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"Effectiveness of Combination with Motivational Interviewing and Integrated with Cognitive Behavioral Therapy on Clinical and Functional Outcomes in Substance Use: A Systematic Review and Meta-Analysis"

Running title: MI+CBT combo improves substance use outcomes

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MICBT group had a considerably reduced positive syndrome scale score at 12 months compared to the control group (MD, -0.82; 95% CI, -3.31: 1.67, I^2= 52%). As compared to the control group, the MICBT group had reduced AUDIT at 12 months (MD, -1.79; 95% CI, 3.39: -0.20, I^2= 55%). Relapse rates were comparable in the MICBT and control groups (RR, 0.97; 95% CI, 0.66: 1.44, I^2 = 50%).
Conclusion: Relapse rates, general functioning, and negative symptoms did not vary significantly across groups, indicating that MICBT may be especially useful for treating positive symptoms and alcohol-related issues.
Keywords: Motivational Interviewing; Cognitive Behavioral Therapy; Clinical; Functional; Substance Use

Eficacia de la combinación de la Entrevista Motivacional integrada con la Terapia Cognitivo-Conductual sobre los resultados clínicos y funcionales en el consumo de sustancias: una revisión sistemática y metaanálisis.

Abstract:

Introduction: Cognitive behavioral therapy (CBT) and motivational interviewing (MI) are two common psychosocial therapies for substance use disorders (SUDs).
Objectives: We aimed to synthesize the efficacy of in combination MI with CBT for the treatment of drug abuse.
Methods: A systematic review and meta-analysis were carried out using the PRISMA standards. From the beginning of PubMed until January 2026, searches were conducted using the Cochrane Library, Scopus, and Web of Science. The results included the identification test for alcohol use disorders, relapse rate, global evaluation of functioning scale score, and syndrome scale score.
Results:

How to Cite This Article

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Introducción: La terapia cognitivo-conductual (TCC) y la entrevista motivacional (EM) son dos de las intervenciones psicosociales más utilizadas para el tratamiento de los trastornos por consumo de sustancias (TCS).
Objetivos: Sintetizar la evidencia disponible sobre la eficacia de la combinación de la entrevista motivacional con la terapia cognitivo-conductual (EM-TCC) en el tratamiento del abuso de sustancias.
Métodos: Se realizó una revisión sistemática y un metaanálisis siguiendo las directrices PRISMA. Las búsquedas se llevaron a cabo desde el inicio de las bases de datos hasta enero de 2026 en PubMed, Cochrane Library, Scopus y Web of Science. Los resultados evaluados incluyeron la puntuación de la Prueba de Identificación de Trastornos por Consumo de Alcohol (AUDIT), la tasa de recaída, la puntuación de la Escala de Evaluación Global del Funcionamiento (GAF) y la puntuación de la escala de síndromes.
Resultados: El grupo EM-TCC presentó una puntuación significativamente menor en la escala de síntomas positivos a los 12 meses en comparación con el grupo control (DM = -0,82; IC del 95%: -3,31 a 1,67; I^2 = 52%). Asimismo, el grupo EM-TCC mostró una reducción en la puntuación AUDIT a los 12 meses en comparación con el grupo control (DM = -1,79; IC del 95%: -3,39 a -0,20; I^2 = 55%). Las tasas de recaída fueron comparables entre los grupos EM-TCC y control (RR = 0,97; IC del 95%: 0,66 a 1,44; I^2 = 50%).
Conclusión: Las tasas de recaída, el funcionamiento global y los síntomas negativos no mostraron diferencias significativas entre los grupos. Estos hallazgos sugieren que la combinación de entrevista motivacional y terapia cognitivo-conductual puede ser especialmente útil para reducir los síntomas positivos y los problemas relacionados con el consumo de alcohol.
Palabras clave: Entrevista Motivacional; Terapia Cognitivo-Conductual; Resultados Clínicos; Resultados Funcionales; Consumo de Sustancias.

Introduction

Addiction treatment is essential for physicians, behavioral health professionals, and other social service providers (McGinty & Daumit, 2020). Addiction issues' global prevalence and the resulting suffering would suffice as justification. Worldwide, substance use disorders (SUDs) are the most prevalent preventable cause of mortality (Kassaw et al., 2026). An overdose is responsible for over 30% of these fatalities, which are more than 70% opioid related. Unfortunately, these conditions are frequently overlooked and untreated, despite their high prevalence, disabling nature, and high mortality rate (Abdel Moneam et al., 2023).

Psychosocial therapies continue to be a key component of evidence-based therapy for SUDs despite advancements in pharmaceutical treatments, especially in light of the chronic, relapsing nature of addiction and the intricate interactions between cognitive, emotional, behavioral, and social aspects that maintain drug use (Jhanjee, 2014). Cognitive behavioral therapy (CBT) and motivational interviewing (MI) are two of the most researched and widely utilized therapeutic treatments for substance-related behaviors (Barrett et al., 2025).

MI is one of the most widely used and widely popular evidence-based procedures. MI, a collaborative communication technique, enhances the client's ability to modify their problematic behaviors by increasing internal motivation. Furthermore, MI underscores the importance of a therapeutic alliance that precisely identifies the client's ambivalence or significant values, thereby enhancing the client's autonomy for behavioral modification (Kang & Kim, 2021).

The primary factor that induces a specific behavior is internal motivation, while external motivation is a component of motivation (Gerber et al., 2025). MI is a clinical intervention that is intended to improve the motivation of clients who are undergoing treatment. Feedback, accountability, guidance, a portfolio of tactics, empathy, self-efficacy (FRAMES), discrepancy awareness, a decision-balancing exercise, and ongoing monitoring are all components of MI for the prevention of excessive drinking. These elements are crucial for the modification of clients' problem-drinking behaviors. However, it is imperative to evaluate the context and the process of behavior change, as MI emphasizes the thinking and processes of clients in addition to therapeutic engagement (Pinto e Silva et al., 2022).

In contrast, CBT is rooted in cognitive and learning theories that conceptualize substance use as a learned behavior maintained by maladaptive cognitions, conditioned responses, and reinforcement contingencies. CBT posits that dysfunctional thought patterns—such as expectancies about substance effects, low self-efficacy, and rigid beliefs about coping—interact with environmental triggers to perpetuate substance use. The fundamental objective of CBT is to assist individuals in recognizing, challenging, and modifying these maladaptive cognitive beliefs, all while acquiring practical behavioral skills to manage cravings, avoid high-risk situations, and manage stressors without the need for substance use (Cavusoglu, 2024).

Across a broad spectrum of substance use disorders, such as alcohol, narcotics, stimulants, and cannabis, cognitive behavioral therapy (CBT) has exhibited considerable efficacy. Its structured, skills-based nature makes it well suited for relapse prevention and long-term behavior change. Unlike MI, which primarily targets motivation and engagement, CBT assumes a baseline level of readiness for change and focuses on equipping individuals with tools to maintain abstinence or controlled use over time (Asif et al., 2023).

The purpose of this meta-analysis was to determine effectiveness of combination with MI and integrated with CBT on clinical and functional outcomes in substance use.

Development of the topic:

Our systematic review was conducted in accordance with the criteria established by PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses). Systematic reviews and meta-analyses were implemented to incorporate all randomized controlled trials (RCTs) published between the commencement of the inquiry and February 2026.

Relapse rate, global assessment of functioning scale score, syndrome scale score, and alcohol use disorders identification test were the outcome measures.

Search Strategy and Study Selection

("motivational interviewing" OR "motivational enhancement therapy") AND ("cognitive behavioral therapy" OR "cognitive-behavioural therapy" OR "CBT" OR "cognitive behavioural treatment") AND ("substance-related disorders" OR "substance use disorder" OR "substance abuse" OR "alcohol use")

Inclusion Criteria: For the research to be considered for inclusion, the following criteria were satisfied: 1. Studies that included patients with a diagnosed substance use disorder were included. 2. Studies evaluated CBT and/or MI as primary or standalone interventions. 4. Studies that have been published in the English language.

Exclusion Criteria: 1. Not reporting outcomes. 2. Lacking clearly defined outcomes on substance use. 3. Studies using animals or in vitro models. 4. Letters, case reports, case series, qualitative studies, narrative reviews, commentaries, or editorials that lack original data.

Risk of bias

The Cochrane risk-of-bias instrument (RoB2-2) was used to evaluate the quality of the included studies for RCTs. The procedure is relatively novel and is used to assess trial bias. This evaluation pertains to five domains or levels. These areas may be subject to bias as a result of the randomization procedure, the treatments themselves, the assessment of the outcome, any lacking data related to the outcome, or the reported result. For each area, we classified bias as "low risk of bias," "some concerns," or "high risk of bias" based on its presence. If a study satisfied the criteria in all five areas, we consider it to have a low risk of bias. Nevertheless, the research was determined to have a high risk of bias if even a single domain exhibited symptoms of bias or if more than one domain raised concerns. No domain was determined to be at a high risk, despite the fact that all domains were evaluated as having "some concern" studies if this finding was present. In order to ascertain the

eligibility of studies for inclusion, two authors conducted separate analyses. In the event that they were unable to reach a consensus, they sought the assistance of a third author.

Statistical analysis

Review Manager 5.4 (RevMan) was implemented to execute the aggregated analysis. The Cochrane Collaboration (2020), Version 5.4. For dichotomous variables, the Mantel-Haenszel (M-H) technique was employed to calculate the aggregate risk ratio (RR), whereas the RRs of individual studies were computed for continuous variables. We computed the weighted mean difference (WMD) for aggregated analysis and the mean difference (MD) for individual studies that employed continuous variables using the inverse variance approach. A confidence interval of 95% was implemented to calculate each statistical variable. Using the I^2 test, heterogeneity was investigated. When I^2 exceeded 50%, heterogeneity was detected using the M-H or inverse variance random-effects model. The fixed-effects model was implemented when the I2 value was less than 50%, underscoring the homogeneity of the data. Following the determination that the specific outcome was associated with a high risk of bias in the studies, a sensitivity analysis was implemented. We considered a p-value of less than 0.05 to be indicative of significance.

Results:

A search of a digital database yielded 1494 documents. We selected 935 items for title and abstract filtering after identifying 559 duplicates. In addition, 884 documents were excluded due to their failure to satisfy our inclusion criteria. We thoroughly examined the whole texts of 51 documents. We found 5 papers that fulfilled our inclusion criteria for analysis after applying a comprehensive examination to the texts. **Figure 1**

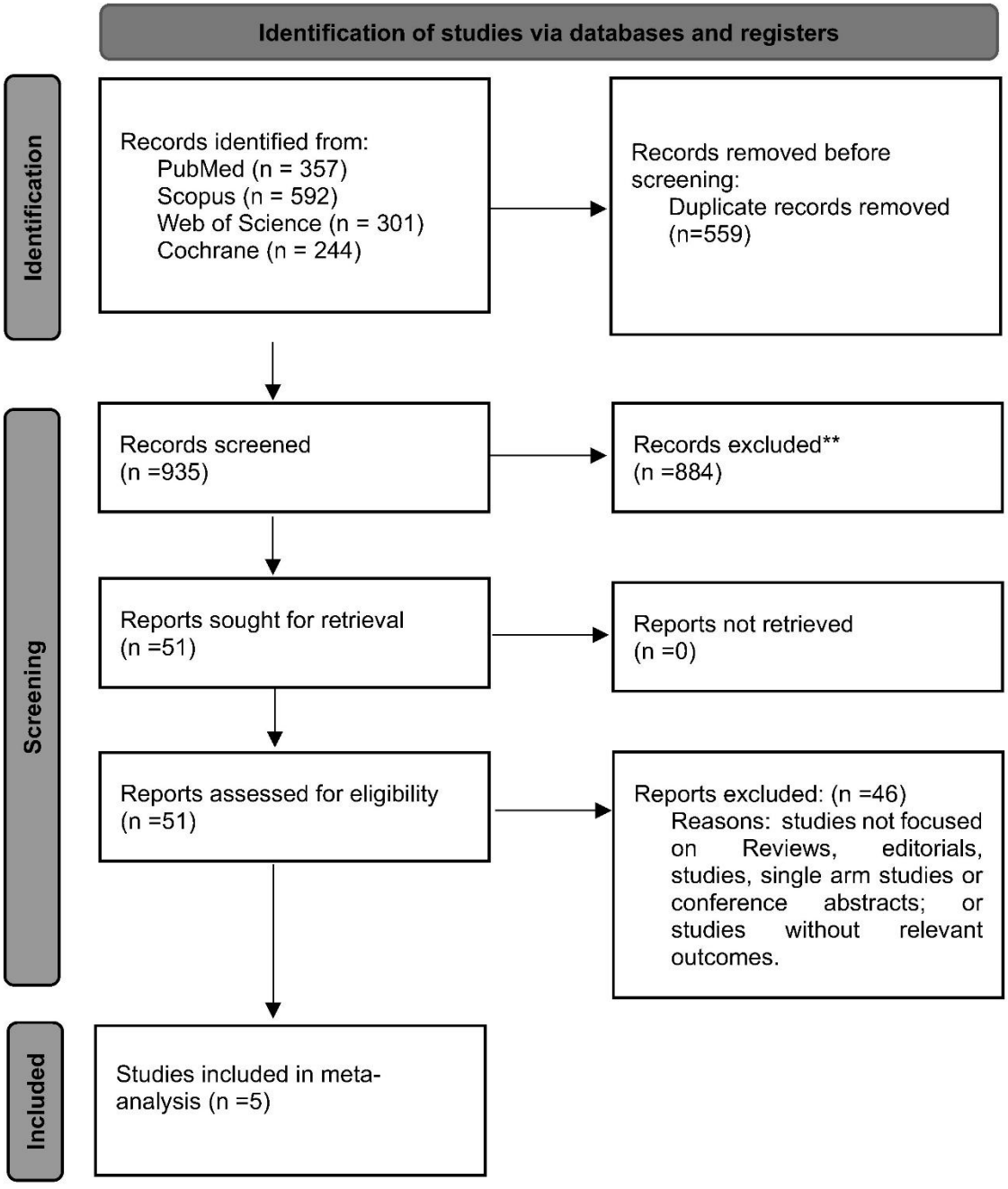


Figure 1: PRISMA flow diagram of searching process and screening

The characteristics of the studies included in the analysis are summarized in Table 1. In terms of age and sex, no statistically significant difference was observed in the four trials **(Barrowclough et al., 2010; Hides et al., 2011; Madhombiro et al., 2020; Na et al., 2015)** that were included.

Table 1: Characteristics of included studies in the meta-analysis

Study	Study design	MICBT group	Control group	Age				Sex (n)			
				MICBT		Control		MICBT		Control	
				Mean	SD	Mean	SD	M	F	M	F
Barrowclough et al. 2001(Barrowclough et al., 2001)	RCT	18	18	31.1 ±9.69				M=33, F=3			
Barrowclough et al. 2010 (Barrowclough et al., 2010)	Blind RCT	164	163	38.3	10	37.4	9.4	137	26	146	18
Hides et al. 2011(Hides et al., 2011)	Not mentioned	60	28	19.1	1.4	19.5	2	34	26	21	7
Zhong et al. 2015 (Na et al., 2015)	RCT	90	90	38.07	8.34	39.39	9.31	68	22	73	17
Madhombiro et al. 2020 (Madhombiro et al., 2020)	RCT	108	126	43.6	9.4	43	9.3	91	17	93	33

RCT: Randomized controlled trial, M: Male, F: Female. MICBT: Motivational interviewing and cognitive behavioural therapy.

Risk of bias

The risk of biases in individual investigations has been illustrated in **Table 1 in Supplementary file and Figure 2.**

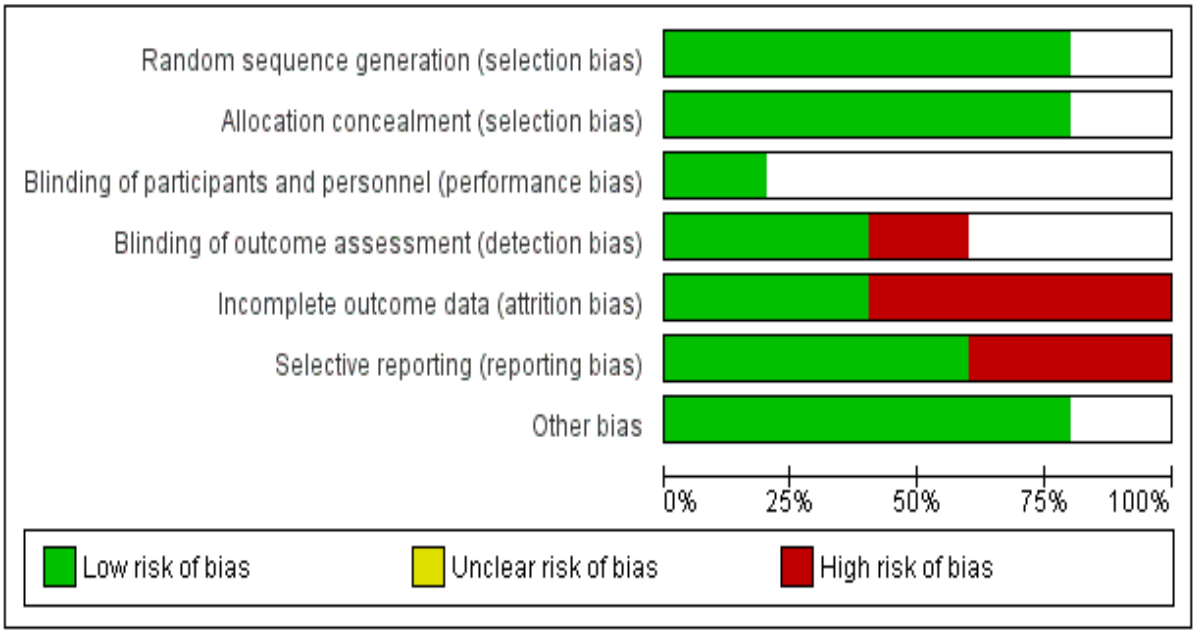


Figure 2: Risk of bias assessment using RoB 2 tool

Clinical Outcomes

Positive syndrome scale score

Positive syndrome scale score at baseline was insignificantly different between MICBT and control (MD, -0.05; 95% CI, -1.15: 1.05, I^2= 0%), based on the findings from two studies (Barrowclough et al., 2001; Barrowclough et al., 2010). Positive syndrome scale score at 12 months was significantly lower in MICBT than control (MD, -0.82; 95% CI, -3.31: 1.67, I^2= 52%), based on the findings from two studies (Barrowclough et al., 2001; Barrowclough et al., 2010).

Figure 3
Negative syndrome scale score
Negative syndrome scale score at baseline was insignificantly different between MICBT and control (MD, 0.81; 95% CI, -0.08: 1.70, I^2= 35%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010). Negative syndrome scale score at 12 months was insignificantly different between MICBT and control (MD, 0.23; 95% CI, -0.77: 1.23, I^2= 29%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010).

Figure 3
Total positive and negative syndrome scale score
Total positive and negative syndrome scale at baseline was insignificantly different between MICBT and control (MD, 2.11; 95% CI, -0.72: 4.93, I^2= 0%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010). Total positive and negative syndrome scale at 12 months was insignificantly different between MICBT and control (MD, -0.3; 95% CI, -8.51: 7.91, I^2= 56%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010).

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Figure 3

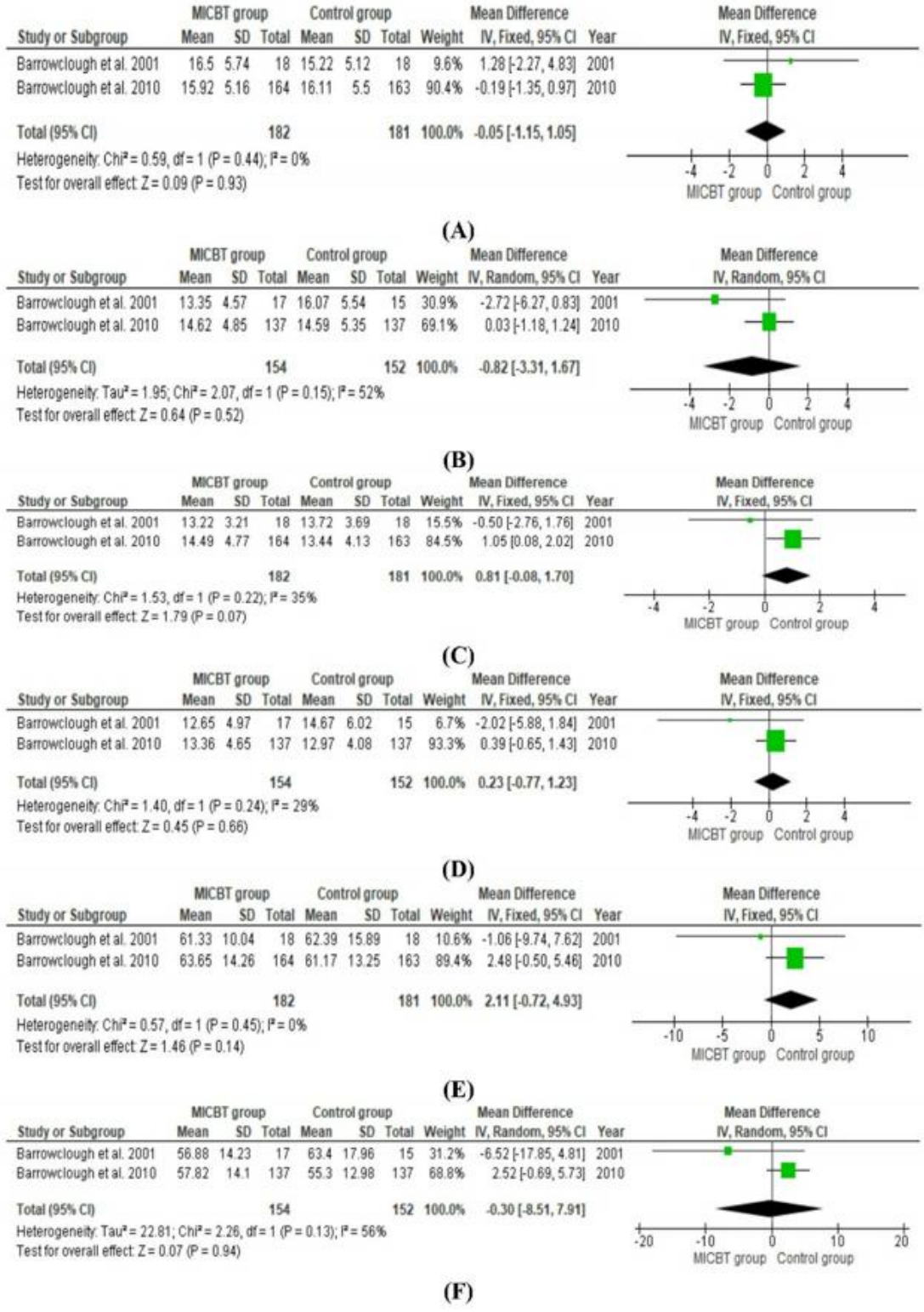


Figure 3: Forest plot of positive syndrome scale score of MICBT versus control. (A): at baseline, (B): at 12 months. Forest plot of negative syndrome scale score of MICBT versus control. (C): at baseline, (D): at 12 months. Forest plot of total positive and negative syndrome scale of MICBT versus control. (E): at baseline, (F): at 12 months.

Functional Outcomes

Global assessment of functioning scale score

Global assessment of functioning scale at baseline was insignificantly different between MICBT and control (MD, -1.54; 95% CI, -3.44: 0.36, I^2= 0%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010). Global assessment of functioning scale at 12 months was insignificantly different between MICBT and control (MD, 3.67; 95% CI, -6.79: 14.14, I^2= 77%), according to two studies (Barrowclough et al., 2001; Barrowclough et al., 2010). **Figure 4**

Relapse rate

In three studies (Barrowclough et al., 2001; Barrowclough et al., 2010; Na et al., 2015), relapse rate was insignificantly different between MICBT and control (RR, 0.97; 95% CI, 0.66: 1.44, I^2= 50%). **Figure 4**

Alcohol use disorders identification test (AUDIT)

In two studies **(Hides et al., 2011; Madhombiro et al., 2020)**, AUDIT at baseline was insignificantly different between MICBT group and control group (MD, -1.18; 95% CI, -3.57: 1.21, I^2= 86%). In two studies **(Hides et al., 2011; Madhombiro et al., 2020)**, AUDIT at 6 months was significantly lower between MICBT and control (MD, -1.79; 95% CI, -3.39: -0.20, I^2=55%).

Figure 4

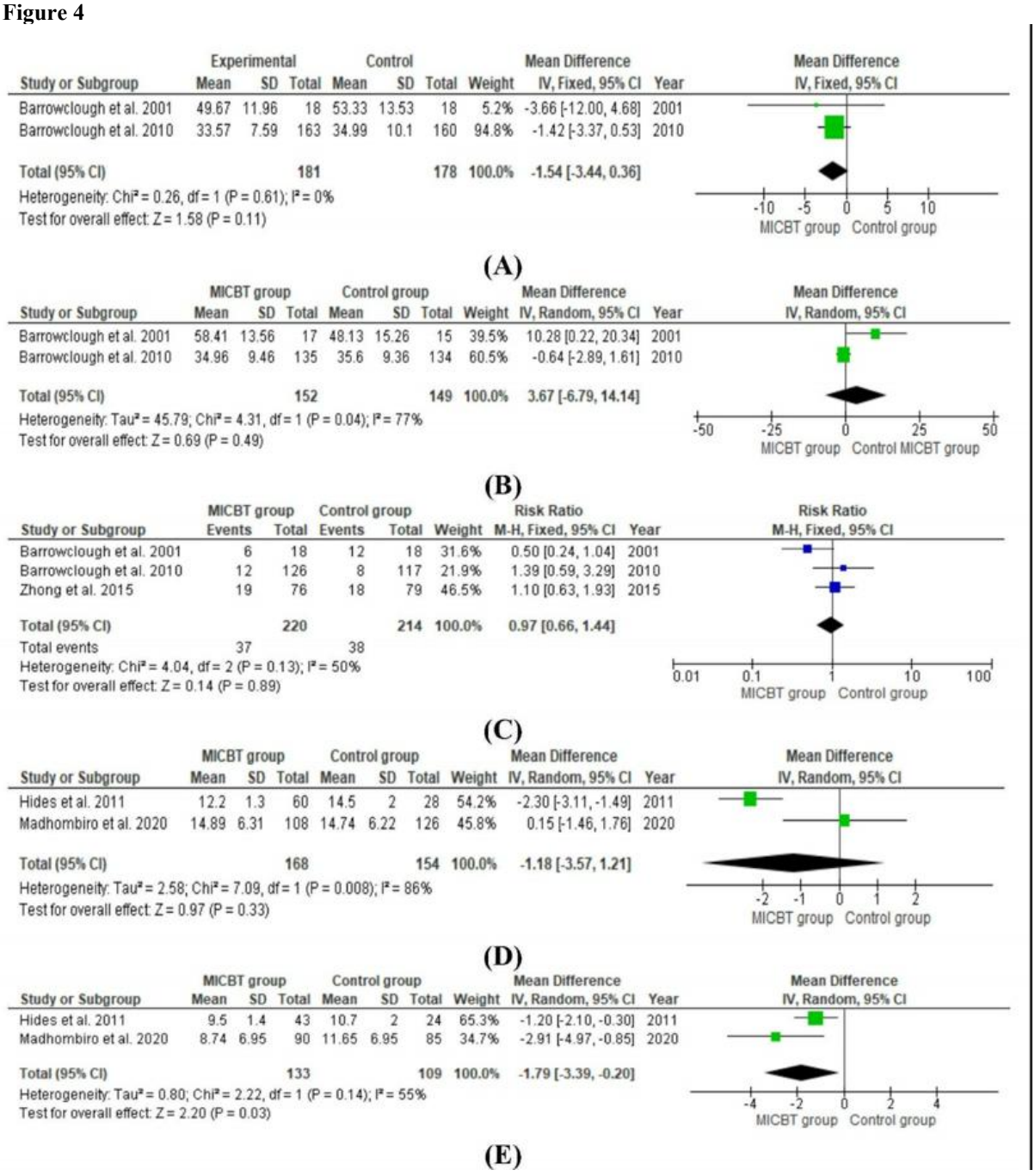


Figure 4: Forest plot of global assessment of functioning scale of MICBT versus control. (A): at baseline, (B): at 12 months, (C) Forest plot of relapse rate of MICBT versus control. Forest plot of AUDIT of MICBT versus control. (D): at baseline, (E): at 6 months

Discussion

MI and CBT are well-established treatments for substance use disorders, targeting motivation and maladaptive behaviours respectively. Combining both approaches (MICBT) may enhance treatment effectiveness by integrating motivational enhancement with relapse prevention skills. The purpose of this systematic review and meta-analysis was to compare the efficacy of MICBT on substance use outcomes and relapse prevention with control group.

Positive syndrome scale score was insignificantly different score at baseline between both groups (MD, -0.05; 95% CI, -1.15: 1.05, I2= 0%) and was significantly lower at 12 months in MICBT than control (MD, -0.82; 95% CI, -3.31: 1.67, I^2= 52%). Barrowclough et al. (Barrowclough et al., 2001) reported findings similar to our meta-analysis, supporting a potential benefit of MICBT, whereas Barrowclough et al. (Barrowclough et al., 2010) showed an opposite trend. Differences in intervention components, sample characteristics, and follow-up conditions may account for this variation.

In terms of baseline or 12-month ratings on the negative syndrome scale or the combined positive and negative syndrome scale, there was no significant difference between the two groups.

Barrowclough et al. (Barrowclough et al., 2010) reported results consistent with the overall pooled findings, showing no significant advantage of MICBT on negative or total PANSS scores. In contrast, Barrowclough et al. (Barrowclough et al., 2001) demonstrated an opposite trend, which may indicate variability related to differences in sample characteristics, illness chronicity, substance use severity, or intervention structure.

Global assessment of functioning scale score was insignificantly different at baseline and 12 months between both groups (MD, -1.54 and 3.67; 95% CI, -6.79: 14.14 and -3.44 to 0.36, I^2= 0% and 77% respectively). Barrowclough et al. (Barrowclough et al., 2010) reported findings consistent with the pooled results, showing no clear functional advantage of MICBT over control. In contrast, Barrowclough et al. (Barrowclough et al., 2001) demonstrated an opposite trend, which likely contributed to the high heterogeneity at follow-up.

AUDIT was insignificantly different score at baseline between both groups (MD, -1.18; 95% CI, -3.57: 1.21, I2= 86%) and was significantly lower after 6 months in MICBT group than control group (MD, -1.79; 95% CI, -3.39: -0.20, I^2=55%). Madhombiro et al. (Madhombiro et al., 2020) is similar to our results. In contrast, Hides et al. (Hides et al., 2011) showed insignificant differences at 6 months between both groups. Changes in the characteristics of the study population (such as disease stage or substance use severity), variations in the control group's customary care, the intensity and duration of the intervention, the size and statistical power of the sample, and so forth may all be contributing factors to this disparity. Evidence of moderate heterogeneity and inconsistent effect estimates across trials is consistent with methodological and clinical heterogeneity.

The relapse rate was not substantially different between the MICBT group and the control group (RR, 0.97; 95% CI, 0.66: 1.44, I^2= 50%). This result is comparable to that of to Barrowclough et al. (Barrowclough et al., 2010) and Zhong et al. (Na et al., 2015) while in Barrowclough et al. (Barrowclough et al., 2001) study, two-thirds of the patients who received routine psychiatric care experienced a relapse within 12 months. Furthermore, there is some evidence that these patients escalated their substance abuse, as well as a decrease in their overall functioning and an increase in positive schizophrenia symptoms. Consequently, there is some evidence that our patient group was indicative of other patients who had comorbid schizophrenia and substance use disorders.

Limitations

Despite the important insights generated, several areas warrant further investigation. Researchers should prioritize large-scale, multicenter RCTs with standardized outcome measures in their future research. Many of the trials that were included were centered on the short- to medium-term outcomes. Future trials should incorporate intersectional variables such as socioeconomic status, justice system involvement, parenting responsibilities, and exposure to physical or sexual abuse.

Conclusion

MICBT group showed significant reductions at 12 months in positive symptoms and AUDIT compared with the control group. Significant differences were not observed between groups in negative symptoms, overall functioning, or relapse rates, suggesting that MICBT may be particularly effective for managing positive symptoms and alcohol-related problems.

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