1

Where and Why Motivational Interviewing Fits

Constant or overwhelming feelings of worry, fear, and dread can create great suffering and misery for those who are repeatedly hijacked by anxiety. When severe enough, it is common for anxiety (and the accompanying search for safety) to eclipse critical priorities such as educational or career advancement, forming satisfying relationships, and leisure pursuits, or more generally feeling joy and contentment. It is also not uncommon to see people limping along in their jobs, relationships, or activities but feeling chronically distressed, unsatisfied, or even depressed. Such feelings often prompt people to consider treatment.

While one might assume relief from these highly noxious feeling states would be incentive enough to work toward overcoming them, people are surprisingly conflicted about being less anxious or depressed and about taking action to bring about these ends. Change is difficult and fraught with ambivalence, including conflicting and often opposing motives and feelings. Individuals with anxiety commonly wrestle with such ambivalence. While they may be aware that anxiety is causing problems and have a desire to be free from it, familiar patterns have a seductive quality, despite the many problems they may create. Moreover, it is difficult and demanding to face one's fears, a necessary step in overcoming anxiety, and this is typically not done without significant reluctance and reservations.

Although motivational interviewing (MI) was originally developed as a method to help people work through conflicted feelings about drinking, it is also highly relevant and adaptable to the treatment of anxiety and related problems. Having the tools to help clients process their mixed feelings about change, in an atmosphere of acceptance and understanding, enables a ther-

apist to help clients more confidently and effectively move toward change. And MI is now striking a chord with helpers seeking to facilitate change in many different domains and with many different populations.

My own attraction to MI arose from my experience in working primarily within a cognitive-behavioral orientation to treat those suffering with anxiety and depression. I saw the enormous value of cognitive-behavioral therapy (CBT) for many clients, but for others this approach seemed to fall flat. Realizing that CBT strategies worked very well if a client used them, I began to advocate more vigorously for their adoption by my less engaged clients—with predictably poor results. Rather than increasing their willingness to change, my attempts at advocacy for CBT seemed to alienate my clients further. These interactions would often end in argument, frustration (on both sides), and therapeutic impasses. Moreover, the clients I struggled with would continue to occupy my thoughts in a way that my motivated clients did not. My exposure to MI offered me a complementary skill set that I did not possess at that time. Most critically for me, MI offered a humane and more satisfying way of viewing behavior and working in harmony with my clients, rather than wrestling with them. And this approach, although initially intended for the treatment of substance abuse, seemed to be highly relevant and valuable in navigating the ambivalence about change that I routinely saw in working with those suffering from anxiety and depression.

MI offers a humane way of viewing behavior and working in harmony with clients, rather than wrestling with them.

In recent years, issues of treatment nonadherence and noncompliance have taken center stage. Helpers working in many areas, from medication adherence to lifestyle change to alleviating the suffering of those with anxiety and related problems, are increasingly observing the pernicious problem of lack of client engagement with change, even when help is available and offered. In some ways it seems counterintuitive that clients, even in the presence of great suffering and a clear desire for change, would resist change. Why would people not do what is—even to them—clearly in their best interests? In such a situation it is natural to assume, as I previously did, that clients lack knowledge and direction. Perhaps they don't know how to change.

Let me recount some recent experiences that I had with helpers in my own life when writing this book, in order to position MI in the context of common, intuitive approaches to accomplishing behavior change. When I went to see my family physician for my annual checkup, he quite matter of factly told me that I should use less salt—use it either while cooking or sprinkle it on top of food while eating, but not both. What he didn't seem to appreciate or inquire about however, was my deep love of salt and all

things salty. And he seemed to assume that correcting my information gap (although I was already aware of the potential health dangers of excessive salt) would be enough to elicit my compliance. After all, this was for the good of my health.

Then I joined a gym where the fitness assessor seemed slightly more aware of issues of noncompliance. She explained that many people join the gym but then stop coming after a time—a situation she admitted she was at a loss to understand. She stressed that she could only give me the information and point me in the right direction but that it was up to me to decide whether to comply. Although she was explicitly acknowledging my freedom to choose and the words sounded right, something was missing. I was left feeling that she was either attempting to coerce me or didn't really care if I complied. Clearly helpers of all stripes, while recognizing the need to improve engagement with treatment, are struggling to figure out how to accomplish this and are often ineffective, despite their well-intentioned efforts.

In a sense, it is striking that we have developed so many effective strategies and approaches to help clients with anxiety accomplish change and yet we have neglected a fundamental truth that everyone from lay people to clients to trained professionals readily acknowledges: that change is impossible unless one wants to change. And once sufficient interest and motivation for change are present, change seems far less difficult and daunting and tends to proceed far more smoothly. As articulated by Sheldon, Williams, and Joiner (2003), clinicians who are technically proficient and knowledgeable about methods of facilitating change or action will often find themselves impotent if they are unable to build motivation and help clients work through their conflicting, powerful, and often contradictory feelings about change.

In this book, I suggest that efforts to get people to change, such as those of my family physician and my fitness appraiser, are destined to fail if they are devoid of relationship and context—of interest in the person, their reactions, life circumstances, preferences, beliefs, and values. Through situating attempts to explore and build motivation for change in the context of the person and a secure therapeutic relationship, MI offers a uniquely engaging way forward to facilitating client active involvement with treatment and change, one that is complementary to more action-oriented approaches that are prevalent in the treatment of anxiety and related problems.

We have developed effective strategies to help clients change anxiety, but change is impossible unless one wants to change.

In this chapter, I briefly describe the major anxiety disorders and their current treatment. I then consider why it makes sense to integrate MI into the treatment of anxiety and

commonly co-occurring problems such as depression, and provide an overview of this proposed integration.

OVERVIEW OF ANXIETY DISORDERS AND THEIR TREATMENT

There are several major types of anxiety disorders (see Barlow, 2002, for a more complete elaboration). In descending order of prevalence, they include:

- Specific phobia or fear of circumscribed objects or situations (e.g., heights, injections, flying). Even though specific phobias are the most prevalent type of anxiety, they are less likely to present to treatment than the other types of anxiety, which are typically more complicated, distressing, and impairing.
- Social phobia (fear of embarrassment or humiliation in social or public situations).
- Posttraumatic stress disorder (PTSD; persistent reexperiencing of a traumatic event, distress associated with exposure to reminders of the event, and emotional detachment)
- Generalized anxiety disorder (GAD; excessive, uncontrollable worry in a number of areas such as health, work performance, the well-being of others, finances, etc.).
- Agoraphobia (fear of being unable to escape or of being alone in the event of a panic attack).
- Panic disorder (recurrent unexpected panic attacks—sudden escalation of multiple somatic fear symptoms such as heart racing shortness of breath) which is often associated with the development of agoraphobia.
- Obsessive–compulsive disorder (OCD; recurrent and intrusive thoughts, images, or impulses such as fears of contamination or thoughts of harm toward others and/or repetitive actions aimed at reducing anxiety or neutralizing obsessive thoughts).

All anxiety disorders involve bodily arousal, threat-related thoughts and beliefs, and avoidance, each influencing the others to maintain the experience of anxiety (Dozois & Westra, 2004). While the focus of the threat differs among the various types of anxiety, anxious arousal is triggered by external cues (e.g., needles in injection phobia, social situations in social anxiety, reminders of the traumatic event in PTSD) or internal cues (e.g., heart racing or dizziness, obsessive unwanted thoughts, worry itself) that signal the presence of threat. These situations are given catastrophic

appraisals (e.g., heart racing may be interpreted as indicative of an impending heart attack or death in panic disorder, social interaction may represent the possibility of shame or embarrassment in social anxiety), and the client experiences a sense of having limited personal control over the feared events, hypervigilance or chronic anticipation of encountering feared situations, and attention narrowing to concentrate on the focus of threat.

All anxiety disorders involve attempts to take protective actions to reduce threat and reestablish safety. Most typically these involve attempts to escape or avoid feared stimuli, with the particular pattern of avoidance being consistent with the specific situations that are feared. While outright avoidance of feared situations is common, many attempts at avoidance are more subtle. For instance, a person may remain in a frightening situation but initiate behaviors (e.g., using alcohol, carrying safe objects) or thought processes (e.g., distraction, mental rehearsal) to dampen the anxiety and worry (Dozois & Westra, 2004). Unfortunately, these attempts at avoidance serve to perpetuate the very anxiety from which one seeks relief. They reinforce the perceived danger of the threat and perpetuate a lack of self-efficacy or control in managing the threat. Avoidance also serves as negative reinforcement (temporary alleviation of anxiety). In essence, by avoiding, the person fails to learn some basic truths about potential dangers: that negative predicted events do not always occur, and, even if they do, that they are manageable and not as disastrous as the anxiety predicted.

Prevalence of Anxiety and Associated Problems

Anxiety disorders are the most common of all mental disorders, with high 1-year and lifetime prevalence rates of 17% and 25%, respectively (Kessler et al., 1994). They are associated with much distress, suffering, and related problems, and, if left untreated, anxiety disorders tend to persist and recur. Studies of quality of life among individuals with anxiety disorders reveal a picture of marked impairment in many areas, including educational and career development, employment, and relationships (Mendlowicz & Stein, 2000). In fact, the reduced quality of life reported in individuals with anxiety disorders is comparable to, and in some instances worse than, major medical illnesses (e.g., Rubin et al., 2000).

An individual with an anxiety disorder often has other associated mental health problems, most commonly depression, other anxiety disorders, and substance abuse (Barlow, 2002). Most striking is the relationship between anxiety and depression. About 50% of those who have an anxiety disorder are also depressed (Brown, Campbell, Lehman, Grisham, & Mancill, 2001), and this rate climbs to 76% when considering lifetime diagnoses (Brown & Barlow, 2009). Anxiety is also more likely to precede depression than the reverse (Brown et al., 2001; Cole, Peeke, Martin, Truglio, & Seroc-

zynski, 1998). The extensive overlap between anxiety and depression has raised questions as to whether they are distinct syndromes (Barlow, 2002). Accordingly, treatment protocols that consider the commonalities among the anxiety disorders (e.g., Norton & Hope, 2005) and between anxiety and depression (e.g., Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010) have emerged recently. In short, anxiety disorders are common, often associated with marked impairment, distress, and reduced quality of life, and without treatment they tend to persist.

Treatment of Anxiety

Effective treatments for anxiety disorders have been developed, most notably CBT (Barlow, 2002; Norton & Price, 2007). Large effects in reducing symptoms have been consistently reported across numerous well-controlled studies. Various treatment guidelines now recommend CBT as the first-line approach to treating anxiety disorders (e.g., National Institute of Clinical Excellence, 2004; Swinson, 2006).

Although CBT treatments typically consist of multiple types of interventions (e.g., self-monitoring, cognitive restructuring, relaxation training), most emphasize exposure to feared situations/stimuli as a critical and necessary component of treatment. By facing, confronting, and remaining in threatening situations, a client can extinguish fear, experience new learning, and develop more adaptive coping skills, reducing the need to avoid feared situations in the future. Reductions in the threat occur as new evidence is accumulated that differs from catastrophic predictions. Hence, heavy emphasis is placed on helping the person to approach feared situations. In general, exposure to unwanted, aversive, and avoided experiences is a common goal in approaches to treating anxiety.

WHY APPLY MOTIVATIONAL INTERVIEWING TO ANXIETY?

Ambivalence about Change

Ambivalence about change is extremely common, even among those who have decided to enter treatment. In fact, up to two-thirds of individuals entering treatment for mental health problems can be classified as being in either the precontemplation (not yet actively considering change) or the contemplation (considering change but conflicted) stage of change. That is, they are significantly uncertain or undecided about change and therefore are unlikely to use action-oriented strategies (O'Hare, 1996). While people desire change, they simultaneously fear it. Existing patterns and ways of being have a seductive and compelling quality and frequently threaten and

sabotage efforts to change. As Mahoney (2003) has noted, many of the processes that we see as pathological are actually efforts at self-protection and cohesion and therefore can be highly resistant to change.

Research with those suffering from anxiety suggests that many individuals enter treatment reluctantly and with significant reservations about engaging with therapy (e.g., Dozois, Westra, Collins, Fung, & Garry, 2004; Simpson, Zuckoff, Page, Franklin, & Foa, 2008). For example, among those with OCD considering treatment, Purdon, Rowa, and Antony (2004) found that 94% of their sample articulated at least one treatment-related fear. The most common fears included concerns about intensifying anxiety and fears of failure in treatment, rendering the individual more hopeless. Other concerns included fear of success (resulting in increased expectations from others) as well as fears of disclosure and therapist judgment. Such fears of treatment have been identified as a major cause of the failure to seek help for mental health problems (e.g., Kushner & Sher, 1989). That is, individuals contemplating seeking help must balance their desire for symptom relief against potential concerns about, and the costs of, seeking help.

Individuals who worry excessively often see worry as a problem while simultaneously holding positive beliefs about worry (e.g., "Worry is motivating," "Worrying protects me and prepares me for negative events") and are therefore ambivalent about relinquishing it (e.g., Borkovec, 1994; Westra & Arkowitz, 2010). Even something as noxious as rumination, which is common in depression, can be perceived as a positive attempt to find answers or understand past mistakes and failures (Papageorgiou & Wells, 2001). Moreover, self-blame, self-criticism, and withdrawal are often familiar response styles learned as a way to cope with environmental and interpersonal stress, and are adaptive and "safe" behaviors when in conflict with powerful others, such as early attachment figures (Gilbert & Irons, 2005). At times, such defensive strategies will bring temporary relief. Similarly, there is a high degree of ambivalence among individuals who contemplate suicide; they want to die, but they also want to live with less pain (Jobes & Mann, 1999). And the ratio of the strength of the wish to live to the wish to die is a critical determinant of future suicide-related behavior (Kovacs & Beck, 1977).

Resistance in Therapy

Much of what is thought of as resistance or noncompliance in psychotherapy may be a reflection of this ambivalence about change (Engle & Arkowitz, 2006). This may explain why many clients remain in treatment but either fail to comply or comply only minimally with recommended treatment procedures. For example, homework assignments are frequently

recommended across various types of psychotherapy, and in some forms of treatment (such as CBT) they are regarded as essential. However, homework noncompliance is a common clinical reality. In surveys of practicing CBT therapists, deviations from the assigned task are commonplace, with only a minority of clients identified as totally compliant (Kazantzis, Lampropoulos, & Deane, 2005). And homework noncompliance has been described as the rule rather than the exception in CBT (e.g., Helbig & Fehm, 2004). Moreover, resistance to therapist direction has been identified as a strong predictor of both subsequent engagement with the tasks of treatment (Jungbluth & Shirk, 2009) and outcome (Aviram & Westra, 2011; Beutler, Harwood, Michelson, Song, & Holman, 2011).

Treatments that direct clients to take action toward change require a relatively high level of client motivation. Thus, limited engagement with treatment among those who are ambivalent about change may be at least partially responsible for limiting response rates to these treatments. For example, despite the well-established efficacy of CBT in the treatment of anxiety and depression, a substantial number of patients do not engage or respond adequately (e.g., Westen & Morrison, 2001). In a survey of expert CBT practitioners, the most frequently cited reasons for insufficient treatment response were, by a wide margin, "lack of engagement in behavioral experiments" and "noncompliance" (Sanderson & Bruce, 2007). Strong convergent evidence has emerged for the importance of resistance to change and treatment as an important process marker indicating the use of supportive rather than directive strategies (e.g., Beutler et al., 2011), with the addition of MI substantially reducing resistance in CBT for anxiety (e.g., Aviram & Westra, 2011). And active involvement in and receptivity to the treatment process is consistently related to better outcomes (e.g., Orlinsky, Grawe, & Parks, 1994).

The Evidence for Motivational Interviewing in the Treatment of Anxiety

Even though MI is a well-supported treatment in the substance abuse domain (e.g., Hettema, Steele, & Miller, 2005) and it seems to make sense to integrate it into the treatment of anxiety and related problems such as depression, research has only recently begun to test the value of adding MI to existing treatments for these conditions (Westra, Aviram, & Doell, 2011). Consistent with the early stage of this work, this research includes uncontrolled case studies and controlled pilot studies. Case study data supporting adding MI and motivational enhancement strategies including MI have been reported for a range of anxiety disorders, including OCD (Simpson & Zuckoff, 2011), GAD (Westra & Arkowitz, 2010), social anxiety disorder (Buckner, Roth Ledley, Heimberg, & Schmidt, 2008), panic

disorder (Arkowitz & Westra, 2004), health anxiety (McKay & Bouman, 2008), and mixed anxiety and depression (Westra, 2004).

In studies that have compared MI to psychoeducational or no-treatment controls, MI is demonstrating promise in:

- Increasing treatment seeking among those with social anxiety who are not yet seeking care (Buckner, 2009).
- Increasing problem recognition and treatment attendance for PTSD (Murphy, 2008).
- Increasing receptivity to recommended treatments such as exposure and response prevention for OCD (McCabe, Rowa, Antony, Young, & Swinson, 2008; Tolin & Maltby, 2008).
- Improving response to CBT for anxiety more broadly (Westra & Dozois, 2006) and GAD in particular (Westra, Arkowitz, & Dozois, 2009)

In a larger controlled trial of adding MI (or no MI) as a pretreatment to CBT for GAD, MI was found to substantially improve worry reduction among those with the most severe worry at the outset of treatment (Westra et al., 2009). In this study, those of high worry severity who received MI as compared to those who did not, showed substantially lower levels of resistance (i.e., higher receptivity to change) in CBT, and this accounted for their higher levels of worry reduction in treatment (Aviram & Westra, 2011). While promising, these studies have a number of important limitations, and future research, using rigorous controlled designs, is needed to determine the value of adding and/or integrating MI with other treatments for anxiety and depression.

Research on the use of MI to manage depression is still in the very early stages. A number of supportive uncontrolled case studies using MI for depression (Arkowitz & Westra, 2004; Brody, 2009) and suicidal ideation (Britton, Patrick, Wenzel, & Williams, 2011; Britton, Williams, & Connor, 2008; Zerler, 2009) have been reported. Swartz and colleagues (2006) developed and examined the impact of an engagement interview, which drew heavily on MI principles, with mothers of psychiatrically ill children (who suffer from very high rates of mental health problems, especially depression, yet rarely seek treatment). In one study, among the 13 individuals who received the interview, 85% went on to complete the subsequent treatment (interpersonal therapy for depression) and showed significant improvement (Swartz et al., 2006). Similar findings with another difficult-to-engage population—pregnant, depressed, economically disadvantaged women—have also been reported. In this study, 68% completed a full course of treatment as compared to only 7% of the usual care group (Grote et al., 2009).

Even a brief dose of MI (10–15 minutes) resulted in higher levels of engagement with an Internet-based treatment designed to prevent depression among at-risk adolescents, compared to brief advice from their primary care physician (Van Voorhees et al., 2009). Similarly, Simon, Ludman, Tutty, Operskalski, and Von Korff (2004) used structured MI exercises to enhance engagement of depressed primary care patients in telephone CBT, finding that this group showed lower depression scores as compared to those receiving treatment as usual. Finally, Britton and colleagues (2011) have recently adapted MI to address suicidal ideation (MI-SI). MI-SI is a single-session treatment designed to access and enhance clients' motivation to live and engage in life-enhancing activities. This treatment was reported to be well tolerated, but the intervention has yet to be tested for its efficacy in improving treatment retention and outcomes in controlled studies.

TWO WAYS TO USE MOTIVATIONAL INTERVIEWING

In this book, I suggest there are two major ways to use MI in the treatment of anxiety and related problems: (1) using MI to build motivation among those who are significantly ambivalent about change and (2) using MI as a foundational framework for guiding those who are ready to take action toward change.

Using Motivational Interviewing to Build Motivation

One way of integrating MI in treatment involves using it in the face of high levels of client ambivalence about or resistance to change. And this represents the way that MI has typically been thought about and used: to build resolve or momentum to change in the presence of ambivalence about and resistance to change. For example, it may be clear from the initial interview or early in treatment that specific attention needs to be paid to building motivation for change. A client may express skepticism or ambivalence about change, have previously failed in attempts to change, or have low expectations for being able to change. Alternatively, motivational impasses may arise (or recur) when the client is taking action to change. For example, a client may oppose therapist suggestions or show low levels of engagement with in-session or between-session tasks. At these times, shifting out of an action-oriented approach and into MI temporarily may be useful until client motivation and engagement with the tasks of change are established (or reestablished).

Thus, MI can be used as a pretreatment and/or integrated into more action-oriented treatments when motivational impasses occur. These are

the most common ways that MI has been thought about and utilized, and they seem to be particularly indicated when clients are "stuck" and resist active efforts to change. Indeed, in a recent study of client accounts of their experiences of MI for worry, the largest dimension that emerged was reports of increased resolve, momentum, and determination to change (Marcus, Westra, & Angus, 2011). Furthermore, evidence suggests that MI is synergistic with other therapies; that is, the effects of MI are stronger (Burke, Arkowitz, & Menchola, 2003) and more enduring (Hettema et al., 2005) when it is used in an adjunctive capacity.

One major objective of this book, then, is to extend the application of MI to the treatment of anxiety and the problems with which it commonly co-occurs. To this end, I describe and illustrate the application of MI to building motivation and enhancing resolve for change among those suffering with various anxiety disorders, as detailed by the original developers of MI, William Miller and Stephen Rollnick (2002). Strategies for building motivation can be used whenever resistance and ambivalence emerge over the course of treatment. Accordingly, in Part II of this book, Assessing Readiness for Change, various ways of recognizing ambivalence and resistance are outlined. Such skills are necessary in order to identify when the strategies for building resolve and increasing motivation are indicated and, more generally, to build sensitivity to hearing resistance to change and to promote flexibility in responding to it. Part III, Understanding Ambivalence and Building Resolve, outlines the application of MI to building motivation and enhancing commitment to change among those with anxiety and related problems. Specifically, the MI skills of understanding ambivalence (Chapter 5), reframing resistance to change (Chapter 6), evoking and elaborating change talk (Chapter 7), and developing discrepancy (Chapter 8) are discussed in the context of work with anxiety and related problems.

Using Motivational Interviewing Beyond Building Motivation

Although MI is typically thought of as a method to build motivation, it does not have to end there. That is, a clinician does not have to pick up MI to enhance motivation for change and then put it down again once the client seems ready to change. Upon learning MI, you begin to see other possibilities for fitting it into your broader practice, such as:

- Being more evocative generally (e.g., stopping before answering a client's question in order to have the client answer it first).
- Explicitly recognizing clients' autonomy to choose, even when they are committed to change (e.g., often saying "Only you can know what is best").

- Becoming more sensitive to hearing how clients talk about change (developing a kind of radar for resistance whenever it arises, including during the action phase).
- Starting to think about your role differently (i.e., as more of a guide rather than an expert teacher) even when the client is taking action.
- Appreciating the subtleties and complexities of the gentle, powerful art of reflective listening and how it can be used to advance planning for and processing change (realizing for example, that how you reflect things can lead someone to further elaborate or back away from a previous statement or position).
- Generally finding yourself becoming increasingly sensitive to how engaged the client is with the process of treatment, on a moment-to-moment basis, over the entire course of therapy.

All of these things are consistent with MI, and learning MI can change you. It can make you more sensitive, not only to issues of motivation and resistance to change but also to client engagement and disengagement with the process of treatment. It can also make you more sensitive to how you present things and how you come across in therapy and, more broadly, to the significance of the underlying interpersonal and communicative process that occurs between client and therapist.

Perhaps because of this heightened sensitivity, you find yourself working in harmony with your clients more often or even most of the time (even when you're not "doing MI") and experience the process of therapy to be a real partnership where each person contributes valuable expertise. If you are less familiar with client-centered therapy (on which MI is based) and were trained in a more directive model of therapy, learning MI can heighten your awareness of the significance, difficulty, power, and complexity of skills like empathic listening, providing unconditional positive regard, rolling with resistance, and, more broadly, developing a safe and collaborative therapeutic relationship. You begin to wonder (and sometimes struggle) about how such skills can be integrated into your practice more broadly, even when motivation is not an issue.

Learning MI can change you as a clinician.

Thus, in addition to enhancing motivation, there may be other possibilities for integrating MI into treatment. In particular, MI has much to tell us about the underlying interpersonal process of therapy or *how* treatment can be conducted. MI rests on the foundations of client-centered counseling (Rogers, 1951, 1957, 1965), described in MI language as "MI spirit," which refers to a particular attitude or way of being with clients. Accord-

ingly, this spirit is considered more critical than any particular method within MI (see Chapter 2). Indeed, when you talk to MI practitioners, you realize that what is shared in common more than anything else is a way of thinking—a particular way of looking at people, change, and one's role in this process. The impact of this attitude can be most readily observed in the interpersonal process between client and therapist. It informs or translates into a particular manner in which the therapist interacts with clients (e.g., evoking client expertise and strengths, recognizing and safeguarding client autonomy, avoiding power struggles, and the like).

In this sense then, *MI can serve as a foundational framework into which other treatments can be integrated*. This extension of MI to supporting action toward change naturally emerges from the underlying spirit or attitude of MI. This spirit constitutes a platform or framework that informs how more action-oriented therapies might be conducted. Thus, combining the client-centered spirit of MI (ways of being) with the technical merits of other treatment approaches (ways of doing) may constitute a meaningful and powerful point of integration. Moreover, a wide variety of specific intervention methods to promote behavior change can be integrated into, or conducted from, an MI stance. This may be particularly the case since MI was not originally intended as a standalone therapy and makes no claims about which strategies are superior for achieving behavior change (Miller & Rollnick, 2009).

Significant advances have been made in developing effective interventions for helping those suffering with anxiety and depression to achieve relief from these debilitating conditions. Action-oriented treatments such as CBT (e.g., Barlow, 2002), acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 2012), mindfulness awareness (Segal, Williams, & Teasdale, 2001), and behavioral activation (Martell, Addis, & Jacobson, 2001), among others, have repeatedly demonstrated their efficacy as treatments for anxiety and co-occurring problems of depression. While the importance of collaboration, empathy, and the therapeutic alliance have clearly been acknowledged in these approaches, less attention has been paid to proficiency in the relational aspects of therapy as compared to technical proficiency with specific interventions.

In other words, many action-oriented treatment protocols are typically better at specifying *what* to do rather than *how* to do it. That is, describing the underlying interpersonal process and therapist attitudes conducive to effective intervention are less well specified. Arguably, the relational context in which change strategies are presented and implemented is an important determinant of client receptivity to them. And specific interventions or change methods can never be disembedded from their relational and communicative context. Importantly, extending the MI relational stance

(and the methods that emerge from it) into the action phase of therapy can avoid some of the pernicious problems of resistance and noncompliance that more directive approaches can often create.

Variability in relational skills may be an important area that accounts for therapist variability in outcomes despite similar levels of technical competence (e.g., Huppert et al., 2001). It may be likely that those therapists who are more proficient in generating positive outcomes by using action-oriented treatments are more relationally adept (e.g., sensitive to resistance and alliance ruptures, flexible, empathic, attuned to fluctuating client needs and engagement, warm). For example, more-effective CBT therapists are characterized by clients as more client-centered (evocative, collaborative), while less-effective therapists are described as more compliance-oriented and as prioritizing their own expertise (Kertes, Westra, & Aviram, 2010). And CBT therapists who go on to generate clients high in expectations for a positive outcome show vastly better skill at maintaining a friendly, collaborative atmosphere in the presence of client opposition or disagreement than those therapists whose clients went on to be pessimistic about treatment outcome (Ahmed, Westra, & Constantino, 2010).

In other words, what may differentiate more- from less-effective action-oriented therapists is the underlying attitude of the therapist or the interpersonal spirit in which treatment takes place. This conclusion is echoed by colleagues who have often observed, "Good therapists [practicing my particular approach] are sensitive to relationship and client engagement issues and flexible in response to fluctuating client motivation." Arguably, these underlying process variables need to be explicitly specified and operationalized, especially if they are skills capable of differentiating success and failure with a particular treatment. And MI may provide a vehicle for specifying, at least in part, an effective process for conducting therapy.

Thus, with respect to the second way to use MI, Part IV of this book, Extending Motivational Interviewing into the Action Phase, presents some ways in which MI can inform treatment even when ambivalence about change is not (or is less) present. Specifically, I discuss and illustrate methods for evoking, building, and elaborating client expertise in envisioning, planning for, and processing efforts to change (Chapter 9). I also discuss means of bringing in therapist expertise while protecting and reinforcing client autonomy (Chapter 10). In addition, I suggest a major role for empathy and listening reflectively in the action stage to accomplish common and important goals in the treatment of anxiety and related problems, including self-confrontation, exposure to avoided experience, and promoting self-acceptance (Chapter 11). Finally, I outline the MI strategies for rolling with resistance and illustrate their use with clients in the action stage of therapy to process the natural fluctuations that occur in client resolve to take action (Chapter 12).

SUMMARY AND CONCLUSION

In short, ambivalence about treatment and change is common in clinical practice, including among those seeking relief from anxiety and depression. Most people come to therapy in great pain, and often they are confused and conflicted about the origins of this pain and what they want to change. This ambivalence may give rise to resistance, noncompliance, or limited and reluctant engagement with taking action to change. Noticing this often profound ambivalence, and working with it while abstaining from imposing one's own agenda, preferences, values, and desires, is a key part of MI.

Research on MI for anxiety and related problems is just beginning, but existing evidence is consistent in supporting the potential of MI to enhance engagement with and response to other treatments including CBT (Westra et al., 2011). It is particularly promising that MI is demonstrating efficacy with populations (treatment refusers, those reluctant to seek care) and subsets of populations (e.g., high severity) that are typically treatment-nonresponsive and difficult to engage. Moreover, the key clinical skills of MI such as empathy, cultivating a positive therapy relationship, and flexibility in responding to fluctuating client needs are important contributors to client benefit from therapy generally, and these skills seem to be especially indicated when navigating ambivalence and resistance.

As such, integrating methods to address ambivalence, reduce resistance, enhance intrinsic motivation, and prepare people for change complements more action- or change-oriented approaches to the treatment of anxiety. I have argued that this can be done in two ways: (1) through using MI (as originally conceived) to enhance motivation among those who need this and (2) through extending the underlying spirit and methods of MI into the action phase to help clients conceptualize, plan for, implement and process the changes they wish to make. Doing so may not only improve the effectiveness of major approaches to the treatment of anxiety and related problems such as depression but also facilitate training in the process factors and therapist attitudes that most influence client engagement with therapy.

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