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Cognitive and Behavioral Practice 23 (2016) 205-220

Cognitive and Behavioral Practice

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Integrating Motivational Interviewing and Brief Behavioral Activation Therapy: Theoretical and Practical Considerations

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Behavioral Activation and specifically the Brief Behavioral Activation Therapy for Depression (BATD) has a strong record of empirical support but its focus on practical out-of-session activation-based assignments can lead to poor levels of adherence if efforts to enhance motivation are not prioritized. Towards this end, this paper describes the assimilative integration of Motivational Interviewing (MI) and BATD to improve clinical outcomes by integrating MI's focus on building and maintaining motivation to change into BATD. The paper provides an overview of MI and BATD, theoretical issue raised in integrating the two approaches, and examples of how this integration results in a nondirective and motivation-focused approach to conducting BATD.

Behavioral Activation (BA) is a well-established and effective treatment for depression (Cuijpers, van Straten, & Warmerdam, 2007; Ekers, Richards, Gilbody, 2008; Mazzucchelli, Kane, & Rees, 2009). The theoretical underpinnings of BA are rooted in early behavioral approaches to depression (e.g., Lewinsohn, 1974), and it was most clearly established through a landmark dismantling study indicating that the behavioral aspects of cognitive behavioral therapy (CBT) produced results comparable to the whole treatment package (Jacobson et al., 1996). This early work was followed by subsequent development of the BA treatment approach (Martell, Addis, & Jacobson, 2001; Martell, Dimidjian, Hermann-Dunn, & Lewinsohn, 2010) and further empirical work showing BA was comparable to CBT and medication, and even superior under some conditions (Dimidjian et al., 2006; Dobson et al., 2008).

Given the increasing need to develop brief, empirically supported psychotherapies evidenced over the past decade, Lejuez, Hopko, and colleagues developed a shorter and more narrowly focused version of the protocol, Brief Behavioral Activation Treatment for Depression (BATD; Lejuez, Hopko, LePage, Hopko, & McNeil, 2001; Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011). This approach is typically administered in 5 to 12 sessions and focuses solely on the core aspects of activation, such as daily monitoring, identification of core life values, valued activity selection and planning, and contracting for social support where barriers to activity completion are experienced. To date, there are multiple studies that indicate its efficacy in reducing depression in a range of clinical samples, including community individuals in outpatient and inpatient treatment (Hopko, Lejuez, LePage, Hopko, & McNeil, 2003), older adults experiencing complicated bereavement (Acierno et al., 2012), veterans with PTSD (Strachan et al., 2012), substance users in the community (MacPherson et al., 2010) and in a residential treatment setting (Daughters et al., 2008; Magidson et al., 2011), and among individuals with significant medical conditions including cancer (Hopko, Armento, et al., 2011).

While the evidence for BA and BATD is promising, the practical aspects of the approach and the focus on between-session activities (often referred to as "homework") raise barriers regarding the need for developing patients' motivation and willingness to engage in these important therapeutic components. Supporting this assertion, Dimidjian and Hollon (2011) identified patient motivation as one of the key factors in preventing treatment failure in BA, and Baruch, Kanter, Bowe, and Pfennig (2011) had provided a thorough discussion of homework issues in BA. Morevoer, Hopko, Armento, et al. (2011) suggested that issues of motivation and adherence may be especially relevant to BATD given that, even compared to BA more broadly, BATD has a more narrow focus on activation and out-of-session activities that may impact patient acceptance of the approach and

[1] Video patients/clients are portrayed by actors.

Keywords: retention; homework; Motivational Interviewing; Behavioral Activation

adherence with its content if not presented in a manner sensitive to these issues.

BA and BATD manuals include specific recommendations that support collaborative and supportive strategies to enhance patient motivation and adherence (Lejuez et al., 2011; Martell, Dimidjian, Herman-Dunn, & Lewinsohn, 2010) both in the introduction and review of assignments (Kanter, Busch, & Rusch, 2009; Martell et al., 2010). However, the efficacy of the recommended approaches has not been assessed. Yet, even with a strong focus on assignment adherence, the potential for nonadherence is a threat to therapy progress (Hopko, Magidson, & Lejuez, 2011). Adherence is also an issue for CBT therapies more broadly and many of the commonly used approaches to improve homework adherence in other structured therapies have shown limited efficacy (Bryant, Simons, Thase, 1999). Given these challenges, the current paper considers the potential benefit of integrating BATD with Motivational Interviewing (MI), an approach that directly focuses on these issues. Indeed, interventions combining MI with other treatment approaches have often resulted in improved treatment outcomes, but studies also have highlighted challenges in integrating MI with more directive therapies.

In mental health, MI has been combined with CBT to increase treatment initiation and adherence for various psychiatric disorders (Arkowitz et al., 2008; Arkowitz & Westra, 2009; Westra & Arkowitz, 2011). MI has most often been used as a precursor to treatment (Carroll, Libby, Sheehan, & Hyland, 2001; Merlo, et al., 2010; Swartz, et al., 2008; Westra, Arkowitz, Dozois, 2009; Westra & Dozois, 2006; Zuckoff, Swartz, & Grote, 2008). Such studies have found that a pretreatment MI intervention resulted in improved outcomes, including better treatment response (Merlo, et al., 2010; Westra, Arkowitz, & Dozois, 2009; Westra & Dozois, 2006); higher self-efficacy (Westra & Dozois, 2006), homework adherence (Westra & Dozois, 2006; Westra et al., 2009), and decreased resistance (Aviram & Westra, 2011). Other studies with a pretreatment MI intervention also added a booster session in case a patient's motivation subsides during the other treatment (COMBINE, 2003; Simpson, et al., 2010). However, these studies did not specifically assess the effects of the booster session.

More recently, there has been increased interest in fully integrating MI into other treatments in order to maximize the patient's engagement and motivation throughout the treatment and lessen resistance or nonadherence to different treatment components. In such integrations the therapist does not come in and out of an MI approach. Instead, MI is woven into the fabric of the other treatment, resulting in their seamless integration (Arkowitz & Westra, 2004). Although full integration of MI into other treatments remains in its infancy, it has shown promise. For example, an intervention that integrated MI into pharmacotherapy sessions for depressed Latino outpatients ($N = 50$) retained 80% of the patients during 12 weeks of treatment, compared to historical controls of 40% to 50% retention of similar patients at 12 weeks (Balán, Moyers, & Lewis-Fernandez, 2013; Lewis-Fernandez et al., 2013). Similarly, Barrowclough et al., (2001) fully integrated MI into CBT for substance misuse in patients with psychosis. The integrated treatment resulted in significantly greater improvement in patients' general functioning than routine care posttreatment and at a 12-month follow-up as well as a reduction in positive symptoms, symptom exacerbations, and substance use over the 12-month period from baseline to follow-up.

However, combining or integrating MI with more structured therapeutic approaches can be difficult, much like the challenges faced when integrating more collaborative aspects of CBT such as collaborative empiricisim and guided discovery (Tee & Kazantzis, 2011) into the more traditionally directive aspects of CBT, such as psychoeducation, the role of clinician as expert, and structured manualized CBT treatments (Overholser, 2011). The integration of MI with other psychotherapies can highlight differences between the approaches in what is considered to be the role of the therapist and patient, helpful patient-therapist interactions, and how to best help the patient overcome the problem.

These differences were clearly observed by Simpson et al. (2010) who, as part of a study that added MI to Exposure/Response Prevention (EX/RP), rated the EX/RP sessions using the Motivational Interviewing Treatment Integrity rating system to assess MI consistency during EX/RP sessions. Findings showed that although the study clinicians were competent in the use of MI during the MI portion of the treatment, ratings for MI consistency during the EX/RP portions were quite low, highlighting the differences between the two treatment approaches.

Another challenge focuses on the ability of clinicians to conduct both treatment approaches effectively. For example, Moyers and Houck (2011) and Simpson et al. (2010) found that their therapists had difficulty identifying when the patient was sufficiently motivated and the treatment should move from MI to more structured components, and, vice versa, when there were junctures in the treatment which called for a switch back to MI before continuing with the other components of the treatment.

Our assimilative integration (Messer, 1992, 2001) of MI and BATD aims to overcome the challenges faced in other interventions that combined MI and directive therapies by carefully considering the conceptual fit between the two approaches and how the specific techniques used in each approach interact with those of the other approach. For example, how might key educational