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BRIDGING MOTIVATION AND COGNITIVE CHANGE: AN INTEGRATED INTERVENTION FOR SEVERE METHAMPHETAMINE USE DISORDER: A CLINICAL CASE STUDY

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Abstract

An integrated approach combining Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) suggests a flexible framework for addressing cognitive, emotional, and behavioral difficulties associated with stimulant use disorders. Both are effective psychosocial interventions for stimulant use disorders. This case report adds the limited literature on integrated interventions in Pakistani inpatient rehabilitation settings by demonstrating the feasibility of a brief, seven-session approach, initially addressing treatment motivation and subsequently targeting maladaptive cognitions and relapse-related behaviors. The case describes a 28-year-old unmarried male diagnosed with Severe Stimulant Use Disorder (Methamphetamine/ICE; DSM-5-TR; ICD-10-CM: F15.20), presenting with intense cravings, anxiety, anger, and impaired occupational functioning following persistent methamphetamine use. Assessment included behavioral observation, semi-structured clinical interview, baseline assessments, Mental Status Examination (MSE), Drug Use Disorders Identification Test (DUDIT), University of Rhode Island Change Assessment Scale (URICA), and DSM-5-TR checklist. Seven psychotherapy sessions integrated MI and CBT techniques, including double-column, cost-benefit analysis, and triple-column techniques, evidence for and against, affirmations, eliciting change talk, scaling questions, problem-solving, and relapse prevention planning. Outcomes showed a DUDIT reduction from 33 to 12, anxiety from 7/10 to 5/10, anger from 8/10 to 5/10, and cravings from 8/10 to 6/10. URICA indicated progress from contemplation to action. Findings demonstrate the feasibility of this integrated approach.

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1.Theoretical and Research Basis for Treatment

Methamphetamine use disorder (MUD), a chronic and relapsing substance use disorder. The hallmark features of MUD incudes serious psychological, social, occupational, and physical repercussions. Methamphetamine continues to be one of the most widely used illegal stimulants in the world, significantly increasing mortality, impairing functioning, and causing psychiatric illness. Anxiety, depression, irritability, aggression, cognitive impairment, and persistent craving are common symptoms of methamphetamine use disorder, and they all contribute to high relapse rates even after treatment (American Psychiatric Association, 2022). There are presently no widely accepted pharmaceutical treatments that reliably lessen methamphetamine habit or stop relapse, in contrast to opioid use disorder. As a result, cognitive behavioral therapy (CBT), motivational interviewing, and other psychosocial therapies continue to be the first-line treatment for methamphetamine use disorder.

Motivational Enhancement Therapy (MET) is a short, structured, person-centered approach to psychological treatment to build intrinsic motivation and resolution to change. MET draws on motivational interviewing techniques to guide the exploration of the clients' ambivalence around drinking, to highlight problems associated with drinking and to identify reasons for quitting, all without being confrontational or accusative. Instead, the approach utilizes empathy, feedback, reflective listening and approach focused collaboration with the client to enhance self-efficacy and personal accountability (Miller & Rollnick, 2013).

Chen et al. (2023) report on a single-arm pilot trial of Echo-APP, a virtual digital programme of psychotherapy, using motivational techniques, to treat patients with methamphetamine dependence. 47 patients were treated with a single MET session; results showed significant increases in both treatment motivation and motivation to abstain from drugs, as well as significant decreases in craving, as self-reported. This recent, direct evidence (not yet peer reviewed) demonstrates that MET has been used in the treatment of methamphetamine use disorder, but as it did not include a control group and treatment effects were measured immediately pre- and post-treatment, the findings are very preliminary, and do not demonstrate that MET was responsible for the results.

Prabmaroeng et al. (2024) –A 32 inpatient sample with amphetamine use disorder was treated with a multichannel motivational enhancement therapy programme in a quasi-experimental trial. The experimental group had significantly lower scores after treatment (9.75) than before (28.63) and when compared to the control group (17.13). These results are recent clinical evidence for using MET with amphetamine use disorder. However, small sample and quasi-experimental design should hinder the generalization to the general population and the treatment of methamphetamine use disorder should not be assumed from here.

De Giorgi et al. (2018). The systematic review included all randomized controlled trials of psychosocial interventions (e.g. Motivational interviewing, cognitive behavioral interventions and contingency management) in stimulant use disorders. The authors concluded that "a number of psychosocial interventions may be effective in treating stimulant use disorder" but "evidence does not suggest that one psychosocial intervention is clearly superior." The review gives further evidence in support of considering motivational-based strategies as part of individualized stimulant-use treatment.

The combination of MI and CBT provides a clinically oriented approach for engagement/retention and cognitive-behavioral relapse prevention strategies targeting motivation to change behavior and problem-solving specific addictive cognitions respectively. Recent evidence indicates that the efficacy of psychosocial interventions varies depending on the type of intervention and the specific outcomes assessed. Minozzi et al (2024) (Cochrane systematic review) in 64 RCTs (8,241 participants) concluded that psychosocial interventions reduced premature

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Volume 4 • Issue 5 • September 2026

treatment dropout when compared to no intervention or usual treatment, and there was some benefit found for specific abstinence outcomes (though these differed depending on comparisons and follow-up time points). Importantly, few studies described individualized treatment approaches for methamphetamine use disorder (or combining MI and CBT). The clinical description of the processes involved in providing individual treatments remain an important focus for future research. The clinical practice guideline recommends contingency management as the current standard of care for stimulant use disorder and include CBT in the treatment armamentarium that may be provided concurrently. These results support the use of structured and empirically supported psychological treatments but caution the interpretation of individual case outcomes.

The findings are also of relevance to the Pakistan context. A meta-analysis conducted by researchers of Pakistani universities-Shahzadi et al. (2023) of MI and motivational enhancement techniques and CBT for treatment of substance-use disorder found generally supportive evidence for the former but also heterogeneity across the various included studies. In addition, this case study provides a detailed account of the use of MI-based engagement and of CBT-based coping and relapse-prevention strategies within an inpatient rehab setting in Pakistan. While one case cannot determine the effectiveness and generalizability of this approach, it can serve to demonstrate how evidence-based psychological principles and techniques can be tailored to the individual presenting problem and change process of a specific client.

The summary exhibits how integrating motivation and coping skill interventions as similar yet distinct goals during treatment of severe methamphetamine use disorder was valuable for clinical practice. Despite the clinical significance of motivational and cognitive-behavioral approaches in substance use treatment, there remains a need for detailed clinical accounts of their integration within inpatient rehabilitation settings in Pakistan. The present case report discourses this gap by describing a brief seven-session intervention in which motivational interviewing principles were initially used to reinforce treatment engagement, followed by cognitive-behavioral strategies to report substance-related cognitions, emotional triggers, cravings, and relapse risks. Its contribution lies in documenting the practical application of this sequential approach within a Pakistani rehabilitation context.

2. Case Introduction

M.H. was a 28-year-old unmarried male who was admitted to an addiction treatment center after self-referred seeking treatment for methamphetamine (ICE) use. M.H. was the second child of four siblings and had been suffering from symptoms of anxiety, anger, and recurrent urges secondary to substance use for a period of around 8 months. On admission, he followed the center's structured daily routine, which included medication group therapy, and rehabilitation activities. The client received intervention within an inpatient rehabilitation setting in Pakistan. The treatment consisted of seven individual sessions conducted by a trainee clinical psychologist under the supervision of a licensed clinical psychologist. The intervention followed a progressive approach, beginning with motivational interviewing strategies and progressing towards cognitive and behavioral techniques to address substance-related difficulties.

3.Presenting Complaints

M.H. reported experiencing anxiety, anger, and methamphetamine-related cravings for approximately eight months prior to seeking treatment. These concerns were reported in the context of his substance use difficulties and were identified as key targets for therapeutic intervention. At intake, he rated his anger at 8, anxiety at 7, and craving at 6 on a 0–10 scale. In addition to the client's verbal descriptions, subjective ratings of anxiety, anger, and craving

JOURNAL FOR SOCIAL SCIENCE STUDIES
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Volume 4 • Issue 5 • September 2026

were recorded on a 0–10 scale to display the perceived intensity of these experiences. Higher scores denoted greater subjective severity. These ratings were used for clinical checking throughout the intervention and were not considered standardized psychometric measures. Although he had asked for treatment, he was ambivalent about changing his use, which became an important consideration in planning therapy.

4.History

The client belonged to a helpful nuclear family consisting his parents, three sisters, and himself. He specified a close emotional relationship with his mother and elder sister. He described his family environment as stable and supportive, with no informed history of psychiatric illness or substance use disorders among first-degree relatives.

Before matriculation and F.A qualification, the client competed his early education in a Madrassa. The client was an average student in his class but had very good relationships with his teachers and classmates. He also completed an Amazon freelancing course to progress his vocational skills.

Before the beginning of substance use, M.H. worked as a broker in Dubai for approximately one year before returning to Pakistan due to family responsibilities. Then, he worked as an online freelancer and reported satisfaction with his occupation. However, as his methamphetamine use increased, his motivation, productivity, and occupational functioning worsened significantly. The client was unmarried and he was involved in a romantic relationship that ended before his substance use. His elder sister's death in 2020 was a significant life event that contributed to emotional distress and social withdrawal. After he recognized together with peer pressure, the breakup as a major emotional stressor that, lead to the initiation and progression of methamphetamine use.

The client stated initiating ICE (methamphetamine) use in early adulthood following peer pressure and emotional discomfort related to the loss of his romantic relationship. Over approximately eight months, his use progressed from occasional to regular consumption despite significant psychological, social, and occupational consequences. He acknowledged loneliness, interpersonal conflicts, unresolved grief, negative emotions, and association with substance-using peers as the primary triggers for continued use and relapse risk. Before the start of substance use, M.H. was socially active, emotionally stable, and religiously inclined. He regularly recited the Quran, offered prayers, spent time with family and friends, and enjoyed his job of freelancing, online gaming, and playing snooker. When he came to the rehabilitation center, he followed to a structured daily routine involving medication, individual psychotherapy, group therapy, and rehabilitation activities. The substance was used through inhaling, with a typical amount of 1 gram and a frequency of 2-3 times. The client also experienced significant psychosocial stressors, including the death of his sister in 2020 and a relationship breakup, which were explored during the clinical assessment.

5.Assessment

A preliminary clinical interview was conducted utilizing a semi-structured clinical interview, to gather information on the presenting problem, psychosocial history, pattern of substance use, emotional functioning and reasons for treatment. Followed by behavioral observations and mental status exam to gather information on the client's appearance, behavior, mood, thought process, cognitive functioning, insight and judgment. Client appeared well-groomed and neatly dressed, with appropriate personal hygiene, cooperative attitude, maintained eye contact and engaged actively in the process of assessment. Psychomotor activity was increased with frequent fidgeting and shifting of postures. Affect was mildly anxious and congruent with client's reported mood, speech was normal in rate, volume and flow, thought process was logical, coherent and goal-oriented. No delusions, hallucinations, suicidal ideation or homicidal ideation were reported and observed. Attention, concentration and memory functions

JOURNAL FOR SOCIAL SCIENCE STUDIES
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ISSN (Online): 3006-2071 | ISSN (Print): 3006-2063
Volume 4 • Issue 5 • September 2026

were intact. Insight and judgment were assessed as adequate. Client reported negative impact of substance use on his personal and professional life and expressed feeling of guilt.

Clinical interview elicited approximately 8 months of methamphetamine (ICE) use following a broken romantic relationship, and associated with using substance-using friends. The client reported: cravings; anxiety; anger outbursts; work-related impairment; and continued substance use, despite problems it created in his life. The functional analysis identified one main group of triggers for cravings episodes and emotional distress: interpersonal conflict; loneliness; reminders of his former romantic relationship; and surrounding oneself with the substance-using friends.

Standardized Instruments

Four instruments were used to establish readiness for change, severity of drug-related problems, symptom count, and diagnostic status.

University of Rhode Island Change Assessment (URICA)

The URICA measures readiness to change across stages (McConnaughy et al., 1983). M.H. was classified in the contemplation stage, indicating that he recognized a problem but remained undecided about changing his use. This result guided the decision to begin with MI.

Drug Use Disorders Identification Test (DUDIT)

The Drug Use Disorders Identification Test (DUDIT) was developed by Berman et al. (2005) to identify drug-related problems and assess patterns of drug use. This was given to determine the level of drug-related problems experienced by the client and the severity of their drug use. Client's score was 33, which was interpreted as a high level of drug related problems and probably reflects severe drug related impairment. This was considered when determining the severity of the client's substance use in conjunction with the other assessment findings and the clinical interview.

DSM-5-TR Checklist – Stimulant Use Disorder

Stimulant Use Disorder DSM-5-TR Checklist/Criteria for a stimulant use disorder to be present, based upon the diagnostic criteria set forth by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2022), each symptom must be documented. The DSM-5-TR Checklist for Stimulant Use Disorder was utilized to evaluate the diagnostic criteria and/or symptoms for use with a stimulant. The results of the checklist, and the face-to-face clinical interview and behavioral observations, guided the addition of a diagnosis of Severe Stimulant Use Disorder with methamphetamine (ICE; F15.20).

Baseline Clinical Ratings

Alongside the standardized assessment measures, subjective clinical ratings were acquired to monitor the client's perceived levels of anxiety, anger, and craving. Each symptom was graded on a scale ranging from 0 to 10, with higher scores representing greater perceived intensity. These ratings worked as additional indicators of clinical progress rather than independent diagnostic measures. The Drug Use Disorders Identification Test (DUDIT) and University of Rhode Island Change Assessment (URICA) were also administered to assess substance-related difficulties and inclination for behavioral change, respectively.

Summary

Overall assessment in the substance section was clinically significant impairment in cravings, anger, anxiety, and unhelpful coping. Baseline subjective ratings included anger 8/10, anxiety 7/10 and cravings 6/10. Social stressors, feelings of loneliness, cues of being in relationships, and influence of peers seem to have contributed to the onset and maintenance of substance use. The assessment results contributed to the use of a treatment plan that incorporated cognitive behavioral therapy (CBT) and motivational interviewing (MI) in addressing substance use

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An International Peer-Reviewed Open Access Journal

ISSN (Online): 3006-2071 | ISSN (Print): 3006-2063
Volume 4 • Issue 5 • September 2026

behaviors and emotional dysregulation, unhelpful coping strategies, and motivation toward recovery.

6.Case Conceptualization

The formulation used the predisposing, precipitating, perpetuating, and protective (4Ps) framework (Kuyken et al., 2009), summarized in Table 1. M.H.'s unresolved grief and limited strategies for managing anger and anxiety left him vulnerable. The breakup and peer pressure precipitated first use, then it became self-reinforcing: methamphetamine temporarily reduced emotional pain, but guilt, conflict, loneliness, and work problems followed and increased distress, which in turn increased craving and the tug toward using peers (Figure 1). Family support, religious practice, insight, and engagement in rehabilitation were protective.

The conceptualization led to three treatment decisions. First, MI was introduced first because M.H. was contemplative, guilt, and continued to self-medicate, risking dropout and resistance, if we did not assess his reasons for change first. MI's person-centered approach (Rogers, 1951) was appropriate, as this client had retreated after loss and shame, and had yet to take responsibility for his change. Second, CBT came second because, although his maintenance cycle was driven by modifiable forces (triggers, thoughts, and emotions), building skill also requires a committed client. Third, selected techniques fit specific aspects of a cycle rather than offering a generic package: functional analysis and thought records to the ICE trigger and control beliefs, anger education, breathing, and timeout to anger, urge surfing and cue change to craving, assertiveness training and role-play to peer-group pressure, and relapse-prevention mapping for the high-risk state and cue. To promote persistence and overcome resistances, performance confidence was also refined by targeting short, rehearsed successes (Bandura, 1977).

7.Course of Treatment and Assessment Progress

The intervention was carried out in the counseling room of the rehabilitation center where the client was admitted for treatment. To ensure privacy and reduce distractions, sessions were executed by the trainee clinical psychologist individually in a therapeutic environment. The intervention combined MI (Miller & Rollnick, 2013) with CBT (Beck, 2011) in a seven-session individual model. The intervention was delivered over seven individual sessions of 40-45 minutes and followed a mainly sequential MI–CBT structure. Due to a high severity of methamphetamine use and ambivalence to change, the initial sessions focused on motivational enhancement, exploring ambivalence, developing discrepancy, and strengthening commitment to change. Subsequent sessions highlighted cognitive and behavioral strategies, including identification of triggers, cognitive restructuring, emotional regulation, craving management, assertiveness training, and relapse prevention. Although the intervention progressed from MI to CBT, selected motivational strategies, such as affirmations and self-efficacy enhancement, were strengthened during later sessions to maintain engagement.

Sessions 1-2 (Motivational Interviewing) The therapist demonstrated the MI spirit of partnership, evocation, autonomy and compassion. OARS - open-ended questions, affirmations, reflective listening, and summaries - was utilized to explore the client's history of substance use and his concerns about its impact on [health, family, occupation] - and an exercise in decisional balance, along with importance and confidence rulers, was used to explore the client's readiness for change. Change talk - desire, ability, reasons, need and commitment - was selectively reinforced and discrepancies between use and values were explored without creating confrontation.

Sessions 3-4 (Cognitive Component) The client was taught the application of the cognitive model (situations, thoughts, feelings, behaviors, cravings). Functional analysis of personal triggers (e.g., boredom, peers, stress) and automatic thoughts leading to using was also completed. As automatic thoughts and cognitions were identified, discussed, and challenged (e.g., using

JOURNAL FOR SOCIAL SCIENCE STUDIES
An International Peer-Reviewed Open Access Journal

ISSN (Online): 3006-2071 | ISSN (Print): 3006-2063
Volume 4 • Issue 5 • September 2026

Socratic questions, evidence, thought records), equivalents of functional, balanced thoughts were generated.

Sessions 5-6 (Behavioral Component and Relapse Prevention). Behavioral skills taught included craving management, drug refusal assertiveness, scheduling of pleasurable activities and balanced routines, and avoiding or avoiding high-risk settings. Client's homework assignments were given between each sessions and completed tasks were reviewed at the beginning of each session. A relapse prevention plan was designed which consisted of an early warning signs, a plan for handling lapses, and sources of support.

Treatment progression from one to the next was centered on the client's demonstrated understanding and consistent application of previously learned skills rather than a prearranged timeline. New therapeutic techniques were presented only after the client showed sufficient command, active participation, and independent practice of earlier interventions. For the duration of treatment, verbal praise, positive feedback, collaborative reflection, and recognition of progress worked as reinforcement for adaptive coping behaviors and treatment adherence.

The intervention was concluded after seven sessions with mutual agreement between the trainee clinical psychologist and the client. During the final session, all therapeutic techniques were reviewed, relapse prevention strategies were reinforced, and the client exhibited satisfactory understanding of the coping skills acquired throughout treatment. The client showed confidence in independently utilizing these strategies following discharge and accepted increased insight into the psychological, cognitive, and behavioral factors contributing to his substance use.

Treatment and Implementation Outcomes

Overall, the treatment ensued improvements in anger regulation, anxiety management, craving control, self-awareness, assertiveness, and relapse prevention skills. At the time of intake, the client met the criteria for severe methamphetamine use disorder [based on DSM-5 criteria / clinical interview; edit as per your assessment]. The client's total score on the Drug Use Disorders Identification Test (DUDIT) was 33 (range 0–44) at baseline, which falls in the range indicating probable substance dependence (Berman et al., 2005). At post-intervention, the DUDIT total score decreased to between 10 and 12, a reduction of 21 to 23 points, or approximately 64%–70% (Figure 1a). Though the post-intervention score remained above the cut-off for drug-related problems, the magnitude of the decrease indicates a significant reduction in the severity of substance use and its associated consequences.

Readiness for change was assessed using the University of Rhode Island Change Assessment (URICA). At baseline, the client was in the contemplation stage, reflecting ambivalence about changing his substance use. At post-intervention, the client had improved to the maintenance stage, indicating that he was actively working to withstand behavioral change and prevent relapse.

Craving, anger, and anxiety were monitored using self-ratings on a 0–10 scale. Craving decreased from 6 at baseline to 3 at post-intervention (a 50.0% reduction). Anger decreased from 8 to 5 (37.5%), and anxiety decreased from 7 to 5 (28.6%) (Figure 1b). Figure 2 demonstrates the percentage reduction across the DUDIT and the three self-rated domains. The largest reduction was observed in overall substance use severity, followed by craving, anger, and anxiety, respectively.

It is important to note that all outcome measures were based on client self-report and did not include clinician-administered or biological verification (e.g., urine drug screening) [remove if you had these]. The direction of change was nonetheless consistent across the DUDIT, URICA, and self-ratings, which suggests a coherent pattern of improvement rather than change on a single indicator. Furthermore, the client attended all seven scheduled sessions (100% attendance), completed assigned homework tasks, and expressed confidence in using the learned coping skills independently after discharge.

In Figure 2, a decrease can be seen in the client's

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An International Peer-Reviewed Open Access Journal
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Volume 4 • Issue 5 • September 2026

overall symptomatology. In terms of substance use, a clear reduction is observed from baseline to post-intervention on the DUDIT, accompanied by progression in the stage of change. In terms of associated difficulties, craving, anger, and anxiety all decreased following the integrated MI–CBT intervention.

Following the seven-session intervention, improvements were observed in the client's self-reported anxiety, anger, and craving ratings. The DUDIT score also showed a reduction in reported substance-related problems from baseline to post-treatment. Furthermore, the URICA findings proposed a change in the client's readiness for behavioral change. However, these findings should be understood cautiously, as the intervention was conveyed alongside the routine inpatient rehabilitation programme. Therefore, the observed changes cannot be accredited exclusively to the MI–CBT intervention.

Client Prognosis for Continued abstinence is guarded to good, considering that this client's level of desire for change has significantly improved and the reduction in his cravings and improved emotional regulation has allowed him to continue actively engaged in treatment. There is a strong probability that continued abstinence will occur, if he maintains appropriate coping skills, utilizes all the relapse prevention strategies and receives continued psychosocial treatment support; however, because stimulants have a chronic and relapse-prone course, the possibility of re-lapse may exist (McHugh et al., 2010).

8.Complicating Factors

The counseling room was shared, which limited privacy and at times constrained disclosure about the relationship and family conflict. This is a recognized threat to confidentiality (American Psychological Association, 2017). Other complications were the concurrent routine rehabilitation program, which may account for some of the change, and the therapist's trainee status. These simultaneous services may have contributed to the observed clinical improvements. Furthermore, the intervention was carried by a trainee clinical psychologist under supervision, which should be considered when interpreting the therapeutic process and outcomes.

9.Access and Barriers to Care

The client was admitted voluntarily and had family support, which are not typical of all patients. In Pakistan, barriers include stigma around substance use, limited availability of trained psychotherapists, cost, and the lack of continuing outpatient services after discharge. These are especially relevant because return to the same peer group is a major relapse risk. An additional challenge in substance-use recovery alarms continuity of care following release from inpatient rehabilitation. Limited access to reasonable psychological services, social stigma, and insufficient availability of trained mental health professionals may restrict individuals' opportunities to receive consistent outpatient support. These barriers highpoint the importance of developing accessible follow-up services and community-based relapse-prevention support for individuals recovering from substance use disorders.

Limitations

(1) This is a single case, so findings cannot be generalized. (2) Treatment was brief and was not followed up, so the durability of change is unknown. (3) Outcomes depend mainly on self-report and a single therapist's observation, which are open to response and social-desirability bias. (4) Concurrent inpatient treatment cannot be separated from the psychotherapy. (5) Toxicology data were not available to confirm abstinence, and a post-treatment symptom checklist is not reported (Kazdin, 2017).

10.Follow-Up

No formal follow-up data were available when this report was written, so the durability of change is unknown. Follow-up at 1, 3, and 6 months is recommended, reviewing abstinence, craving, emotional state, and use of coping skills, with

JOURNAL FOR SOCIAL SCIENCE STUDIES
An International Peer-Reviewed Open Access Journal

ISSN (Online): 3006-2071 | ISSN (Print): 3006-2063
Volume 4 • Issue 5 • September 2026

repeat DUDIT and URICA. Booster CBT sessions, continued MI, family involvement, and participation in a relapse prevention or self-help program are recommended.

11.Treatments Implications of the Case

This case highpoint the clinical value of integrating Motivational Interviewing (MI) with Cognitive Behavioral Therapy (CBT) to report the interrelated motivational, cognitive, and emotional difficulties linked with severe methamphetamine use disorder. The integration offers a clinically relevant framework for exploring ambivalence toward change while simultaneously targeting maladaptive thought patterns, emotional dysregulation, and craving-related responses. For clinicians working in inpatient rehabilitation settings, this approach may help align treatment strategies with the client's willingness for change and individualized psychological needs. The case also underlines the importance of incorporating emotional and cognitive targets into substance use treatment rather than focusing exclusively on abstinence. Further systematic investigation is warranted to evaluate the feasibility and effectiveness of this integrated approach across diverse rehabilitation settings in Pakistan.

The findings agree with broader evidence that psychosocial treatments help retention and may reduce use and craving, though effects on use itself vary across studies (De Crescenzo et al., 2018).

12.Recommendations to Clinicians and Students

Clinicians working with clients presenting with severe stimulant use disorder should work from an integrated approach directing both substance use related and motivational, emotional, and cognitive processes facilitating ongoing use and relapse. Motivational Interviewing may be helpful in engaging clients with the intervention, exploring ambivalence, and increasing client motivation to change. Cognitive Behavioral Therapy can be helpful to support clients to become aware of dysfunctional thinking patterns and how these might impact affect and behavior, to manage cravings and cravings-related emotional dysregulation, and to apply relapse prevention skills. Clinicians should regularly assess and monitor motivation for change, substance use, cravings, and their associated factors including negative affect and emotional regulation difficulties throughout the intervention process rather than only at baseline. Students and trainee clinical psychologists should be able to deliver evidence-based addiction interventions in a compassionate, non-judgmental stance and adapt the therapeutic response to the stage of change, client's presenting issues and response to intervention. Knowledge of relapse risk factors and supervised clinical practice, documentation, and case formulation are especially important when working with clients with severe stimulant use disorder.

Table 1

Factor	Formulation
Predisposing	Unresolved grief after his elder sister's death; limited adaptive strategies for managing anger and anxiety
Precipitating	Romantic breakup with perceived betrayal; peer pressure to use
Perpetuating	Methamphetamine used to avoid emotional pain; craving; avoidance; poor assertiveness; continued contact with using peers and exposure to stressors, producing a self-reinforcing cycle of use and distress
Protective	Strong family support; religious practice; good insight; active engagement in rehabilitation; high motivation to remain abstinent

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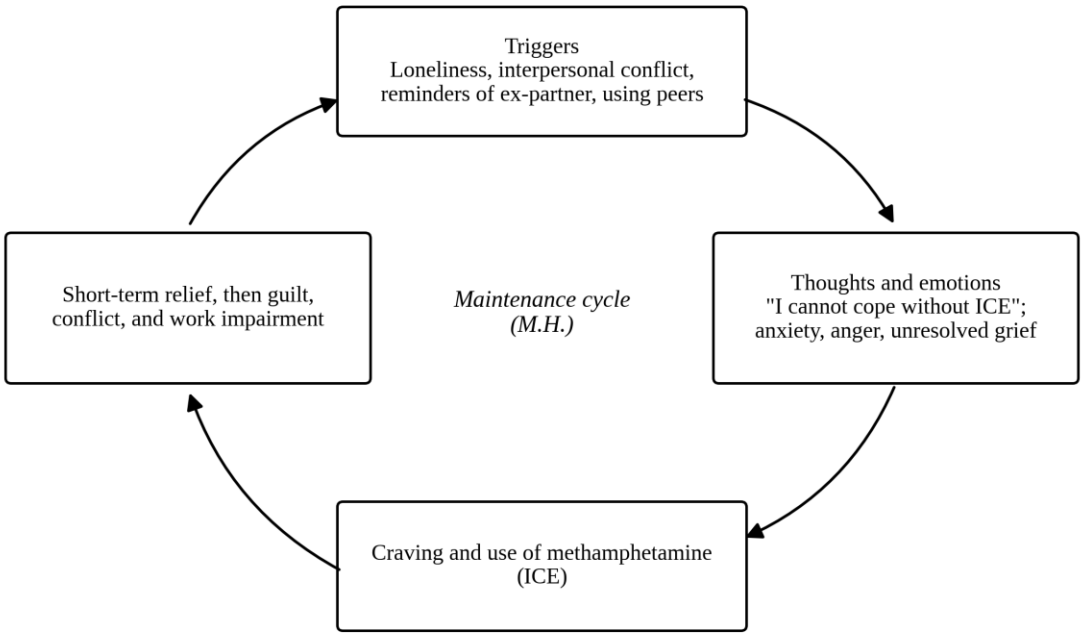
Volume 4 • Issue 5 • September 2026

Figure 1 ***Client-Specific Maintenance Cycle of Methamphetamine Use for M.H.***



Note. Original figure prepared by the authors from the case formulation.

Table 2 ***Treatment plan integrating MI and CBT techniques***

Session	Focus	Techniques	Observed response
1	Rapport, assessment	Active listening, empathy, reflection, validation; confidentiality and goals; URICA and DUDIT intake	Engaged; discussed substance use history openly
2	Ambivalence; awareness of consequences	MI: decisional balance, developing discrepancy, eliciting change talk; CBT psychoeducation (addiction cycle, craving cycle, case formulation, anger iceberg); bibliotheraphy	Recognized costs of ICE use
3	Triggers and thoughts	Functional analysis; daily thought records; triple-column technique, evidence for and against, cost-benefit analysis	Identified emotional and interpersonal triggers; began challenging thoughts independently

JOURNAL FOR SOCIAL SCIENCE STUDIES
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Volume 4 • Issue 5 • September 2026

Session	Focus	Techniques	Observed response
4	Anger and anxiety	Anger psychoeducation; diaphragmatic breathing; timeout and brief walks; Butterfly Hug and grounding	Reported better recognition and regulation of anger
5	Craving	Craving psychoeducation; urge surfing; distraction; contact with family; changing environmental cues; MI self-efficacy and change talk	Used alternative responses to craving
6	Peer pressure	Assertiveness training (passive, aggressive, and assertive styles; DESC model; "I" statements); role-play and reverse role-play of peers offering drugs; MI affirmations	Increased willingness to refuse and communicate needs
7	Relapse prevention	Trigger and high-risk-situation mapping; coping cards; role-play; MI commitment strategies; review of skills; overview of the Twelve-Step model	Expressed commitment to recovery; could describe each skill and when to use it

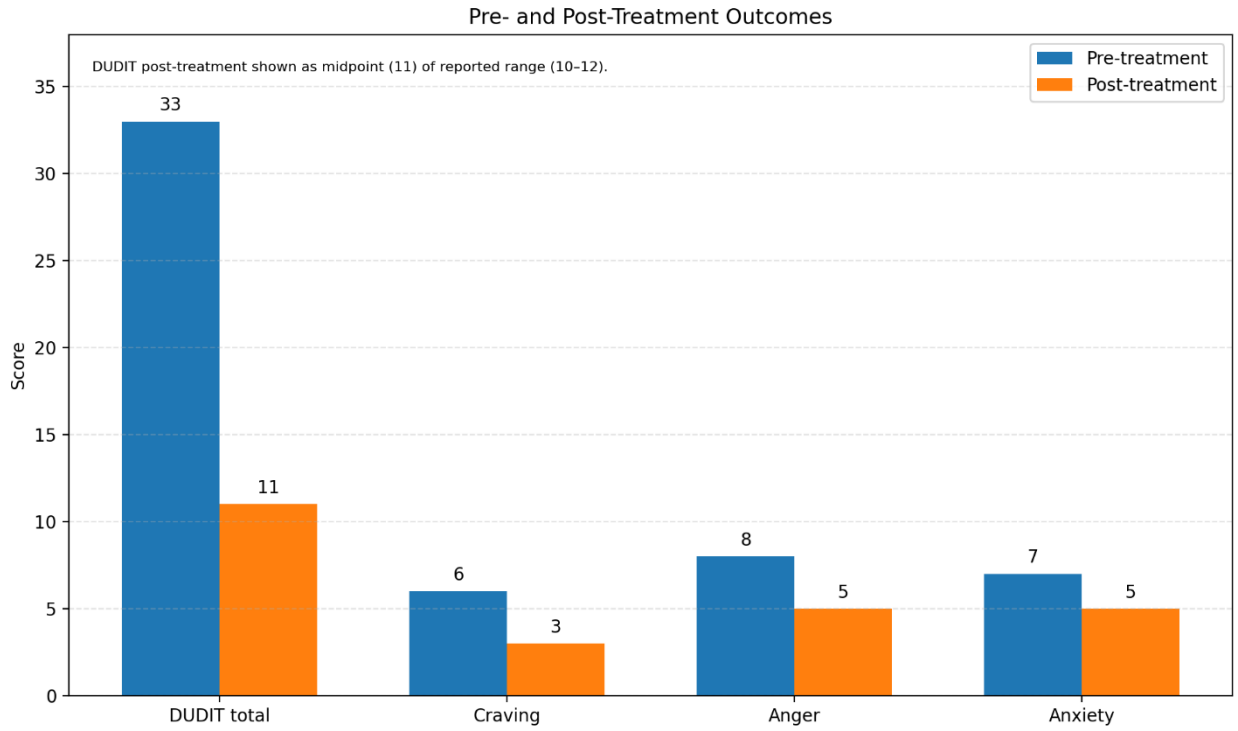
Table 3 ***Pre- and post-treatment outcomes***

Measure	Pre-treatment	Post-treatment	Change
DUDIT total (0–44)	33	10–12	−21 to −23 points
URICA stage of change	Contemplation	Maintenance	Contemplation to maintenance
Craving (self-rating 0–10)	6	3	−3
Anger (self-rating 0–10)	8	5	−3
Anxiety (self-rating 0–10)	7	5	−2
Sessions attended		7 of 7	

JOURNAL FOR SOCIAL SCIENCE STUDIES
An International Peer-Reviewed Open Access Journal

ISSN (Online): 3006-2071 | ISSN (Print): 3006-2063
Volume 4 • Issue 5 • September 2026

Figure 2



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