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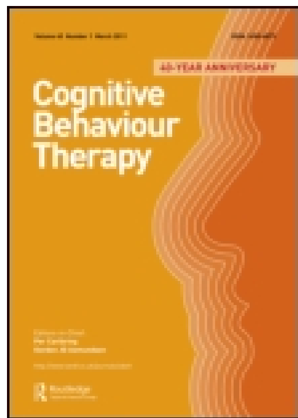

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Managing resistance in cognitive behavioural therapy: The application of motivational interviewing in mixed anxiety and depression

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Managing Resistance in Cognitive Behavioural Therapy: the Application of Motivational Interviewing in Mixed Anxiety and Depression

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Abstract. While cognitive behavioural therapy is highly effective in the treatment of anxiety and depression, a substantive number of individuals either refuse treatment, fail to respond to treatment or respond only partially. Arguably, ambivalence about change or about engaging in treatment tasks may in part be related to incomplete recovery rates in cognitive behavioural therapy. Motivational interviewing is a client-centred, directive treatment originally developed in the addictions domain whose goal is to enhance motivation for change by understanding and resolving ambivalence. This method has consistently received support for enhancing outcomes in the addictions domain, particularly when used as an adjunct to further treatment. As yet, motivational methods have not been generalized to the treatment of prevalent mental health problems, such as anxiety and depression. The present paper presents the application of a treatment targeting motivation (motivational interviewing adapted for anxiety and depression) to the management of resistance in cognitive behavioural therapy for 3 clients with mixed anxiety and depression. Motivational interviewing is conceived as an adjunct to highly effective traditional cognitive behavioural therapy methods, which is indicated for use with clients resistant to and significantly ambivalent about change-based techniques for managing anxiety or alleviating depression. *Key words: motivational interviewing; motivation; treatment resistance; cognitive-behavioural therapy; anxiety; depression; ambivalence.*

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Cognitive behavioural therapy (CBT) is a highly efficacious treatment for the management of anxiety and depression (Chambless et al., 1996). However, response varies tremendously, even to a treatment as effective as CBT, and a large number of individuals fail to benefit. When stringent criteria for recovery are applied, about 60% of individuals with anxiety can be considered partial responders or non-responders in CBT (Jacobson, Wilson, & Tupper, 1988; Westen & Morrisson, 2001). A considerable number of clients either fail to complete treatment (up to 36%; Elkin, 1994) or respond less than optimally to CBT for depression (Ilardi & Craighead, 1994). Post-CBT remission rates are around 50% (Elkin, 1994) and the average post-CBT depression score continues to be in the mildly depressed range (Cuijpers, 1998). Moreover, treatment refusal rates can be substantive. For example, up to 25% of individuals offered response prevention and exposure for obsessive-compulsive disorder will refuse this effective treatment (Franklin & Foa, 2002).

Ambivalence about change may, in part, be related to limited treatment completion and partial or non-response to CBT. Support for ambivalence about change has been most clearly explored in generalized anxiety disorder. These individuals have been found to hold both negative (e.g. "Worry interferes with my concentration and problem solving") and positive (e.g. "Worry motivates me and prevents bad things from

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happening") beliefs about worry simultaneously (Borkovec & Roemer, 1995; Freeston, Rheaume, Letarte, Dugas, & Ladouceur, 1994). A similar conceptualization is emerging with regard to rumination in depression (Papageorgiou & Wells, 2001) where those with recurrent major depression have been found to endorse positive beliefs about rumination (e.g. "I need to ruminate about my problems to find answers to my depression"). Moreover, up to two-thirds of individuals entering treatment for mental health problems can be classified as being at a "pre-action" stage of change; that is significantly ambivalent about change so as to preclude the active adoption of change-based strategies (Dozois et al., in press; O'Hare, 1996).

Ambivalence or "resistance to treatment" may arise when compliance with the requirements of effective CBT is needed (e.g. exposure in anxiety, behavioural activation in depression, homework). While some clients are clearly willing to commit themselves to the rigors and risks of action-based treatment, others appear much more undecided about this prospect. This ambivalence is often expressed indirectly in treatment through homework non-compliance, failure to drive or take an active role in sessions, or "arguing" with the therapist (see Newman, 2002) for a more complete elaboration of resistance in CBT). For example, rates of homework compliance show much individual variability throughout CBT with higher rates of compliance associated with more positive outcomes (e.g. Burns & Spangler, 2000; Schmidt & Woolaway-Bickel, 2000). Moreover, homework non-compliance is a commonly acknowledged issue among CBT practitioners (Huppert & Baker-Morissette, 2003; Leahy, 2001). Examples of recommended strategies designed to enlist compliance include challenging the automatic thoughts underlying non-compliance (Burns, 1989) or negotiating compliance with a task approximating the original homework task (Huppert & Baker Morissette, 2003; Leahy, 2001). High levels of resistance may also result in therapists feeling frustrated with clients, helpless in their efforts to move the client forward, and feeling as though they are working harder than the client. As Miller and Rollnick (2002) noted, this can often result in pejorative conceptualizations of the client as "unmotivated for change", negatively impacting the therapeutic relationship necessary for successful recovery.

Motivational interviewing (MI: Miller & Rollnick, 2002) offers a very different approach to the management of resistance and the understanding of ambivalence. Resistance is considered the product of the client's ambivalence as well as the interaction between the therapist and client. As such, the manner in which the therapist responds to resistance to change greatly influences the amount of resistance (Moyers & Rollnick, 2002). When resistance is encountered, consistent with the principles of MI, the therapist reflects it, sides with it, or even amplifies it, rather than confronting it directly. Similar strategies (e.g. disarming) have been detailed by Burns (1989). In MI ambivalence is regarded as a normal part of the change process. The "unmotivated" client can be reconceptualized as undertaking the important task of exploring their options, rather than being resistant to change. MI may be highly complementary to CBT since the focus is on preparing the client for change, whereas CBT outlines excellent tools and procedures for producing change itself. In short, MI may provide methods for moving ambivalent clients forward to increase the probability of utilization of active strategies for producing change such as those contained in CBT. For a more thorough elaboration of the unique contributions of MI to CBT for anxiety and mood disorders see Arkowitz and Westra (in press).

Existing research on MI supports the efficacy of these methods, particularly when used as adjuncts or preludes to other treatments (Burke, Arkowitz, & Dunn, 2002). In their meta-analytic review of MI studies in health behaviours and addictions, Burke, Arkowitz, and Menchola (2003) concluded that studies using MI as treatment preludes (to diverse treatments such as inpatient care, risk reduction, medication and case management) yielded a moderate effect size (0.51) which was more than double the effect size of studies using MIs as stand-alone treatments. Moreover, Burke, Dunn, Atkins and Phelps (in press) report a modest but significant additive effect of MI (average effect size of 0.31, *n* of 4 studies) when used as a supplement to CBT for substance abuse compared with no pre-treatment. While limited in number and methodological quality, studies in mental health populations have consistently supported the benefits of MI preludes in improving treatment adherence (Martino, Carroll, O'Malley, & Rounsaville, 1999; Swanson, Pantalon, & Cohen, 1999) and enhancing response rates to standard treatments (Kemp, Kirov, Everitt, Hayward, & David, 1998). In the

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area of anxiety, treatments designed to enhance motivation for change are beginning to emerge but as yet there are no existing studies on MI integration with CBT for these prevalent mental health problems (Murphy, Rosen, Cameron, & Thompson, 2002; Taylor, 2004).

This paper presents a series of 3 case studies applying MI at different stages in CBT at which resistance was encountered. Each case was selected to illustrate how MI can be used as an alternative intervention to continued CBT for managing treatment resistance or treatment non-response. Specific instances of applying MI principles (expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy; Miller & Rollnick, 2002) are identified in each case. The first case uses MI as an alternative to CBT for an individual with major depression and multiple anxiety disorders who failed to resonate with the rationale for CBT and refused to consider homework as part of treatment. The second case applies MI in the context of treatment non-response for an individual who failed to benefit, despite compliance, with CBT for depression and generalized anxiety disorder. The third case demonstrates the application of MI for an individual who partially responded to CBT for pronounced social anxiety and depression, yet remained highly symptomatic and refused to engage with more substantive exposures in treatment. I would suggest that each of these points represents commonly encountered impasses in the application of CBT. A brief discussion of alternative hypotheses for outcome follows each case, followed by a general discussion of the role of MI in the presence of resistance to CBT and suggestions for more controlled research studies.

Case 1: MI as a prelude to CBT

Client information and presenting problem(s)

Ms A is a young mother of 3 small children. On Structured Clinical Interview for DSM-IV (SCID-IV: Spitzer, Williams, & Gibbon, 1994) her presentation was consistent with major depressive episode (severe), social phobia and panic disorder with agoraphobia. The most prominent problem for Ms A was her depression. She exhibited intense hopelessness and had made several non-serious self-harm attempts. Ms A also reported psychotic features accompanying her depression, including hearing voices swearing at her and "punishing" her, at times encouraging her to do self-harm. She was virtually housebound secondary to fear of panic and pronounced social anxiety. Ms A was followed for medication management but medications yielded minimal benefit.

Treatment planning

I presented Ms A with the option of CBT for depression. In order to facilitate hopefulness regarding her prognosis, I described the response rates to CBT and the positive prognosis in depression and anxiety. I further explained the treatment rationale, model, and expectations, including homework and graded behavioural task assignments, and cited specific examples from Ms A's history suggesting she was a good candidate for this approach. Ms A was highly adverse to this treatment plan, particularly the suggestion of homework. She noted that she did not feel that there was anything she could do at the present time to treat her symptoms other than medication and announced that if treatment involved homework that she would not return for another session. We explored her concerns about behavioural activation in some detail and these seemed to centre on a fear that the voices would "punish" her more severely if she attempted to recover from her depression; a prospect which she found intolerable. I attempted to engage her in experimenting with this prediction (i.e. "Your anxiety tells you that the voices will get worse if you take steps toward recovery. Is there any room for doubt in that prediction or are you 100% sure? Would it be worthwhile to try a few exercises and see what happens to the voices and your mood?") This resulted in further resistance to the notion of treatment. I then attempted to negotiate a focus on panic or social anxiety, which was also met with strong reluctance. In addition to a fear of symptom intensification, she articulated strong pessimism that self-help activities could be of any benefit for her.

Shifting treatment focus

It became clear that remaining with a CBT framework would have resulted in treatment dropout or, at minimum, compliance issues and limited progress. Recognizing the pronounced ambivalence ("I want help and want my depression to subside, yet I am afraid of investing myself in recovery efforts"), I suggested an alternative approach of MI. I reflected with Ms A that she seemed to be of "two-minds" about her

depression and this seemed to be keeping her paralysed in moving forward on managing her mood and anxiety. I offered the analogy of smoking as a typical example of the presence of ambivalence (which she easily resonated with as a smoker who was toying with the idea of quitting). I suggested to her that if she decided to contract to meet together, that the focus would not be on actively changing her mood or doing exercises or homework toward this end. Rather, the focus would be solely on reflecting on the "battle" in her mind, understanding this dilemma, and being curious about it. She became much more animated and engaged with this discussion and readily contracted to meet for 5 sessions toward this end.

Motivational interviewing (MI)

A decisional balance exercise was undertaken on the "pros and cons of staying the same" (i.e. remaining depressed). As with most individuals, initially Ms A was somewhat dumb-founded at the idea that there could be any "benefits" to her emotional problems; with some encouragement she began to formulate a response. Ms A volunteered that staying the same meant "no hassle". At this stage, when beginning the decisional balance, the therapist's role is to help the person elaborate each pro and con in order to fully understand it, validate it, and elicit the value behind it. For example:

Ms A: Not changing means that no-one will be pressuring me. I can't stand people always telling me I need to do things differently, be more active, stop crying. I feel so rotten, I just want to let myself be. I don't have the energy to do anything else. It's all I can do to just manage my kids activities. I can't do anything else. I don't want to do anything else!

HW (expressing empathy): So if I'm hearing you correctly, you're feeling that it would be really nice if people would just leave you alone! You don't need the stress and aggravation of other people trying to push you to do things you're not feeling up to doing. Life is hard enough, without all that added pressure.

Ms A: Exactly! People can just leave me alone.

HW: So one "pro", if we could call it that, is that staying the way you are, not making any changes, reduces your stress level. It's easier than the alternative. How important is it to you to have reduced stress and hassle, say on a scale of 1 to 10 with 10 being it's critical and 1 being not important at all.

Ms A: Very important. Eight.

HW: Why 8 and not 10?

Ms A: Well, there is a part of me that thinks that I do have to do those things eventually. I know I have to push myself, just not yet.

HW: What are the other good things about staying depressed?

Eliciting the value behind each aspect of the "problem" is particularly critical with the pros to the *status quo* as these are often difficult for a client to articulate and admit. The therapist's role is to be highly empathic, to enable the client to fully explore the factors keeping them locked in the problem from which they are seeking liberation. Ms A went on to list other "advantages" to the *status quo* including "I get to sleep all day and that takes my negative thoughts away", "No risk of disappointment if I try and fail", and "No risk of being punished by the voices". She remarked that she resonated strongly with the pros to staying the same and this captured how she felt. In fact, she rated the decisional balance at this point as 100/0 (i.e. "I see no down sides right now. No reasons to change").

I reaffirmed that Ms A was free to stay depressed (i.e. siding with resistance) and then gently suggested that often "there can be some down sides for people to being depressed". I also suggested that if there were absolutely no down sides, she probably wouldn't be coming in for our meetings. I also linked her presence with one of the pros on her decisional balance (i.e. freedom from hassle) and became curious as to why she would continue to make the effort to attend sessions (i.e. developing discrepancy). I inquired, "Is it a hassle to come in to these sessions?" She responded affirmatively and we processed what were the reasons for working to overcome that "hassle". She became silent and tears welled up. She softly noted, "My depression hurts my children". Noting the presence of very strong affect, we spent the remainder of the session focused solely on this perceived cost. I encouraged her to persist with this line and prompted her with questions like "Exactly how do you know it hurts your children? Give me a recent example of a time you knew your depression was hurting your kids. How are you feeling as you talk about the impact of your depression on your kids? How important is it to you to be a good mother? How much does it bother you to see yourself hurting your children?" She became highly tearful and at one point noted that she was angry with me for making her think of the impact of her depression

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on her kids. I validated her torment and reaffirmed her freedom of choice (i.e. supporting autonomy and self-efficacy) by noting that "This seems enormously painful for you. I can clearly see that. You don't have to do this. In fact, you don't even have to be here right now. What would be the advantages to continuing to explore the impact of your depression, what would be the disadvantages?" Questions or exercises often evoke strong affect in clients during MI and there can be an accompanying tendency to avoid that affect. Consistent with the client-centred nature of the treatment, the client is not "forced" to persist but offered choices and encouraged to evaluate the potential impact of each choice.

Ms A persisted and identified that she felt guilty for not being able to play with her children, not being able to accompany them to outings for school, and not taking them to the park. She noted feeling scared by her suicidal thoughts and the impact of acting on those thoughts for her children. She described how being a great mother was a fundamental value in her life and how much she cared for her children's welfare. She detailed examples of how when her children found her crying they would become sad and probe her for what was wrong. This left her with even more self-hatred at having engendered her children's concern. She also identified that if her depression and anxiety were to persist unabated, she realized the negative impact it would have on them and noted that she recognized anxiety in her youngest son similar to her own fears. In addition to the implications for her children, Ms A noted other costs to her depression of being on disability benefits for income support and not being able to work.

Upon greater understanding of the ambivalence, the therapist helps the client work with the ambivalence. This can be done through multiple methods including developing discrepancy. Ms A was encouraged to explore the degree to which her withdrawal and avoidance behaviour fit with the high value she placed on being a mother. Discrepancy can also be developed between the 2 sides of the ambivalence. For example, "Staying the same allows you freedom from hassle, yet it seems like it creates hassle for you as well. Can you clarify that?" or "On a scale from 1 to 10, how well is withdrawing working to control negative thoughts?"

Rolling with resistance is an integral component of MI. For example, at the fourth session of MI, Ms A announced that she had tried something different and played with her children more in the past week, as well as having forced herself to do her own groceries. Being a relative MI novice at that time and elated at this development, I jumped in to applaud her efforts. "That's great! What was the impact on your mood?" She responded with "I did it but I did not enjoy a second of it. I'm not sure that I will continue. It was too hard." To manage this resistance, I shifted back to a more client-centred stance and facilitated *her* exploration of her recent change in approach. I stated, "This is very interesting. Now you have a sample of what the impact is when you withdraw and you also now have a sample of the impact, if any, when you try something a bit different. I hear you saying that pushing yourself is not very enjoyable and probably will lead to no good. That makes sense to me given the big advantages of staying the same. What are your thoughts about where you go from here?" She responded with "I'm thinking that I'm going to continue pushing myself. It may not have paid off this week but I think if I keep going it might". She also noted that she had put the decisional balance exercise on her bedroom mirror and looked at it often, reflecting particularly on the impact of her emotional problems on her children. She noted becoming increasingly aware of the negative impact of her depression and avoidance on her kids and becoming more intolerant of this impact.

By the end of the fifth session of MI, Ms A continued to report that she was being more active, especially with her children and even noted that the odd time her enjoyment seemed to be returning. With these developments, it became clear that Ms A was moving into the preparation stage of change. Her scores on indices of depressive symptoms reflected some minimal improvement, particularly on measures of depression, but persistent and elevated symptomatology on indices of both anxiety and depression were apparent (Figures 1 and 2).

Cognitive behavioural therapy

Having come to the end of our 5-session contract, and noting some markers of her movement toward preparation for change, I offered Ms A 2 options and encouraged her to reflect at some length before deciding. First, we could contract for a course of CBT for depression and anxiety. Care was taken to explain the differences in this treatment approach compared with our previous sessions (i.e. homework, expectation of improvement). Second, she could decide to discontinue

treatment and return when she could see her way clear to a more active form of treatment such as CBT. She reflected for a week and decided to pursue CBT. We contracted for 10 sessions, and she evidenced enormous improvement over the course of this treatment. She was consistently compliant with homework, including behavioural activation and exposure and relapse prevention exercises. Figures 1 and 2 illustrate the marked reductions in symptomatology with this treatment.

Six months later, Ms A recontacted me, indicating that her depression had returned. We met and I offered her the option of recontracting for a time-limited course of either CBT or MI. She choose MI and noted that she didn't feel ready to activate as she was still stinging immensely from the disappointment of her relapse. Her depressive relapse was not nearly as intense as her first episode (BDI of 24) and within 4 sessions she had begun to successfully reinitiate the strategies she had used to recover from her previous episode (BDI post-treatment = 6). She also had a panic episode and this was also used as fodder for supporting relapse prevention and consolidation of gains in anxiety management.

Case discussion

Although Ms A participated actively and engaged well with MI, she only changed significantly after the implementation of CBT techniques. It might be argued that if these techniques had been implemented straight away and without the MI, that she might have responded equally well. In the absence of a controlled study to investigate this issue, that alternative hypothesis cannot be ruled out. Clinically, in the presence of enormous resistance to the mere suggestion of homework, it is hard to imagine how she would have hooked in to CBT. I suspect that she may have dropped out if the homework issue was pursued (as it must be for effective CBT, Burns & Spangler, 2000; Schmidt & Wollaway-Bickel, 2000). If she remained in treatment, this may have set up an adversarial dynamic impeding the development of the therapeutic relationship. In contrast, MI

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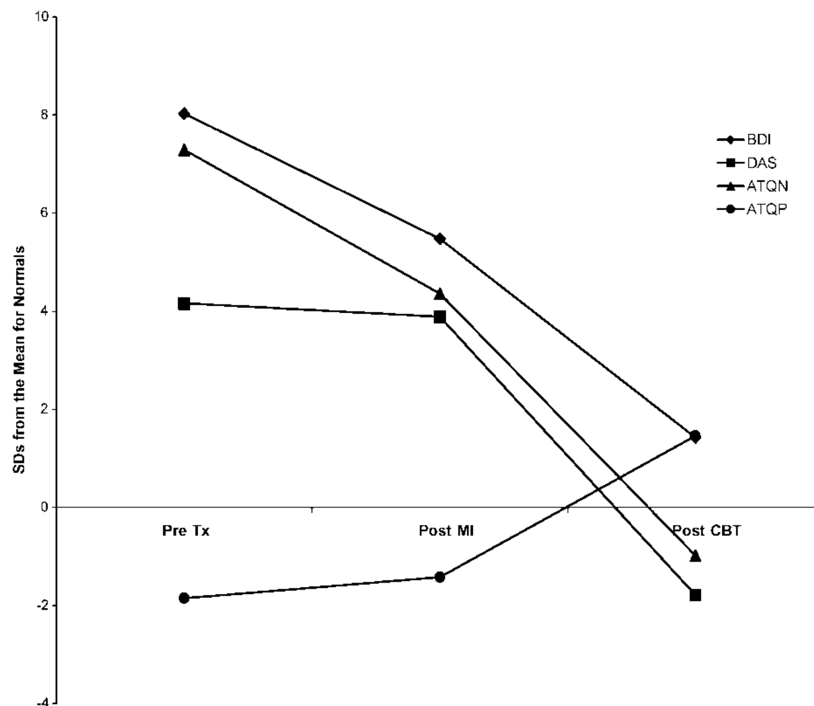

Figure 1. Changes in depressive symptoms, Ms A. BDI = Beck Depression Inventory (Pretx = 54, Post MI = 40, Post CBT = 16), DAS = Dysfunctional Attitudes Scale (Pretx = 187, Post MI = 181, Post CBT = 74), ATQN = Automatic Thoughts Questionnaire Negative (Pretx = 128, Post MI = 96, Post CBT = 38), ATQP = Automatic Thoughts Questionnaire Positive (Pretx = 55, Post MI = 66, Post CBT = 141).

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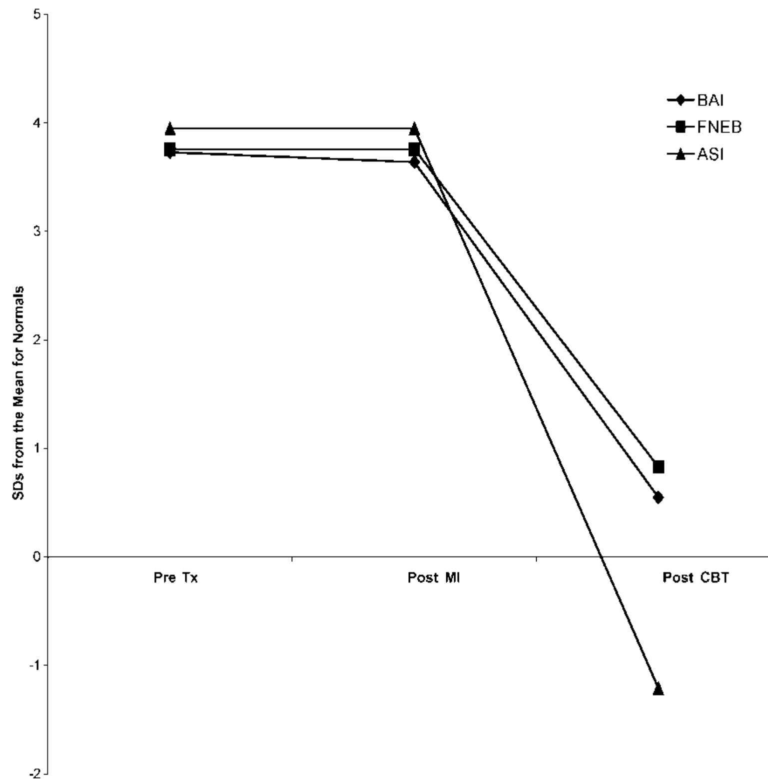

Figure 2. Changes in anxiety symptoms, Ms A. BAI = Beck Anxiety Inventory (Pretx = 41, Post MI = 40, Post CBT = 12), FNEB = Fear of Negative Evaluation Scale – Brief Form (Pretx = 60, Post MI = 60, Post CBT = 38), ASI = Anxiety Sensitivity Index (Pretx = 71, Post MI = 71, Post CBT = 24).

seemed to have fostered the development of a strong therapeutic alliance (see Burns & Auerbach, 1996). One possible advantage of MI, then, seems to be its ability to engage those who are initially unwilling to take a more active approach to their care. It may provide therapists with a viable alternative for proceeding in those who are not yet in the action stage.

Case 2: MI after a failed course of group CBT

Client information and presenting problem(s)

Ms B has a history of recurrent major depression (she estimates at least 2 episodes a year for the past 20 years), each treated with pharmacotherapy with some benefit but continued inter-episode symptomatology. She presented on diagnostic interview (Spitzer et al., 1994) with some depressive features and pronounced chronic worry consistent with a diagnosis of generalized anxiety disorder. The most salient domain of worry for Ms B was the welfare of her 2 adult sons. She noted being overprotective and feeling overly responsible for their well-being, happiness, safety and success, and clearly linked this with her ongoing struggles with mood. She noted being constantly available to her family in the form of childcare assistance, borrowing vehicles and money, household tasks and so on. Ms B has been married for many years to a man she described as alcoholic and emotionally unavailable.

Cognitive behavioural therapy

A course of CBT group therapy for depression was recommended and the group leaders noted active participation with the group but minimal homework compliance. Minimal compliance persisted despite repeated efforts by the group and the leaders to problem-solve for more active

homework completion. Consistent with this, Ms B's scores on measures of depressive symptomatology were largely unchanged from pre- to post-CBT (Figure 3). After completing the group program, Ms B reported enormous subjective benefit in having had exposure to self-help techniques for mood management but stated, "I think these techniques would really work if one applied them. I saw other people using them and they really seemed to help them." She readily acknowledged putting little effort into application of the strategies and indicated that the major obstacle to doing homework (e.g. being more assertive with her children, taking time for self-nurturing activities) was her enormous guilt. We contracted for a brief individual course of CBT since Ms B resonated strongly with the CBT rationale for treatment. I reasoned that closer follow-up and reinforcement of behavioural activation exercises and assistance with assertiveness might be of benefit. Ms B. was marginally compliant with homework exercises but even individual CBT yielded only minimal benefit in terms of mood control.

Motivational interviewing (MI)

Given the failure of group and individual CBT to produce mood improvement and Ms B's clear ambivalence about limit-setting and assertiveness, I provided her with the option of a brief course of MI to explore her ambivalence in interpersonal relationships. Ms B was highly receptive to this, particularly in view of her clear belief that she needed to be assertive, yet her inability to follow through with these intentions. I underscored that MI would not require homework or change *per se*, but rather reflection on and curiosity about the possibility of change.

In an effort to understand and explore her ambivalence in greater detail, Ms B began a decisional balance exercise on "Being there 100% for others". She quickly elaborated numerous benefits to sacrificing her own time for others, many of which were highly affect-laden, including "Makes me feel needed", "Feels like I

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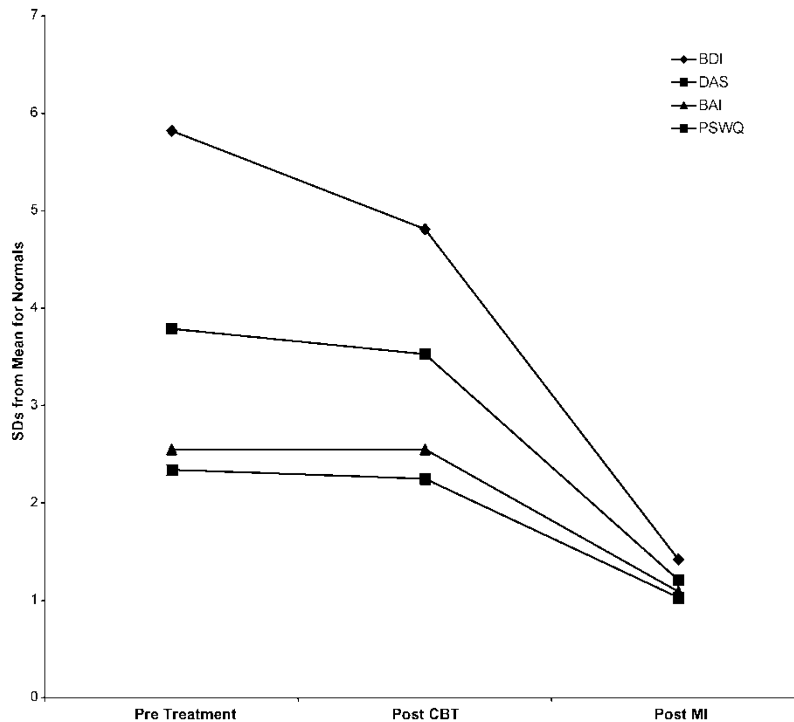

Figure 3. Changes in symptoms, Ms B. BDI = Beck Depression Inventory (Pretx = 42, Post CBT = 37, Post MI = 14), DAS = Dysfunctional Attitudes Scale (Pretx = 180, Post CBT = 178, Post MI = 129), BAI = Beck Anxiety Inventory (Pretx = 30, Post CBT = 30, Post MI = 17), PSWQ = Penn State Worry Questionnaire (Pretx = 61, Post CBT = 60, Post MI = 46).

have a purpose in life", "Feels good to contribute", "Others would give me grief if I held them accountable", "No guilt", "Being overprotective protects kids", "Habitual and therefore comfortable", and "Makes my children happy".

Ms B discussed life experiences that helped shape her excessive nurturance of others. This is not routinely elicited by the therapist as part of MI but, in exploring the functional value to their symptoms, a number of clients elect to elaborate on the origins of these "benefits". She reported that as the eldest of 5 children and having been raised in a household where her father was always absent secondary to work and alcohol abuse, that care-taking became a normal part of her life. Moreover, she described how she bore the nearly exclusive responsibility for her kids since their father was unavailable secondary to his alcohol abuse and frequent absences. The role of the therapist in MI is to facilitate the client's understanding of the "positive" aspects of something seemingly dysfunctional and to facilitate the person's appreciation that the "problem" is driven by purity of motive (e.g. "who doesn't want to feel that they have a purpose in life or feel like they are contributing"). In the case of Ms B, I suggested to her that developing a highly nurturing style made sense in view of the circumstances and was adaptive for her (i.e. expressing empathy). Asking her to relinquish this by being assertive was like asking her not to have a purpose in life or to expose her children to risk and unhappiness; something that everyone would and should resist! During this discussion, Ms B began to question the continued utility of this pattern. She noted increasing resentfulness at feeling unappreciated and also described that she now needed to devote more time to her own care. Accordingly, we proceeded to elaborate the drawbacks of "Being there 100% for others" and Ms B articulated things such as "Makes me feel used", "Makes me feel like a failure because my children aren't independent", and "Makes me depressed".

With identification of the nature of the ambivalence, we proceeded to work toward greater development of discrepancy between her values and her current behaviour. I asked Ms B what she valued in her life and if the future worked out extremely well, what she would envision. She highlighted themes of freedom and adventure, such as taking a Caribbean vacation and going white-water rafting. Ms B was asked how consistent these goals were with her current behaviour. She noted many inconsistencies and as she reflected more actively about the future and her aspirations, she developed increasing resolve about the need for change. Further, MI focused on assisting Ms B to critically evaluate the extent to which the desired goals were being achieved or questioning the degree to which her actions were yielding the intended results. For example:

HW: You mentioned that you don't have to feel guilty as long as you make sure everyone's needs are met all the time. How well is that working, say on a scale of 1 to 10, with 10 being "What a great strategy, I would recommend it to anyone" and 1 being "It doesn't really work at all".

Ms B: About a 5.

HW: So it works to some degree. Tell me about the distance between 5 and 10. Why not a 10 (developing discrepancy)?

Ms B: Well, I end up feeling guilty a lot of the time anyway, even though I'm doing everything I can. It often seems that it's never enough and they just want more all the time. And they really learn how to "play" me; how to say just the right things to make me cave.

We also engaged in a "devil's advocate" role-play between the 2 sides to her ambivalence about change where I articulated the non-change arguments and Ms B articulated the change arguments. The idea behind the role-play is not to "convince" the client that change is better, but rather to place them in the position of developing and articulating possible change arguments. For example:

HW: I don't do well with guilt. I think it's better for me to not rock the boat than it is to start setting limits with my kids. It may be unpleasant but it's better than feeling guilty.

Ms B: Well, you probably will feel guilty for a while but eventually that will pass. It always does.

HW: Yes, but they'll be mad at me. It will hurt them if I start telling them I'm not going to babysit all the time. What will they do? They'll think I don't care about them.

Ms B: Even if they do get mad, it won't last forever. Besides, it will be good for them to learn to stand on their own 2 feet better. You know that they don't do that enough. As far as not thinking you care, there's certainly plenty of evidence that you do care, so if they do think that, they're wrong. Besides, you can simply reassure them that doing less doesn't mean you care less.

HW: But it makes me feel really good to know

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that I am giving them things that I never had as a kid. I want them to be happy.

Ms B: That's great but you need to have a life too. And what good are you to them or anyone when you're depressed all the time?

When the individual begins to show signs of change, these are explored and elaborated in the spirit of greater understanding and curiosity. For example, after the third session of MI, Ms B presented to the session appearing visibly brighter in affect. She was better groomed than on previous meetings and announced that she had begun setting limits with her sons. She cited several specific examples of this, including setting limits on how often she would babysit and insisting on significant notice prior to babysitting. She also noted insisting on rent money from her son in exchange for allowing him to live in the home. In MI, the therapist explores such examples from the client's perspective, rather than rewarding or discouraging such behaviour and seeks to foster self-efficacy. For example:

HW: So this sounds different for you. Is it?

Ms B: Yes. Speaking up when I don't like something is very unusual for me.

HW: What did you like or not like about it?

Ms B: Well, I was pretty nervous at first but then it wasn't as bad as I thought. Frank was mad at me for a couple of hours after I told him he needed to check with me before assuming that I would babysit. But he seemed to get over it. Besides, I thought it was okay that he was mad. If he wants to feel that way, I can understand it. He's just adjusting to the new me.

HW: You mentioned that guilt was a huge factor that kept you from setting limits with your sons in the past. What happened there?

Ms B: I had some guilt at first but then it went away. And besides, it felt great having more time to myself. I feel less "put upon" and almost feel like I'm doing my boy's a favour by forcing them to have to be more responsible. Frank even started looking for an apartment; something I've been wanting him to do for ages.

HW: On balance, was this more of a good thing or a bad thing?

Ms B: A good thing. It's about time I stood up for myself.

HW: And how exactly did you get yourself to make that change? This is something that is no easy task for you.

Ms B: I have felt so miserable for so many years and figure I want to live the rest of my life with some happiness. I know that won't happen if I don't make a change. Besides, my kids don't need me the way they used to and I need to start thinking about my own health for a change.

We went on to explore the merits and disadvantages of continuing to be assertive as well as the possible obstacles to continued change. Consistent with MI, the client's self-efficacy is consolidated through questions such as "What does that say about you that you did this?" "What strengths do you possess that brought this about?" "What resources do you possess that tell you that you could continue to make changes if you wanted to?"

By the fifth session of MI, Ms B reported that she was considering leaving her husband. She complained about the total lack of intimacy in their relationship and his continued distance and drinking. We explored various options for addressing her concerns, including marital counselling and separation. Ms B was sounding increasingly resolved about the need for change and continued with limit-setting with her sons with good effect. In fact, several of her scores at the end of these 5 sessions of MI (see Figure 3) were in the normal range and residual symptomatology was in the mild range. We contracted to meet for 3 follow-up sessions monthly for consolidation of gains and relapse-prevention. Ms B also noted that she had begun to discontinue antidepressant medication and was feeling significantly more satisfied in her work.

Case discussion

This case suggests the possibility of MI as an alternative option for those non-responsive to CBT. Again, a viable alternative hypothesis exists. Ms B may have changed anyway with the passage of time, an alternative that cannot be ruled out in the absence of a controlled trial. Perhaps there existed an "incubation period" after which her earlier experience with CBT methods were implemented, and MI failed to add anything significant to her eventual recovery. Again, a major advantage of MI in this case was the implementation of a viable alternative for management, other than continuing to utilize seemingly ineffective CBT techniques at that point in time or discharging the client. Given the relationship of optimism to recovery (Dozois & Westra, 2003; Snyder, Ilardi, Michael, & Cheavens, 2000), one could speculate about the potential impact on optimism while remaining with techniques yielding minimal benefit. Anec-

dotally, it has been my experience that clients become more demoralized when CBT is continued in the presence of minimal to no appreciable benefit. As such, MI may again become a viable alternative in response to specific client profiles; in this case, failure to respond to CBT.

Case 3: MI to address partial response to CBT

Client information and presenting problem(s)

Ms C is a young married woman who presented on diagnostic interview (Spitzer et al., 1994) with severe generalized social anxiety and recurrent major depression (requiring multiple past hospitalizations). She noted being virtually housebound secondary to severe and chronic social anxiety and has limited educational and vocational attainment, and poor interpersonal relationships, as a result. Her social anxiety was identified as her most salient presenting problem and she accepted an offer to participate in an anxiety management group using a CBT approach. She was an active participant with the group and reported some significant benefit secondary to this involvement (Figure 4). Her strong fear of criticism remained largely unabated despite improvements in mobility and, in particular, Ms C complained of a profound fear of urinating in public bathrooms which strongly limited her efforts to improve her mobility further.

Given the positive changes Ms C had begun in the anxiety group, we contracted for a 10-session course of individual CBT to further extend her treatment gains. However, despite recognition of the necessity of exposure and previous positive experiences with other exposure exercises, Ms C was repeatedly unable to complete exposures (e.g. sneezing in public, not wearing her Walkman on the bus, urinating in a public bathroom). She cited chronicity of the problem, no energy, and no time as obstacles to completion. Such exercises repeatedly proved too difficult despite attempts to reconstruct these in a graded fashion. At the end of the 10-session course of individual therapy, Ms C's scores on fear of criticism (see Figure 4) remained elevated and reflective of

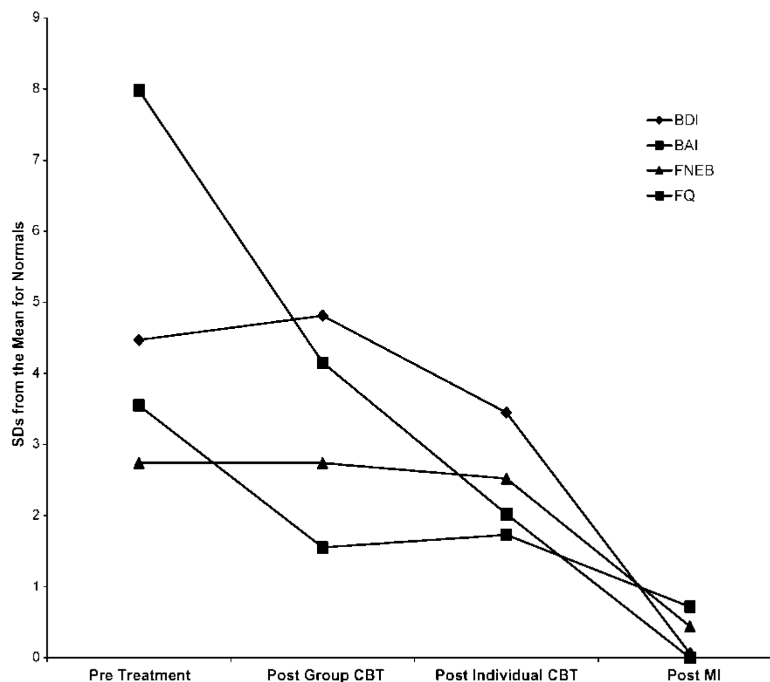

Figure 4. Change in symptoms, Ms C. BDI = Beck Depression Inventory (Pretx = 34, Post Group CBT = 36, Post Individual CBT = 28, Post MI = 8), Beck Anxiety Inventory (Pretx = 39, Post Group CBT = 21, Post Individual CBT = 23, Post MI = 14), FNEB = Fear of Negative Evaluation Scale – Brief Form (Pretx = 52, Post Group CBT = 52, Post Individual CBT = 50, Post MI = 33), FQ = Fear Questionnaire (Pretx = 85, Post Group CBT = 49, Post Individual CBT = 29, Post MI = 10).

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strong continued difficulties. In reviewing her progress, she noted feeling quite discouraged by her inability to make further gains and expressed pessimism about the ability of continued CBT to yield significant benefit. We also discussed the possibility of referring Ms C and her husband on for couples counselling but Ms C was unwilling to discuss this possibility with her husband for fear of his rejecting the proposal.

Motivational interviewing (MI)

Given her clear ambivalence about further homework activities, a shift in focus was suggested to MI or exploration of ambivalence about change, while removing the expectation and goal of change. Ms C was invited to explore the pros and cons of avoiding others and remaining socially anxious. She easily resonated with this task and identified the following: "Keeps me from getting hurt", "Saves energy because it's exhausting to be around others", "Don't risk losing my only friends", and "Don't have to deal with the dissatisfaction I have with my marriage".

Ms C became highly tearful in articulating these "benefits", particularly the freedom from the risk of being hurt. She identified that as a child the family moved frequently. She experienced enormous pain at the repeated loss of close friends and her distress was minimized and invalidated by her parents who told her to "Stop crying. It's just the way it is. You'll make new friends." She was highly tearful as she expressed repeatedly feeling that she was a bad person because of these "failed" relationships and how this contributed to a strong fear of abandonment that persisted to the present day. She described feeling unable to deal with relationships ending and as a result felt it much safer to be avoidant of others and relationships. Furthermore, she described how the only friends she and her husband had currently also had severe mental health problems. As this was a large part of their connection (as was her connection to her husband) she expressed a strong fear that her "improvement" would result in alienating the only people with whom she did feel connected. Moreover, she noted already having such experiences as her increased mobility had resulted in further tension with her husband who complained about her leaving the house. Further movement toward health resulted in Ms C picturing herself being isolated and alone, and having to deal with the unhappiness she felt in her marriage. Finally, Ms C repeatedly expressed a fear of exhibiting sadness and frequently apologized for being tearful in the sessions. In reflecting on this, Ms C noted a fear of her sadness as she predicted that if she allowed herself to cry it may exacerbate sadness and never end.

In MI, the goal of such exploration is not to explicate the developmental origins of current problems *per se*. Rather, the goal is to understand and elicit the values underlying the individual's reluctance to relinquish the present "problem". That is, the therapist repeatedly reflects and summarizes the positive motives underlying the individual's apparent "irrational" behaviour. For example (expressing empathy), "It makes total sense to do everything possible to prevent feeling the pain of loss and rejection, especially if you don't feel you have any ability to deal with those powerful feelings and unleashing them will cause more problems. Staying away from others seems more like a solution than a problem." Or, "So being more outgoing means that you risk ending up with more problems on your hands, like coming face to face with decisions about your marriage and risking having no friends. I can see why you would be so reluctant to take those steps. Sounds pretty rational to me." The therapist also differentially focuses on highly affect-laden items. If unclear, the therapist can ask "Of the reasons for avoiding you've identified, which ones seem the most powerful to you?"

Ms C was then invited to consider any drawbacks to avoiding others. She identified the following: "Continually consumed by my thoughts and worries", "No job, no money, no independence", "Don't have any 'normal' friendships", "Hate being on medications; makes me feel abnormal", and "Constant battles in my mind are exhausting". She noted a strong desire to be more self-sufficient and to command a more powerful position in a relationship. She noted her strong emotional and financial dependency on her husband limited her options in the relationship. In working with her ambivalence, Ms C was invited to write 2 letters outlining the future under conditions of change and no-change (i.e. developing discrepancy between desired outcomes and current behaviour). In the spirit of MI, various suggestions are made which the client is free to act upon or not. Ms C became highly tearful in the process of writing these letters and in reading them in the session (again not a requirement of treatment but rather an invitation). In the "change" letter, she detailed her exhilaration at her freedom from chronic anxiety and limitations

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secondary to psychiatric problems She visualized a more "normal" life with meaningful friendships and self-sufficiency. In the "non-change" letter, she described painful reflections on continuing to endure the absence of joy in her life and her marriage. She described feeling increasingly "abnormal" and hopeless in reflecting on the future. MI also focused on challenging the efficacy of avoiding others in obtaining her goals (i.e. developing discrepancy). For example, "How well is avoidance working in preventing you from being hurt? Saving energy? Ensuring that you don't have to feel sadness or tolerate painful feelings?" Moreover, we focused on developing discrepancy between her stated desires for the future and her current behaviours. For example, "How successful will avoiding others be in helping you to be more self-sufficient? Get a job? Feel more normal?"

After 4 sessions of MI, Ms C identified beginning to make changes in multiple areas of her life. She described that she had recently befriended another woman in her apartment building and they had been going on various outings together. She excitedly described how she had tried on clothing in a store, repeatedly sent the clerk back for different sizes, and noted that she would feel able to return her purchase if for some reason that was required. She noted this being in sharp contrast to her typical style of hurriedly purchasing clothing, not being able to try it on because of the public scrutiny, then throw it in her closet unworn and be unable to return it because of her embarrassment. She noted this having caused substantive guilt in the past for spending money she didn't have. Furthermore, she described being assertive with her father for the first time in years and feeling enormous relief in doing so. Moreover, she described continuing to go out in public and even using public restrooms with ever-decreasing anxiety. She also requested a referral for marriage counselling and noted that she assertively spoke with her husband about this and he agreed to participate. Concomitant with these changes, Ms C described increasing improvement in her mood, having more energy, doing more around the household, and not sleeping during the day. In MI, when an individual makes any change, the therapist explores this in a neutral fashion to facilitate the client's exploration of the pros and cons of the change and to facilitate self-efficacy for further change. For example, "It sounds like you're proud of yourself for having been assertive with your father. What exactly did you like about what you did? Why did you do it? How did you get yourself to do it?"

I continued to follow Ms C for 5 individual therapy sessions delivered every 6 weeks, with the goals of consolidating and extending gains in anxiety, mood management and communication. She experienced 1 significant set-back during this time. This was triggered by an exacerbation of anxiety at the realization that actively pursuing employment would be a logical next step in view of the major improvements in her emotional health. CBT strategies of cognitive reframing and worry exposure were employed to promote Ms C's confidence in this domain. Each of these interventions was delivered within the MI framework of offering suggestions that the client is free to implement or not. She began to pursue active steps toward securing employment, including doing volunteer work and participating with a vocational assistance service. Over this time, Ms C also successfully discontinued all psychotropic medications. Her scores on a variety of indices of anxiety and depression fell into the normal range (see Figure 4).

Case discussion

Ms C illustrates the potential of MI to complement CBT in the face of partial treatment response. The alternative hypothesis in this case is that Ms C, given her previous experience and positive response to CBT techniques, would have implemented these effectively with the passage of time and MI was unnecessary. Again, the major advantage of MI in this case was the ability to provide an alternative mode of intervention, one that preserved and seemed to strengthen the therapeutic relationship. This seemed particularly important in the case of Ms C as she repeatedly noted feeling demoralized by the plateau on her progress and articulated growing pessimism about her potential for more complete recovery. MI seemed to create conditions that allowed her to re-engage with incentives for change and identify more completely the factors blocking more complete recovery.

Discussion

Rather than constituting an argument for replacing CBT, these three cases argue for the potential value of supplementing or integrating CBT methods with MI techniques. Moreover, it may be possible that universal application of MI is not

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required but rather certain client characteristics (i.e. resistance or CBT non-response) may indicate a need to shift treatment methods to motivational techniques. This opinion is also reflected in the writings of motivational theorists. Prochaska and colleagues (Prochaska, Norcross, & DiClemente, 1994) argue for stage-matched therapy with those in action needing action techniques such as CBT, and those in pre-action stages requiring alternative motivational techniques (information provision, contemplation strategies, etc.). Miller and Rollnick (2002) advocate that therapeutic strategies should shift in the presence of "preparation" statements to more active exploration of specific change strategies. It is noteworthy that MI does not preclude the use of change-oriented techniques but rather advocates for discrimination in timing and style (e.g. being invited to make suggestions for how one could change rather than assigning change strategy use through homework).

These case studies are by no means definitive evidence that MI enhances outcome in anxiety or depression. Viable alternative hypotheses exist (e.g. passage of time, being primed by earlier CBT experience) to explain these favourable outcomes. Moreover, other factors influencing motivation may account for the apparent response to MI. Ms A's increasing awareness of the impact of her dysfunction on her children or Ms C furthering her education may have prompted change in and of itself. These hypotheses require systematic empirical investigation in controlled treatment outcome trials such as comparing continued CBT, supportive therapy, no further treatment, and MI in CBT non-responders.

The elements of MI certainly appear to borrow from other existing models of psychotherapy. For example, the exploration of developmental origins of existing problems in Ms B and Ms C, the strong use of empathy and validation in all 3 cases, and the strong emphasis on the elicitation and expression of affect in all 3 cases. The packaging and integration of these strategies, their use in the context of strong theoretical models where ambivalence and motivation are central, and the delivery of these interventions in a time-limited fashion with specific client indications for their use, make MI potentially promising for enhancing CBT outcomes.

In summary, while these 3 cases illustrate some potential of MI to be integrated with or supplement CBT strategies, controlled studies are needed before advocating the application of MI in anxiety and depression. At minimum, the techniques appear to hold promise as alternative strategies for managing resistance to CBT. They represent potentially powerful alternatives therapists can utilize to empower themselves and their clients to move forward in the change process and, as such, stand in contrast to alternatives of continuing with change-oriented techniques alone or unproductively discontinuing treatment.

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