Setting the Stage for the Integration of Motivational Interviewing With Cognitive Behavioral Therapy in the Treatment of Depression

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Unipolar depression is one of the most disabling and costly medical illnesses in the world (Lancet Global Mental Health Group et al., 2007; Moussavi et al., 2007). Cognitive behavioral therapy (CBT), a widely studied and taught psychotherapeutic treatment for depression, is among the recommended evidence-based treatments. Although CBT and other treatments are largely effective, many depressed individuals do not fully respond to treatment, leaving them vulnerable for relapse and poor outcomes over the lifespan. This article explores the integration of Motivational Interviewing (MI) as one possible strategy of enhancing CBT outcomes. MI provides an evidence-based approach to addressing motivation for treatment and emphasizing key therapist-client interactional factors that have been linked to clinical outcomes. As such, it may be synergistic with specific aspects of CBT, such as enhancing therapeutic alliance, motivation, and specifically addressing ambivalence/resistance affecting treatment engagement, retention and adherence to various aspects of the treatment (such as homework). For clinicians learning CBT, MI may also provide a specified model for learning basic psychotherapeutic skills such as empathy, collaboration, and client-centered active listening. Given the urgency of improving the potency of depression treatments, the extent to which the blending of a MI with CBT will improve the overall effectiveness is worthy of clinical research.

Over the past several decades, much has been learned about the nature and treatment of depression. Two large-scale World Health Organization reports now document the worldwide medical disability associated with depression, making improved detection and treatment a global public health priority (Lancet Global Mental Health Group et al., 2007; Moussavi et al., 2007). Progress has also been made in development and study of treatments that are largely effective for unipolar depression. Persons appropriately treated for depression have shorter periods of illness, are less likely to relapse, and have longer periods of inter-depression wellness than those who are not treated, or who are undertreated (Frank et al., 1990; Segal, Williams, & Teasdale, 2002). Both psychotherapy and medication treatment for unipolar depression have received empirical support and have been adopted as part of best practice guideline care (American Psychiatric Association [APA], 2000; see also Hollon, Thase, & Markowitz, 2002, for a review). Cognitive behavioral therapy (CBT) is one of the most widely studied, disseminated, and taught manualized psychotherapies for depression. Despite its documented efficacy in producing depression remission, large numbers of persons treated with CBT do not engage in, commit to, and/or fully respond to treatment (APA, 2000; DeRubeis et al., 2005; Miranda et al., 2003).

This article explores the potential usefulness of one strategy that may enhance CBT outcomes for depression in order to stimulate clinical research and enhancement of psychotherapist training models. Specifically, Motivational Interviewing (MI), an evidence-based approach to improving client engagement and adherence, decreasing resistance, enhancing motivation, and improving specific behavior change targets will be presented as potentially synergistic with CBT in improving overall depression outcomes. Here, synergy is conceptualized as “cooperative action” between two treatments. In their recent chapter, Arkowitz and Burke (2008) outlined MI as an integrative framework that may be used throughout the course of CBT for depression. Specifically, MI can be synergistically blended throughout CBT to enhance motivation, reduce resistance and resolve ambivalence about any aspect of the treatment (such as engagement, adherence, and/or any behavior change associated with depression recovery; Arkowitz & Burke; Arkowitz & Westra, 2004). This conceptualization is similar to that used in the COMBINE study (Miller, 2004), in which the Combined Behavioral Intervention (CBI) integrated several evidence-based elements for the treatment of alcohol use disorders, including MI and cognitive-behavioral skill training (as well as family and social/community involvement, self-help groups, and individualized treatment approach). In that study, treatment integration was also conceptualized as use of an MI...
therapeutic style throughout all phases of the CBI. Psychotherapy integration has been broadly defined elsewhere as “various attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives...characterized by an openness to various ways of integrating diverse theories and techniques” (Arkowitz, 1997, p. 228). Integration of MI with CBT implies that CBT therapists will blend fundamental skills of MI (such as addressing motivation and ambivalence, rolling with resistance, expressing empathy, collaboration, and supporting autonomy) throughout the therapy (Arkowitz & Burke; Arkowitz & Westra).

Although many forms of depression psychotherapy address behavior change (e.g., behavior activation, communication behaviors) with varying degrees of emphasis, the extent to which the merging of evidence-based interventions that specifically target health behaviors (such as MI) will improve depression treatment effectiveness has not been sufficiently investigated. At the same time, research on understanding how to address depression with MI is at an early stage (Arkowitz, Westra, Miller, & Rollnick, 2008). CBT provides a well-developed and studied depression-specific treatment that may be integrated with MI in order to broaden the applicability of MI for depression treatment, pointing to the potential for true synergy between the two interventions.

**Brief Overview of MI and CBT**

**MI**

MI has been defined most prominently by Miller and Rollnick (2002) as a “client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (p. 25). Not intended to be a distinct form of psychotherapy per se, MI may be best understood as a “way of being with people” that was originally developed to help people to change a particular target behavior, and to be integrated with other treatment and intervention approaches. The four key principles of MI are (a) express empathy, (b) develop discrepancy, (c) roll with resistance, and (d) support self-efficacy (Miller & Rollnick, 2002). Recent research suggests that the mechanisms of action of MI include therapist skill on both the relational component (empathy and “MI Spirit”—defined as Collaboration, Evocation, and Respect for Autonomy) and the technical component of MI (evoking high levels of client articulation of commitment to change, known as “change talk”; Moyers & Martin, 2006; Moyers, Miller, & Hendrickson, 2005).

MI has been studied extensively and has been found to be efficacious in improving adherence to and effectiveness of subsequent forms of treatment (Burke, Arkowitz, & Menchola, 2003). There has been considerable research on the efficacy of MI as a treatment-engagement intervention for substance abuse and other behavioral and health issues (see reviews by Burke et al.; Hettema, Steele & Miller, 2005; Noonan & Moyers, 1997). Importantly, however, MI requires less time and resources than other treatments, suggesting it has specific practical utility as an exportable intervention, amenable to integration. MI has similarly been shown to be efficacious as a stand-alone intervention for a number of health behavior domains, including substance use, HIV risk behaviors, obesity, smoking, probation and parole behaviors, treatment and medication compliance, and nutritional behaviors (Hettema et al.). Based on available research and clinical observation to date, it appears that MI is particularly effective for individuals who are ambivalent or resistant to a specific behavior change, and may be less effective for individuals who are clearly committed to behavior change (Hettema et al.). More recently, clinicians and researchers have become interested in adaptation and integration of MI for the treatment of psychiatric disorders such as depression and anxiety (Arkowitz et al., 2008).

**CBT**

A cognitive conceptualization of emotional disorders was first described by Aaron T. Beck in the 1960s and resulted in the formulation of cognitive therapy (CT; Beck, Rush, & Shaw, 1979). In its original and basic form, CT focused on changing negative views and related behavior regarding the self, the world, and the future. CT has since been broadened, emphasizing behavioral theoretical and intervention components, to become more widely known as CBT. Based on a 2000 review, CBT has been shown to be effective in improving outcomes in close to 300 clinical research studies for a variety of disorders, including depression (Butler & Beck, 2000). Although the practice of CBT may be quite varied in content, the basic CBT model emphasizes the interplay between events, thoughts, behavior, and mood. Key methods of CBT have been summarized in a recent learning guide by Wright, Basco, and Thase (2006) and include: a problem oriented focus, individualized case conceptualizations, collaborative empiricism, Socratic questioning, use of structuring, psychoeducation and rehearsal of skills, identifying and modifying automatic thoughts and schemas, behavioral methods to reduce depression generating and maintaining behaviors (behavioral activation), and practice of CBT skills to prevent relapse. Overall, CBT is one of the most widely used and studied psychotherapeutic treatments for unipolar depression.

**Key Similarities and Differences Between MI and CBT**

Clearly, MI and CBT, as currently conceptualized, are not entirely distinct. Indeed, both approaches share several components that are considered to be integral to
expert use of the approach. Foremost, both approaches emphasize a collaborative approach in working with clients. For example, goals and session agendas in CBT work are intended to be collaboratively negotiated with clients. CBT practice involves “checking in” with clients regarding therapeutic goals. Termed “collaborative empiricism,” CBT emphasizes work with the client to formulate and test hypotheses about the links between mood, events, thoughts, and behavior. Likewise, client collaboration is one of the primary domains on which clinicians are rated for adherence to MI. Both approaches are also understood to be most effective when focused on specific problems or behaviors. Supporting self-efficacy, one of the four principles of MI has also been emphasized in most conceptualizations of CBT (O’Leary & Wilson, 1987).

Despite a common emphasis on collaboration, one basic difference is that CBT emphasizes an expert model, where the therapist is assumed to be the key change agent. In MI, the client is explicitly viewed as the expert and key change agent. MI also deemphasizes the use of labels; therefore, an MI clinician would not conceptualize client cognitions as “irrational” or “distorted.” In describing a truly collaborative approach to CBT, Miller (1988) commented that it is “feasible to guide cognitive-behavior therapy towards ends derived from the client’s own core values, rather than towards a single, preconceived notion of which beliefs are ‘rational’ and which ‘irrational’” (p. 54). Enhancement of collaboration, therefore, is another key example of possible synergy between MI and CBT.

**Rationale for Integrating MI with CBT**

Given the widespread use and demonstrated effectiveness of CBT, why might consideration of integration with MI be warranted? Arkowitz and Burke (2008) have enumerated several key reasons why MI integration with CBT is justifiable from the standpoint of enhancing the treatment overall. First, although it is clear that CBT has benefited large numbers of depressed patients, examination of overall response and remission rates in clinical trials clearly reveals room for improvement. A meta-analysis of four types of psychotherapy (interpersonal psychotherapy [IPT], CBT, and psychodynamic psychotherapy) as compared to medication treatment and pill placebo showed overall response rates of CBT to be approximately 50% (Hollon et al., 2002), comparable to IPT and antidepressant medications, all of which outperformed psychodynamic therapy and placebo. Despite overall statistically significant improvements compared to control conditions based on aggregated data, large numbers of depressed patients treated with CBT (or with any known treatment) remain symptomatic (APA, 2000). Incomplete symptom remission has been shown to increase risk of relapse, resulting in greater disability attributable to depression over the lifespan (Kupfer, 1991). Given that chronic depression has been estimated to account for among the greatest functional disability worldwide (Lancet Global Mental Health Group et al., 2007), it is critical for clinical researchers to pursue strategies that improve depression treatment outcomes beyond the 50% to 60% remission rate commonly achieved in clinical trials.

Arkowitz and Burke (2008) also highlight the fact the MI “fits the symptoms” of depression. Symptoms and features of depression such as motivational deficits and ambivalence about change are specific MI foci. Recent studies have shown evidence that patients with more severe depression who were nonresponsive to CBT showed greater improvement with behavior activation than with cognitive foci or with antidepressant medications (Coffman, Martell, Dimidjian, Gallop, & Hollon, 2007; Dimidjian et al., 2006), illustrating a promising role for embedding strategies to improve adherence with specific health behavior changes (Arkowitz & Burke, 2008). Importantly, MI has been designed and tested in relatively brief formats to be used as adjunctive to other treatments. In addition to sharing an emphasis on behavior change and collaboration, both CBT and MI explicitly emphasize beliefs/client perspectives and behaviors as intervention targets, providing logical points of blending between the two approaches.

As outlined by Taylor and Asmundson (2004), people come to treatment for a variety of reasons and with varying levels of motivation. Overall, MI can be integrated throughout CBT whenever motivational issues arise. In an earlier article describing integration of CBT and MI for anxiety and depressive disorders, Arkowitz and Westra (2004) highlighted the fact that CBT does not formally address ambivalence about treatment or change; rather, it focuses on assisting clients with specific changes and skills. In that sense, MI adds a specific and strategic focus on building motivation for change. MI may be blended to enhance motivation for initial treatment engagement (Zuckoff, Swartz, & Grote, 2008), treatment retention, and with adherence to various aspects of the treatment (such as homework behavior-activation strategies). Therefore, fundamental MI skills can synergize with CBT by enhancing treatment adherence and outcomes (Arkowitz & Burke, 2008).

Another rationale for integration is that MI directly and strategically addresses key predictors of CBT outcomes found in several studies (Arkowitz & Burke, 2008). Empathy, a fundamental MI skill, has been linked to CBT outcome in treatment studies (Burns & Nolen-Hoeksema, 1991, 1992; Miller, Taylor, & West, 1980). In a study investigating the process of CT in 64 depressed outpatients (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996), emotional experiencing, defined as the client’s ability to focus on and accept their affective reactions, was
Integrating MI and CBT for Depression

Research on behavior change across a number of domains has provided evidence that intervention strategies must overlap with patient personal processes, such as motivation and self-efficacy (DiClemente, 2007). It is clear that CBT was originally conceptualized and is commonly defined in treatment manuals (Beck, 1995) as a framework, within which psychotherapists should employ clinical judgment in collaboratively tailoring the treatment to individual patients. As discussed above, skilled CBT therapists are empathic (Burns & Nolen-Hoeksema, 1991; Miller et al., 1980), responsive to client needs, collaborative, and respectful of client autonomy to make decisions. Other CBT therapists, however, may lack adequate training, supervision, and experience in skillfully employing the treatment. MI offers an operationally defined, specified method for guiding therapist responsiveness to patients that may be integrated within CBT (Arkowitz & Burke, 2008). Miller (2008) has offered four broad perspectives that may be used to guide MI integration with psychotherapy: (a) a belief in human potential for growth and change, (b) emphasis on the central role of volition (choice and decision-making), (c) understanding and acceptance of ambivalence, and (d) close attention to client and clinician language. MI, therefore, may provide an organized framework for training psychotherapists to deliver CBT in a way that is

Clinical Applications of CBT and MI

The therapeutic alliance and therapist responsiveness to client needs may have a strong influence on successful behavior change outcomes. Engagement in treatment and change in specific depression-related behaviors can be challenging for therapists and patients because they are often met with ambivalence or resistance. Furthermore, it has become increasingly clear that recovery from depression may involve a number of specific behavioral change targets including treatment adherence, increase in reinforcing activity, as well as specific cognitive and interpersonal changes (Hollon et al., 2002). These interactional factors and behavioral change factors that influence treatment outcome represent fundamental MI skills. Each of these areas of CBT-MI synergy are considered below. Specific areas of CBT-MI integration will be discussed, along with clinical vignettes.

Client-Therapist Relational Factors

Research on behavior change across a number of domains has provided evidence that intervention strategies should offer multiple perspectives that may be used to guide MI integration with psychotherapy: (a) a belief in human potential for growth and change, (b) emphasis on the central role of volition (choice and decision-making), (c) understanding and acceptance of ambivalence, and (d) close attention to client and clinician language. MI, therefore, may provide an organized framework for training psychotherapists to deliver CBT in a way that is

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strategically responsive and flexible, collaborative, and empathic. Empathy is explicitly emphasized in MI training and supervision and supervision tools have been developed to improve therapist empathy (Arkowitz & Burke, 2008). These training and supervision approaches on the relational components of empathy, collaboration, evocation of patient perspectives, and respect for client autonomy may be strategically integrated with CBT.

Depression psychotherapy research has shown that much of the variance in depression outcomes is attributable to patient factors (Beutler, Crago, & Arizmendi, 1986), such as the patient’s contribution to the alliance (Krupnick et al., 1996) and feeling understood, and clear and organized in self-expression (Ablon & Jones, 1999). This and other research implies that, in many clinical instances, effective therapeutic approaches (such as MI) emphasize evoking therapeutic elements from patients rather than imparting expert information. This is in contrast to the commonly used notion and resulting language implying that psychotherapists “deliver” treatment. Instead, expert psychotherapists move between imparting useful knowledge, direction, guidance, and evoking client perspectives, skills, resources and strengths. As such, both CBT and MI offer empirically based elements that may be integrated.

**Initial Treatment Engagement**

Most people with depression do not present for specialty care and therefore must be identified and either treated or referred in settings such as primary care and other medical and community settings (Young, Klap, Sherbourne, & Wells, 2001). Studies of implementation of CBT in nonspecialty settings and with special populations have shown relatively poor treatment adherence (Miranda et al., 2003). For example, studies of CBT for depression in low-income women found high rates of attrition (up to 60%) from treatment (Appleby, Warner, Whitten, & Faragher, 1997; Meager & Milgrom, 1996; Prendergast & Austin, 2001), even with extensive outreach to encourage session attendance (Miranda et al.).

Over the past few decades, MI has been found to be particularly effective in improving follow-through and adherence to other forms of treatment and therefore is promising as an addition to CBT. In a recent chapter, Zuckoff et al. (2008) described a promising approach to assign MI as a pretreatment engagement session for improving adherence to IPT for depression. In addition to substance abuse and depression, studies have also used MI as a pretreatment engagement strategy for anxiety disorders (Westra & Dozois, 2006) and interpersonal violence treatments (Musser, Semiatin, Taft, & Murphy, 2008). These studies have all shown increased adherence to treatment, and, in most cases, with improved outcomes in response to the other treatment. For example, Westra and Dozois reported that three MI sessions prior to group CBT for patients with panic disorder, generalized anxiety disorder, or social phobia resulted in significantly higher expectancy of anxiety change, homework compliance, and treatment response, compared with group CBT alone. Swartz and colleagues (2006) found that one MI treatment engagement session led to high rates (85%) of engagement in IPT and improved depression and functioning outcomes in depressed mothers. In a recent study, 74 patients with cocaine use disorders were randomly assigned to either CBT or CBT plus an initial MI engagement session. Patients who received the MI session attended more drug treatment sessions and reported significantly greater desire for abstinence and expectation of success (McKee et al., 2007). The results of these studies show promise for continued development of MI as a prelude to CBT treatment for depression. This strategy may be conceptualized as a combination as opposed to integration, but is nonetheless a promising line of clinical research with MI and CBT. Arkowitz and colleagues (2008) have outlined the evidence base and applications of MI as an effective and promising prelude to formal treatments for anxiety and affective disorders in their recent volume Motivational Interviewing in the Treatment of Psychological Problems. A treatment engagement vignette is the first of three clinical examples presented below to illustrate MI skills that may be blended into specific CBT clinical interactions.

**Engagement Vignette (MI Skills Presented in Italics)**

T: I see that your primary care physician has referred you for depression psychotherapy. How do you feel about that? (eliciting ambivalence; open-ended question)

C: I’m not really sure what she thought I’d get out of this... I’ve been feeling this way for years.

T: You’re not sure this can help you (rolling with resistance; reflection)

C: Yes, I’ve tried a few things myself, which helps a little, but I don’t know how talking to someone will change anything.

T: You’ve been interested in trying to make this better (reflecting change talk). What kinds of things seem to help a little? (elicitation of additional change talk; open-ended question)

C: Well, when I force myself to walk the dog, I do feel a little better. Also when I get invited out with friends, I can enjoy myself a bit, but I really don’t have the energy do those things that often.
Behavior Activation

Behavior activation is a cornerstone of CBT and is receiving growing research support as a key mechanism of action, especially for more severe depression (Coffman et al., 2007; Dimidjian et al., 2006). As mentioned previously, MI works best and was developed specifically for targeting behavior change. There are a number of specific behaviors that are commonly targeted in behavior activation, such as activity scheduling, exercise, increasing or otherwise changing interpersonal behaviors, and reduction of avoidance behaviors and rumination. Each of these behavior change goals may be met with client ambivalence and resistance.

MI therapists are specifically and strategically trained in recognizing resistance/ambivalence, “rolling” with resistance (i.e., avoiding argumentation), and eliciting and enhancing client language in the direction of change (change talk). Client change talk can be operationalized as client language that articulates motivation for behavior change, particularly articulation of one’s commitment to make a change. Change talk has been found in studies using linguistic coding to be particularly potent in affecting behavior change outcomes. Client defense of the status quo, known as counter-change talk, has been inversely related to behavior change (Moyers & Martin, 2006; Moyers et al., 2005).

Client ambivalence about follow-through with behavior activation tasks may be directly addressed by integration of MI at the point at which resistance is detected by the therapist. Well-trained MI therapists are skilled at using a variety of techniques to elicit and encourage change talk about a specific change while simultaneously rolling with resistance and addressing ambivalence. Therefore, it is important to investigate whether adding MI to the training and overall clinical repertoire of CBT therapists will improve their skill in helping clients with specific depression-related behavior change.

The following clinical vignette illustrates a common contributor to worsening mood (avoidance) that would be a focus of CBT work and how the therapist, upon detection of ambivalence about a specific target behavior change (interpersonal activation), blends an MI style in order to understand and help resolve ambivalence.

Behavior Activation Vignette

T: It makes a lot of sense that being physically and socially active helps your mood, and understandable that depression can get in the way of doing those things. Would it be okay with you if I talked a little bit about how therapy can fit with that? (reflecting ambivalence; eliciting permission)

C: Sure.

T: There is a kind of therapy that specifically helps people do more of the things that make them feel better and to build on the link between mood, energy, activity, and thinking that you have noticed and worked on already (reflective summary with psychoeducation about aspects of CBT linked to the client’s own ideas about change). How would that fit or not fit for you? (elicitation of both ambivalence and change talk about treatment engagement)

C: I would like to have more energy to do things with people, so that makes sense, but I’m still not sure talking about it will help.

T: You’re still a bit mixed on whether focusing on these things in therapy will help and at the same time you want to do what you can to get better (rolling with resistance, reflecting ambivalence). What do you think you want to do? (elicitation of change talk; respect for autonomy)

C: I suppose I could give it a try, I am tired of feeling this way.

T: How has your mood been this week? (open-ended question)

C: Thinking back and looking at this, the weekend was really low. By Sunday I was feeling miserable and thinking about ways to escape. As you can see, I started feeling more depressed Friday after work, but it wasn’t too bad at that point. I didn’t feel like meeting my friends for dinner, so I stayed home alone. Looks like it went downhill from there.

T: How would you have felt if you went with your friends? (evoking mood-related change talk vs imparting suggestion; open-ended question)

C: Probably a little better, but I’m sure they are tired of dealing with me and I don’t want to go out when I am feeling that way.

T: Going out despite not feeling like it would have helped your mood, and you are concerned that feeling a little down would have bothered your friends. (rolling with resistance by reflecting ambivalence)

C: Well, they haven’t come out and said that, but I suspect it’s true, in which case I’d rather be alone.

T: Being alone seems better than bothering your friends, although they haven’t said anything. Your suspicion of their frustration sometimes overrides doing what would help you feel better (reflection: rolling with resistance). How important is it in those cases to boost your mood a bit by going out, from 0 to 10, with 10 being extremely important?
C: I'd say an 8.

T: And why an 8 and not zero? (eliciting change talk)

C: I find, with the use of these logs, that if I can do something about it when I begin to feel down, it does help a bit. Then, I seem to have a little more energy to do things. I can't keep losing whole weekends like this. That is my only time with my kids.

T: Feeling better for yourself and your kids is very important to you (affirmation; reflection of change talk). What do you think will help you next time you are feeling down, but also concerned about the effect on others? (evoking client strategies)

C: I think I will try to force myself to go out anyway, and once I am there, at least try to interact with my friends. It is a good distraction, after all.

T: That makes sense to me. It's important for you to remain committed to this hard work. (affirmation; reflection of behavior change plan)

Homework Compliance

Although some inconsistencies in the literature exist, there is substantial evidence that homework compliance in CBT is an important mediator of outcome (Burns & Nolen-Hoeksema, 1991; Burns & Spangler, 2000; Detweiler & Whisman, 1999; Rees, McEvoy, & Nathan, 2005). One of the key principles of MI is that ambivalence influencing lack of follow-through with a clinical recommendation is normal, and it provides specific strategies and techniques to address ambivalence and resistance. As such, MI provides a clear, specified framework for CBT clinicians to use whenever difficulties with homework completion arise. CBT therapist trained in MI could use lack of homework completion as a signal (resistance) for ambivalence, which would be met with exploration and reflection of the ambivalence. Client language in the direction of change would be targeted and enhanced. The MI skills of exploring ambivalence and evoking client change talk regarding CBT homework is presented below.

Homework Vignette

T: We can take a look at the thought-mood sheet we discussed last week, or we can start with whatever you wish today. What would be most helpful for you? (collaborating on agenda)

C: To be honest, I never got to the thought-mood sheet… I was too busy.

T: You had a lot going on this week (rolling with resistance using reflection). What's it like for you to think about working on this? (eliciting ambivalence; open-ended question)

C: I don’t know, I'm not sure how helpful it will be, and you telling me I can change my thoughts seems impossible.

T: Changing your thinking seems like a bit out of reach right now and you want to make sure you are spending your time on things that will help you (rolling with resistance; using reflection). You are the best expert on you… From your perspective, what is something you can do that is likely to help your mood? (collaboration on goals, emphasizing client autonomy)

C: Well, it has been helpful to tune into what I am doing and thinking when I'm feeling a little better but the sheet you gave me is confusing. I'd rather jot this down on my computer in a different way.

T: It will be helpful to you to track your mood in a way that makes the most sense and is easiest for you (reflection; supporting autonomy). What do you think you’ll do that will work for you? (respecting autonomy; elicitation of strategies)

Conclusions and Future Directions

Clinical research on the efficacy of CBT for the treatment of depression as well as for depression relapse prevention has resulted in clinically meaningful outcomes overall, rendering CBT one of the most widely adopted evidence-based treatments for depression. Depression is associated with tremendous impairment, and the risk of recurrence in the face of incomplete remission is common and evident. Therefore, it is critical to continue to explore strategies to enhance existing depression treatments. MI is an evidence-based strategy for improving retention and outcomes with other formal treatments, for improving specific behavioral change outcomes, and has a primary emphasis on evidence-based clinician interactional factors such as empathy and collaboration. These client-centered factors are known to be contributors to depression psychotherapy outcome.
Future studies are needed in order to determine whether MI integration with CBT will lead to enhanced depression outcomes. First, studies may examine the effect of pre-CBT MI on CBT retention, engagement, alliance, and outcomes (i.e., an additive effect). Second, the synergistic effect of MI on CBT may be studied in randomized, controlled trials in which groups of depressed patients are assigned either to CBT provided by therapists not trained in MI (i.e., therapists rated low in MI adherence and competence) compared to CBT therapists rated high in MI adherence and competence. Key outcomes may include treatment adherence, depression, and functioning outcomes. Ideally, this research would pursue mediators and moderators of outcome. For example, patients high or low on preference/need for directiveness (moderation) may have differential outcomes to CBT with or without MI integration. There is some indication in the literature that patients overall who are high in levels of resistance respond better to MI than to CBT-based approaches (Hettema et al., 2005). Mediators to be explored may include specific depression symptom clusters and the severity of the depression overall. For example, the extent to which an exclusively eliciting interpersonal stance (consistent with MI) would improve therapeutic outcomes with someone with moderate to severe neurovegetative symptoms is unknown.

Overall, it has become increasingly clear that recovery from depression must involve a number of behavior changes, including treatment adherence, increase in reinforcing activity such as exercise, and cognitive and interpersonal change (Holton et al., 2002). MI has been at the forefront of health behavior change research. The extent to which the merging of a well-developed, specific behavior change intervention, such as MI, with an existing psychotherapeutic treatment for depression, such as CBT, will improve the overall effectiveness of depression treatment is certainly worthy of investigation.

References


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