session adaptation of CBT was comparatively clear-cut, the other two interventions required additional consideration. This issue was solved by the creation of Twelve-Step Facilitated Therapy (TSF), focusing on therapists facilitating the client's entry to and compliance with a 12-step program and by creating Motivational Enhancement Therapy (MET) a 4 session protocol. MET became commonly used and unfortunately confusion between MI and MET became pervasive, with many MI practitioners believing that personalized feedback that was added to the original protocol was an essential component of MI.

The successful blending of MI and other interventions for substance abuse is now much more common than the use of "pure" MI (Burke et al., 2004) and (Hettema et al., 2005]). MI is often included in substance abuse interventions with the rationale that it will help engage clients into more effective treatments such as CBT, although more recent studies have incorporated a stand-alone MI condition as well. MI has been combined with psychophysiological feedback (Stotts, Potts, Ingersoll, George, & Martin, 2007) and CBT (McKee et al., 2007) to reduce cocaine use, with results indicating that treatments incorporating MI show superior results to

control conditions that do not include it. Using MI both alone (Stephens, Roffman, & Curtin, 2000) and in combination with CBT (Babor & Marijuana Treatment Project Research Group, 2004) has been shown to reduce marijuana use, though the longer and more complex treatment incorporating CBT seems to produce better outcomes. MI has also been incorporated into the treatment of problem drinking in men who have sex with men (Morgenstern et al., 2007) in a direct comparison of a "pure" MI condition and one blending MI with CBT. For this study, the stand-alone MI condition produced superior results to the lengthier combined treatment, although differences between groups were minimal at follow-up. These studies indicate that the strategy of combining MI with complex cognitive-behavioral treatments produces substance abuse outcomes that are often (but not always) superior to MI as a stand-alone treatment.

Clinical Application

The COMBINE Research Project was a clinical trial funded by the National Institute of Alcoholism and Alcohol Abuse (NIAAA) to investigate the effectiveness of two medications (naltrexone and acomprosate) for heavy drinking, both alone and in combination with each other (The COMBINE Study Research Group, 2003). The research committee prioritized client choice as an element of the treatment, due to evidence indicating the hazards of an rigid, treatment regime (Amrhein et al., 2003, and Gibbons et al., 2003).

The result of this research was the Combined Behavioral Intervention (CBI). CBI was based on the principles of MI (Miller and Rollnick, 1991, and Miller and Rollnick, 2002) and CBT (Kadden, Litt, Cooney, & Busher, 1992). It included components from CBT, MET, and TSF, all originally developed for and evaluated positively in Project MATCH (Project MATCH Research Group, 1997). Although CBI merged elements from each of these treatments, the therapeutic style of MI was used based on strong empirical support for MI as an intervention with substance abusing clients in particular (Wilbourne & Miller, 2002).

CBI includes elements from a number of other empirically based substance abuse treatments in addition to those from Project MATCH such as the Community Reinforcement Approach (Meyers & Smith, 1995) and Alcohol Behavioral Couples Therapy (McCrady, Epstein, & Hirshch 1999). CBI places an emphasis on actively engaging participants' significant other(s) in the treatment process to enhance the strength of the intervention. In recognition of the importance of self-help groups (Humphreys et al., 1997; Kaskutas et al., 2002; and Tonigan, 2001) and social network support (Longabaugh et al., 1993; and Longabaugh et al., 1998) CBI included modules that focused on facilitating the client's use of these natural and instrumental support groups.

The CBI intervention encompassed up to 16 sessions over a 4-month period beginning with 3 sessions of MI, including personalized normative feedback about the client's drinking. Clients and therapists then completed a functional analysis based on the *New Roads* program to identify specific client needs that were being met by drinking (ie: relaxation, mood elevation, etc.) including different ways to address them. Following a functional analysis the client and the

counselor developed a collaborative treatment plan based on a number of options in the *New Roads* session content. These options included content focusing directly on managing drinking (craving, coping with high-risk situations) and sessions addressing a more extensive variety of skills such as job searches, and assertion skill training. The CBI treatment concluded with a session focused on building efficacy for maintaining changes that had been accomplished. Generally, CBI was intended to be a treatment that began with efforts to engage and motivate drinkers, transitioning into specific skills-building modules to facilitate abstinence, with concurrent support to attend mutual support groups and involve concerned others in treatment.

Since the empirical evidence supports both approaches, CBI and MET as effective, these examples are not intended to demonstrate the value of one approach over the other. Instead, they show that there is a genuine difference between using a pure MI approach and one that incorporates elements of other treatments, particularly within a research protocol. *It is worth noting that there is some evidence to indicate that implementing a mandatory treatment plan will reduce client commitment language in MI sessions for drug users who remain ambivalent about changing ([Miller et al., 2003] and [Amrhein et al., 2003]). Clinicians would be wise, then, to weigh the potential benefit of having a treatment plan to "work on" with clients against the cost of lowered change talk and increased resistance that may accrue.*

Abstinence as a Mandatory Treatment Goal

Another problem in weaving MI into CBI was the mandatory focus on abstinence from alcohol as the only appropriate outcome of treatment. In itself, abstinence as a treatment goal is not unable to coexist with MI, however when clients do not support the goal of abstinence it puts the clinician at odds with the client.

This dilemma is one that is common to many treatment settings where abstinence is the only acceptable treatment goal. To address the impasse therapists may encourage clients to try moderation strategies, or refer clients to other clinicians who promote moderate drinking strategies. The way clients are counseled about this is significant. An MI-consistent approach argues for supporting the client's right to choose their own treatment goals, even as the clinician expresses concern and may decline to participate. This option, not available in the CBI research, was another point of poor fit in using MI in a standardized substance abuse treatment protocol.

Conclusions of the Study

Combining MI with other therapeutic interventions requires frequent on-the-fly decisions on the part of the therapist about which elements of the mixture will be used at any given time. Previous combinations of MI and other treatments have sometimes overlooked the way in which these treatments can contradict each other and can therefore force clinicians to make choices that cannot be derived from the treatments themselves. This can occur, for example, when a therapist must come to an agreement with a client about a target behavior for a

cognitive behavioral change plan and yet simultaneously support client autonomy in not making a commitment to change before being ready to do so. Which of these competing goals becomes the priority will depend on the therapist's theoretical perspective and beliefs about how people change. When choice points such as this occur, the therapist must be clear about what guiding principles will be most important if the treatments are not harmonious. Alternatively, decision rules could be identified and priorities established that would allow therapists to proceed with confidence without having to reconsider a theoretical perspective at each choice point. For example, a client could be gently encouraged to proceed with behavior change despite ambivalence (leaning toward a cognitive behavioral approach) or to define ambivalence about change itself as the focus of the therapeutic session (leaning more toward a traditional MI approach). Defining decision rules for predictable choice points in blended treatments would have the advantage of facilitating replication as these hybrids are evaluated and disseminated, and would facilitate fluency and confidence on the part of therapists using them. Finding the boundary where MI and other treatments are compatible, or are not, is likely to become an even more interesting clinical question as plans go forward to blend MI with psychoanalytic, existential, and behavioral treatment approaches. The COMBINE Research Project has broken ground by showing that MI can be successfully combined with other treatment approaches and that the resulting intervention is not always seamless.

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