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Intensive Motivational Interviewing for women with concurrent alcohol problems and methamphetamine dependence

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ABSTRACT

Motivational interviewing (MI) for the treatment of alcohol and drug problems is typically conducted over 1 to 3 sessions. The current work evaluates an intensive 9-session version of MI (Intensive MI) compared to a standard single MI session (Standard MI) using 163 methamphetamine (MA) dependent individuals. The primary purpose of this paper is to report the unexpected finding that women with co-occurring alcohol problems in the Intensive MI condition reduced the severity of their alcohol problems significantly more than women in the Standard MI condition at the 6-month follow-up. Stronger perceived alliance with the therapist was inversely associated with alcohol problem severity scores. Findings indicate that Intensive MI is a beneficial treatment for alcohol problems among women with MA dependence.

1. Introduction

Motivational Interviewing (MI) is a brief counseling intervention that was originally designed to increase motivation for change in problem drinkers (Miller, 1983, 1985). The intervention uses a client-centered, directive approach that emphasizes collaboration between the client and therapist. A variety of supportive techniques are used such as simple and amplified reflections, open questions, summary statements, and affirmations (Miller & Rollnick, 2012). Techniques also include directive interventions such as developing discrepancies between drinking and personal goals, providing feedback, and developing a change plan.

Meta-analyses of treatment studies have shown MI to be effective for alcohol use disorders (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Miller & Rollnick, 2012). Further, MI has been shown to be effective in several different contexts. For example, studies have shown MI to be effective both as a stand-alone treatment for alcohol problems (Heather, Rollnick, Bell, & Richmond, 1996; Project MATCH Research Group, 1997; Sellman, Sullivan, Dore, Adamson, & MacEwan, 2001) and also as a preparation for more intensive treatment (Bien, Miller, & Boroughs, 1993; Brown & Miller, 1993).

Many of the early studies supporting the effectiveness of MI were based on the treatment of problem drinkers, or individuals with less severe levels of alcohol dependence. In addition, most of these studies included participants who did not have serious co-occurring drug or mental health problems. For example, Project MATCH Research Group (1997), a large national study of alcohol dependence, excluded individuals with unstable housing and co-existing drug dependencies. However, these are precisely the types of individuals that addiction treatment practitioners are likely to encounter in publicly funded treatment programs. More recent reviews of the MI literature for individuals with substance abuse and comorbid psychiatric conditions found MI to be highly effective at establishing a therapeutic alliance (Kelly, Daley, & Douaihy, 2012) and found that multiple sessions of MI can be effective at reducing substance use (Cleary, Hunt, Matheson, Siegfried, & Walter, 2008; Cleary, Hunt, Matheson, & Walter, 2009).

Studies of standard MI for illicit drug addiction have found MI to be more effective than weak comparison conditions but equivalent to stronger, active comparison conditions (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Additionally, many of the drug studies examined MI as preparation for more intensive treatment (Burke et al., 2003) and outcomes for these studies have been mixed. While a number of reviews and meta-analyses have concluded standard low-dose MI is effective as a preparation for more intensive drug treatment (Burke et al., 2003; Dunn, Deroo, & Rivara, 2002; Hettema et al., 2005), several other studies contradict these findings by not finding significant effects (Donovan, Rosengren, Downey, Cox, & Sloan, 2001; Miller, Yahne, & Tonigan, 2003; Mullins, Suarez, Ondersma, & Page, 2004; Schneider, Casey, & Kohn, 2000; Winhusen et al., 2008). As noted by Carroll and colleagues (Carroll et al., 2002), most of these studies used relatively large samples and rigorous, well-controlled study designs.

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1.1. Development of intensive motivational interviewing

Surprisingly few papers have been written on modifying MI to address the needs of special populations such as those with comorbidities or a prolonged substance abuse history. Intensive Motivational Interviewing (Galloway, Polcin, Kielstein, Brown, & Mendelson, 2007; Polcin, Galloway, Palmer, & Mains, 2004) was conceptualized primarily as a way to assist clients with illicit drug disorders who might benefit from a larger dose of MI. One goal was to provide 9 MI sessions over 9 weeks to first mobilize and then maintain motivation. We reasoned that ongoing mobilization of motivation to achieve and maintain abstinence would result in better outcomes. Recent research by Korcha, Polcin, Bond, Lapp, & Galloway (2011) has borne this out by showing motivation to maintain abstinence over 18 months is associated with better outcomes. We also posited that the client change plan should not be a static process that is completed after one or two sessions. Rather, clients' change plans should be reassessed and modified based on achievement of goals, need for different approaches to achieving goals, or formulation of new goals. Additionally, research has shown that approximately three months of residential treatment is needed to maximize efficacy of substance abuse treatment (National Institute on Drug Abuse, 1999). The 9 sessions of Intensive MI is long enough to facilitate the transition into the third month of treatment, the critical point of maximizing treatment effect.

The pilot testing of Intensive MI involved recruitment of 30 methamphetamine (MA) dependent individuals who received the 9-session intervention as a stand-alone treatment. Pilot study participants receiving Intensive MI showed statistically significant and clinically meaningful within-group reductions of self-reported MA use as well as decreases in MA-positive urine samples (Galloway et al., 2007).

These promising findings resulted in implementation of a randomized clinical trial. Individuals with MA dependence were randomly assigned to a Standard MI intervention (Martino et al., 2006) with an attention control activity to achieve time equivalence for the Intensive MI intervention. Findings support significant increases in the percent days abstinent from MA between baseline and the 2-month follow-up and these improvements were maintained at the 6-month follow-up. Overall, comparisons did not show significant differences between standard and intensive MI.

Among our sample of MA dependent participants, a majority (75%) also reported some level of problem with alcohol. The current paper examines outcomes for alcohol problem severity among men and women in both study conditions. It was hypothesized that men and women assigned to Intensive MI would have a lower severity of alcohol problems at the 6-month follow-up than men and women assigned to Standard MI. In addition, we sought to explore how measures of the therapeutic alliance were associated with alcohol severity outcomes for men and women.

2. Methods and materials

Participants were randomly assigned to either a single 90-minute session of MI (Standard MI) or nine 50-minute sessions of Intensive MI provided weekly. Individuals in both study conditions took part in outpatient group sessions consisting of cognitive behavioral interventions that emphasized craving identification and management (Galloway et al., 2000; Stalcup, Christian, Stalcup, Brown, & Galloway, 2006).

Group sessions took place 3 times a week for up to 12 weeks. To achieve equivalence in the two study conditions the standard MI participants also attended 8 education classes on nutrition. Two trained MI therapists treated clients in both study conditions. Brief research interviews were conducted weekly during the first 9 weeks. More extensive interviews were conducted at 2, 4, and 6 months after the baseline assessment. The research study provided 12 weeks of outpatient treatment at no cost to the participants, payment of $30 for the baseline interview, $10 each week during the first 9 weeks of study participation, and $50 at the 2-, 4-, and 6-month interviews. Follow-up rates were excellent, with over 90% completing interviews at each follow-up time point. Table 1 provides study protocols for each study condition.

2.1. Recruitment

Study participants were recruited onsite at a Northern California outpatient substance abuse treatment facility and by advertisement in local newspapers, community bulletin boards, and online postings. Study procedures were described by a research associate and interested participants were asked to sign an informed consent before beginning the baseline interview. To maximize generalizability of findings, few inclusion and exclusion criteria were implemented: participation in the study required that participants be 18 years or older, meet past 12 month DSM-IV criteria for methamphetamine dependence, have the ability to speak and read English, be able to give informed consent, and likely to be living in the area in the next 6 months. Individuals were screened by the outpatient treatment facility staff for serious medical or psychiatric problems that would exclude them from study participation and referrals were made accordingly. Individuals with psychiatric conditions that could be managed on an outpatient basis were referred to mental health services while they participated in the study. Once assessed as meeting criteria for participation, individuals signed an informed consent for the study, completed a baseline interview and scheduled their first MI session. All study procedures were approved by the Public Health Institute Institutional Review Board.

2.2. Randomization

Randomization to either the Standard MI or Intensive MI occurred prior to the first MI session. Participants were assigned to a condition using stratified permuted blocks to ensure that gender and MA severity were balanced in both conditions. MA severity was determined by past 30 day use at the baseline interview, operationalized as 10 or more days of MA use vs. less than 10 days of MA use.

2.3. Intensive MI (Polcin, Brown, & Galloway, 2010)

Participants randomized to the Intensive MI condition met with a therapist weekly over a 9-week period (Table 1). The first three sessions were taken from MI-based manuals used by National Institute on Drug Abuse Clinical Trials Network studies (Ball et al., 2007; Winhusen et al., 2008). The first session focused on problem identification, feedback, and reasons for seeking treatment while the

Table 1
Standard MI and Intensive MI study protocols.

	Standard MI	Intensive MI
Baseline intake	X	X
Week 1	One 90-minute session of MI Outpatient treatment begins	One 50-minute session of MI Outpatient treatment begins
Weeks 2–9	8 weekly 60-minute nutrition sessions	8 weekly 50-minute MI sessions
Week 12	Outpatient treatment ends	Outpatient treatment ends
2-Month follow-up interview	X	X
4-Month follow-up interview	X	X
6-Month follow-up interview	X	X

Note: X denotes research interviews.