CHAPTER 1

Integrating Motivational Interviewing and Cognitive-Behavioral Therapy

RATIONALE, APPROACH, AND EVIDENCE

Over the last decade, the field of behavior change has encouraged the integration of different forms of evidence-based treatments by identifying their general factors and shared elements and applying them across multiple behaviors (Abraham & Michie, 2008; Chorpita, Becker, Daleiden, & Hamilton, 2007; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). General factors, sometimes called "common factors," refer to the personal, interpersonal, and other processes that are shared among all psychosocial treatments—for example, therapeutic alliance, empathy, and optimism. These account for much of treatment outcome beyond the specific treatment techniques. "Shared elements" refer to the components of evidence-based clinical practice that are common across distinct treatment protocols—for example, self-monitoring, cognitive restructuring, and refusal skills (Barth et al., 2012).

Scientists have recently advocated for the study of processes that cut across diseases, a paradigm that fits nicely with the shared elements and factors approach to treatment (Bickel & Mueller, 2009; Norton, 2012). By identifying shared elements and relational factors and applying them across different behaviors and symptoms (with specific adaptation for symptom clusters as necessary), we can promote more widespread dissemination of evidence-based treatments and improve the ease of implementation and training. This approach can more easily address common comorbidities and address multiple behavior change. "Transdiagnostic" or "unified" treatments are defined as those that apply the same underlying treatment principles across conditions or behaviors instead of delivering different

specific treatments for different conditions (McEvoy, Nathan, & Norton, 2009). Instead, the protocols are individualized in the treatment planning process. The term "unified" has also been used to refer to unified treatment plans that address mental and physical health such as depression and medication adherence or obesity

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and substance use. We believe the integration of motivational interviewing (MI) and cognitive-behavioral therapy (CBT) can serve as a unified treatment approach to improve mental and physical health, and we have written this book accordingly.

So Why MI?

MI is a collaborative, guiding conversational style used for strengthening a person's own (intrinsic) motivation and commitment for change. After over 30 years of empirical study, MI has proved to be a frontline, evidence-based, successful intervention approach for facilitating positive behavior change, and is increasingly utilized in the areas of substance abuse, mental health, and primary and specialty health care. MI specifies communication behaviors that underlie the relational factors of psychotherapy and thus provides a foundation for client–practitioner communication in multiple settings.

Why CBT?

CBT focuses on changing maladaptive thoughts and behaviors that maintain symptoms and interfere with functioning (Beck, 2011). CBT approaches are some of the most widely disseminated evidence-based treatment elements and they share elements across many diagnoses such as depression, anxiety, substance abuse, attention-deficit/hyperactivity disorder (ADHD), and obesity (Tolin, 2010). CBT is hard work for clients! It requires in-session practice and between-session "homework," work that involves making changes in areas that have been difficult for clients to master in the past. This is why experts (Driessen & Hollon, 2011) say that MI can make CBT work better by specifying strategies to build clients' own motivation to do the hard work, and thereby to help you, as the therapist, avoid being the "bad guy" in this process.

Although CBT has some of the strongest evidence for change in its favor (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), it is also true that many individuals do not respond to treatment, do not adhere to treatment tasks, discontinue treatment prematurely, or, after initial success, are unable to maintain change (LeBeau, Davies, Culver, & Craske, 2013; Naar-King, Earnshaw, & Breckon,

2013). Experts in both CBT and MI have suggested this may be at least in part because some CBT approaches do not specify the skills necessary to support the practitioner's relationship with the client and do not help practitioners strengthen motivation for change at both the onset and during the course of CBT (Driessen & Hollon, 2011; Miller & Moyers, 2015). Thus, integrating MI with CBT may improve both initial response rates and maintenance of change after treatment is completed. MI can make CBT work better!
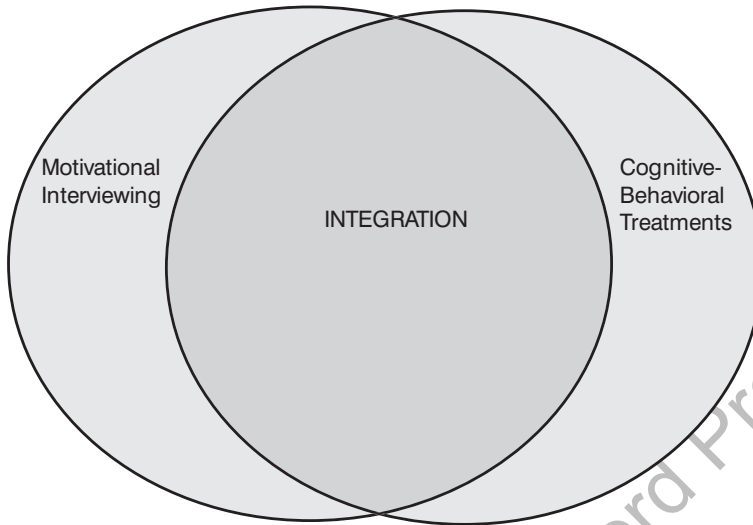
MI–CBT Integration

MI was originally developed to build motivation for *initial* change; MI strategies for enacting and maintaining change have only recently begun to be specified (Miller & Rollnick, 2012). Miller and Rollnick (2002) note that once initial motivation for change has been established, it may be time to move to more action-oriented treatments such as CBT. Thus, incorporating more action-oriented treatments may strengthen the behavior changes that MI has helped to initiate. Yet motivation still fluctuates in strength and direction during enactment and maintenance of change, suggesting that integrating MI with CBT may create a more potent behavioral treatment than either set of strategies alone.

Westra and Arkowitz (2011) discuss several ways in which MI can be combined with CBT. First, MI may be delivered as a brief pretreatment to build motivation for multisession intervention. Second, MI can be used at specific

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moments during CBT when client discord or ambivalence arises. Third, MI can serve as an integrative framework in which other interventions, such as CBT strategies, could be delivered. This book addresses all three approaches using concepts from Miller and Rollnick (2012) that can be applied to different behaviors and concerns. As such, the book can be utilized as the beginning of a transdiagnostic protocol to address various processes of change with both MI and CBT as the underlying core. This book is based on the growing body of research and clinical applications of MI integrated with cognitive-behavioral approaches (including our own ongoing work), and it outlines the clinical skills necessary to deliver this integrated treatment.

We also attempt to delineate where MI–CBT integration is feasible and readily applicable, and where there may be conflicts between the approaches (see Figure 1.1). Moyers and Houck (2011), commenting on one of the only trials using MI as an integrative framework to deliver CBT (Anton et al., 2006), note that MI and CBT are not always a perfect marriage. There are times when the approaches contradict each other and the practitioner must choose which approach will prevail. In these cases, this book will not attempt to choose a side but rather will illustrate

FIGURE 1.1. MI–CBT integration.

your options as discussed in the "MI–CBT Dilemmas" sections at the ends of Chapters 2–8.

What's the Evidence?

Many studies suggest that combining MI with CBT is more effective than usual care in many areas of behavior change such as anxiety (Westra, Arkowitz, & Dozois, 2009), depression with and without comorbid substance use (Riper et al., 2014), cocaine use (McKee et al., 2007); marijuana use (Babor, 2004), smoking cessation (Heckman, Egleston, & Hofmann, 2010), medication adherence (Spoelstra, Schueller, Hilton, & Ridenour, 2015), and weight-related behaviors (Naar-King et al., 2016); however, much less is known about whether either treatment is more effective than a combined treatment approach. The few studies of MI plus CBT compared to MI alone have all targeted substance use and suggest that the combined treatment is often, but not always, more effective than MI alone (Moyers & Houck, 2011). In one meta-analysis (Hettema, Steele, & Miller, 2005), the effect of MI was stronger and lasted longer when combined with another active treatment than when used by itself. Some published trials compared a few sessions of MI as a pretreatment to CBT with CBT alone and found that adding MI improved outcomes for alcohol consumption (Connors, Walitzer, & Dermen, 2002), cocaine use (Stotts, Schmitz, Rhoades, & Grabowski, 2001), generalized anxiety disorder (Westra et al., 2009; Westra & Dozois, 2006), and child behavior problems (Nock

& Kazdin, 2005). To date there are no studies that have compared CBT alone with an integrated MI and CBT approach (i.e., where MI is not just a pretreatment but is integrated throughout treatment). However, two qualitative studies showed that high-empathy counselors were more effective than low-empathy counselors when both provided behavior therapy for alcohol use (Miller, Taylor, & West, 1980; Valle, 1981). In a more recent qualitative study comparing client's perceptions of CBT therapists with more positive and less positive outcomes, clients experienced CBT therapists with more positive outcomes as being more evocative and collaborative, engaging client's expertise, and having more active participation in the treatment process (Kertes, Westra, & Aviram, 2009). As you will see below, these therapists were demonstrating the MI spirit.

To date, studies of transdiagnostic or unified treatments have typically focused on emotional disorders such as the different anxiety diagnoses and depression, often CBT-based with MI as a pretreatment to increase engagement (Folkman, 2011). A review of such studies (McEvoy et al., 2009) suggested that unified treatments are associated with symptom improvement compared to wait-list controls. The unified treatments reviewed typically included CBT elements such as psychoeducation, cognitive restructuring, coping skills, exposure, relaxation training, and behavioral activation. Unified treatments appeared to have similar effect sizes as diagnosis-specific treatments, and there was some evidence to suggest that unified treatments targeting one set of concerns had positive impacts on comorbid conditions or other areas of behavior change. At the time of the McEvoy et al. (2009) review, there were no studies directly comparing a unified treatment to diagnosis-specific treatments. However, a more recent study (Norton, 2012) compared a transdiagnostic group CBT for anxiety disorders (including psychoeducation, self-monitoring, cognitive restructuring, and exposure) to relaxation training and found equivalent effects, though the unified treatment had lower drop-out rates. Unified treatments for co-occurring substance abuse and affective disorders are emerging (Osilla, Hepner, Muñoz, Woo, & Watkins, 2009). This book expands the field of unified, transdiagnostic treatments beyond mental health to substance abuse and health behaviors. It does so by providing an approach to integrating MI, as the foundation for relational factors, with CBT's shared elements. These can be used across different areas of behavior change and symptom remission to improve mental and physical health.

The Spirit of MI

MI is not just a compendium of techniques; it is a style of interacting with people. As such, the foundation of MI is its spirit. According to Miller and Rollnick (2012), the MI spirit consists of four interrelated elements: (1) partnership, (2) acceptance, (3) compassion, and (4) evocation (PACE). *Partnership* is a collaborative, guiding

relationship with you and the client side by side instead of one in front of the other. *Acceptance* involves autonomy support by which you emphasize respect for the person's self-determination and freedom of choice. Acceptance also includes expressing accurate empathy and supporting self-efficacy with an inherent appreciation for the person's worth and an affirming stance. *Compassion* is a dedication to promoting the welfare of others, but is distinct from personal feelings of sympathy or personalization of the experience. *Evocation* is the idea that the client has inherent wisdom and strength for change that you draw out instead of a missing ingredient that you must provide as in CBT approaches.

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MI as Four Processes

In addition to the above four elements, MI is organized in terms of four processes: (1) engaging, (2) focusing, (3) evoking, and (4) planning. These elements are meant to be overlapping and not necessarily sequential. All four processes may be present in each session; later we will discuss how all four processes are present in different components of CBT when you work within an integrated MI–CBT approach. The processes are helpful for organizing your thinking about a session.

Engaging is the process of developing rapport with the client and understanding of the client's dilemma. Why is or isn't the person considering change and what is getting in the way? Engaging is the process of establishing the working relationship, the therapeutic alliance. While a strong working alliance is the foundation of any intervention approach and is consistently discussed in the CBT literature, the practitioner communication behaviors necessary to promote alliance and address ruptures in alliance are rarely specified. MI specifies these behaviors.

Focusing is the process by which a practitioner and a client become clear on the direction and goal of the conversation. Often the direction and associated goals are about changing behaviors, but not necessarily so. The focus may be about a choice (e.g., forgiveness, a job change) or about an internal process (e.g., tolerance, acceptance). The process of focusing is more than agenda setting or treatment planning, with a list of goals or tasks. It is the collaborative process of determining the scope of the conversation, which can include goals and tasks as well as thoughts, feelings, and concerns.

Evoking is the process of drawing out the client's own words about change so that the client him- or herself argues for change instead of the practitioner doing it for the client. In the evoking process, you build intrinsic motivation to change the target behavior/concern of focus. In MI, this is done by eliciting and verbally reinforcing change talk with the kind of reflections and affirmations described below. Change is driven by a person's own desire, ability, reasons, or need to change as opposed to those of somebody else. This is central to MI and particularly relevant

for CBT. Typically, the provider often presents the rationale for treatment components, presents reasons for why particular skills or relevant homework is important, and/or tries to underscore the negative consequences of current thoughts and behaviors. Yet, most people are more likely to believe what they say themselves compared to what someone else tells them.

Evocation may run counter to the natural instinct to "help" clients by correcting what you construe as flawed reasoning or poor decision making or by imparting unsolicited advice. Miller and Rollnick (2002, 2012) describe this phenomenon as the *righting reflex*, the human tendency to correct things that are perceived as wrong. This tendency often translates into premature problem solving and advice giving, which prevents clients from being actively involved in their own treatment process and leads to other forms of disengagement (e.g., emergence of language against change, avoidance of homework assignments). This is a dilemma for CBT practitioners because education about a mental health problem followed by skills training are typically the key elements of treatment. Motivation for change is a function of how important change is to the client and his or her confidence about making the change. MI skills address both of these components of motivation, and MI skills support the client's own motivation for change even when the provider is sharing relevant information or skills training.

If ambivalence is the balancing between change and the status quo, the *planning* process occurs when the balance begins to tip toward change. The conversation naturally turns to statements about a possible commitment to change and options for a plan of action. Miller and Rollnick (2012) subsume the process of implementing change plans and enacting and maintaining change (the targets of CBT elements) within the planning process.

A Brief Overview of Core MI Skills

MI uses a set of core communication skills, in the spirit of MI, to promote the four processes described above. These skills are asking open questions, affirming, making reflective statements, summarizing, and informing and advising. Reflective statements and open questions are the core skills necessary for MI–CBT integration. We will show you how to use them in different ways for different purposes. Reflective statements are used to communicate accurate empathy and to test your hypotheses about how the client experiences the world. Offering reflections involves stating to the person what you heard, possibly adding an emphasis or meaning. Reflections are also used to reinforce or emphasize components of the conversation for strategic purposes (e.g., to explore ambivalence, to strengthen motivation). Reflective statements can also be affirming because they are reflections of what the person said that emphasize his or her strengths or efforts. You can also use a string of reflections to summarize what the client has said. The string

can tie together earlier points, can emphasize the transition from ambivalence to change, and can be used to transition to different components of the session.

While a significant amount of communication can occur from reflective statements alone, open questions can continue to evoke the person's views, concerns, and motivations. In MI, you facilitate conversation with open-ended questions and deemphasize closed-ended questions that elicit a single-word response. Questions and reflections can also be used to provide information and advice in an MI style. In later chapters, you will see how the sequence "ask–tell–ask–reflect" serves this purpose. First, you ask for permission to provide information and elicit the person's interest and knowledge about the topic. Second, you provide information or advice in small, digestible bits. Third, you elicit the client's reaction and reflect the response. This gives you a snapshot of how MI specifies what you say, how you say it, and when you say it. The remaining chapters will show you how to use these communication skills to make CBT work better.

How This Book Is Structured

This guide focuses on the shared elements of the most widely researched CBT approaches such as initiating treatment, assessment and treatment planning, self-monitoring, cognitive and behavioral skills training, promoting homework completion, and maintaining change. A chapter is dedicated to each treatment element, and we present each element in terms of the four MI processes. We do not expect this book to replace MI texts, and consequently MI skills are not presented in as full detail as they would be in an MI-only text. Rather, we refer to MI skills in terms of their integration with CBT; you can refer to MI texts to supplement this information. We utilize examples across multiple behaviors and diagnoses including internalizing symptoms, substance use, and health behaviors. The chapters include activities for your own professional development or for training others (see Activity 1.1 at the end of this chapter). A final chapter reviews future directions including training issues. To demonstrate the unified approach of MI–CBT integration, we intersperse throughout case examples with a range of different target behaviors or problems such as depression, obesity, anxiety, substance abuse, and medication adherence.

MI was never intended to be a comprehensive psychotherapy (Miller & Rollnick, 2009), but rather an approach to behavior change. Yet studies suggest that MI seems to provide a strong foundation for addressing the therapeutic alliance and motivation in the context of other treatments such as CBT. Thus, we support the assertion that MI is not merely a tool for facilitating behavior change but rather has implications for informing psychotherapy in general in the following ways (Miller, 2012). MI emphasizes the belief in the capacity for human growth and change. MI puts the person's choice and decision at the forefront of the therapy

encounter. MI promotes acceptance and compassion for ambivalence. Finally, MI supports careful attention to the language of the practitioner and the client, specifying the general relational factors of psychotherapy. As such, MI may be a trellis that supports psychotherapy intervention delivery (Haddock et al., 2012). By integrating MI with the most commonly shared elements of CBT, we use a transdiagnostic approach and advance the implementation of evidence-based practice. Our hope is to reduce the burden on practitioners. Rather than sifting through multiple manuals and sitting through multiple trainings, you may take core factors and elements as specified by MI–CBT integration and promote their application across conditions and settings.

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MI–CBT Integration Card Sort

Integration can take a number of different forms. Treatment integration involves looking beyond the boundaries of single-school approaches to see what can be learned from the theories and techniques of other perspectives (Strickler, 2011). *Technical integration* is when you integrate techniques from different approaches, while *theoretical integration* refers to the process of bringing together concepts from different approaches that may differ in fundamental ways. *Assimilative integration* is a more recent concept that allows you to maintain a solid grounding in one theoretical worldview while incorporating strategies from other approaches. We believe this book could be applicable to your choice of integration.

ACTIVITY GOAL: This activity asks you to consider the theoretical and technical components of MI and CBT and decide the approach to integration that will work best for you as you utilize this guide.

ACTIVITY INSTRUCTIONS: In the table below, place an X over the words you consider to be descriptors of MI, an O over those you consider to be descriptors of CBT, and an X and an O over those for MI–CBT. When you've finished, answer the questions that follow. This activity may also be done as a card sort: copy and cut out each box in the table. Sort MI-only descriptors into one pile, CBT-only descriptors into another pile, and MI–CBT descriptors into a third pile.

Collaborative	Providing feedback	Agenda setting	Problem solving	Therapeutic alliance
Evoking motivation	Asking permission	Exposure	Case formulation	Providing rationales
Triggers	Empathy	Goal oriented	Assessment	Autonomy
Psycho-education	Identifying triggers	Functional analysis	Identifying distorted cognitions	Eliciting feedback

Reflective listening	Making plans for change	Skills training	Identifying antecedents and consequences	Personal growth and responsibility
Homework	Addressing discord	Treatment planning	Reinforcing change language	Eliciting the client's perspective
Menu of options	Guiding	Self-monitoring	Assessment	Outcome oriented
Increasing activities and mastery	Nonjudgmental	Hypothesis testing	Noticing positive emotions	Socratic questioning

Consider the following questions:

1. Where are the natural overlaps between MI and CBT (boxes with X's *and* O's) ___

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    _____

2. Where MI and CBT don't overlap, are these theoretical concepts or techniques and strategies? _____

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    _____

3. Where can you creatively integrate the theoretical concepts? _____

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    _____

4. If the concepts do not seem like they can be integrated, how might this affect your use of the strategies? This issue will be important later when you might need to make choices between MI and CBT strategies because integration does not seem feasible. _____

    _____

    _____

    _____