

**COMBINING MOTIVATIONAL INTERVIEWING WITH COGNITIVE BEHAVIOURAL THERAPY IN PRIMARY CARE: A LITERATURE REVIEW**

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**Abstract:**

Over the decades, numerous psychological concepts have enhanced our understanding of human behaviours. Specifically, psychotherapies have assisted and improved overall well-being for individuals with problematic behaviour. This literature review will compare the history, theory, principles, and core skills of motivational interviewing (MI) and cognitive behavioural therapy (CBT). This review will illustrate why a combined approach of MI and CBT is more beneficial than using either technique on its own. The evidence available on MI-CBT effectiveness in clinical practice and ways to implement it in primary care is discussed.

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**Introduction**

Over the decades, the understanding of human behaviour has evolved. The behaviours of humans are constructed through their environment, cultural background, attitudes and values (1). Humans have an acceptable range of behaviours dictated primarily by social norms and personality traits (1). The introduction of various psychological concepts has assisted in the explanation of specific individual practices. Psychotherapies have contributed to helping individuals alter problematic behaviour and improve their overall mental health through analyzing thoughts, feeling, beliefs and connections (2). This paper will highlight the core skills and principles of motivational interviewing (MI) and cognitive behavioural therapy (CBT) as well as compare, contrast, and provide evidence for these two therapies. Finally, a discussion will occur about how a combined MI-CBT approach will be appropriate to implement in a primary care setting.

**Cognitive Behavioural Therapy: History, Theory, Principles and Core Skills**

Cognitive behavioural therapy is a form of psychotherapy that recognizes emotions, cognitive thoughts, and links them to behaviours (3). With CBT, reinforcing positive behaviours, teaching, and coaching are some fundamental factors to consider incorporating in sessions (3). The Center for Addiction and Mental Health (CAMH) highlighted that CBT is a short-term problem-focused approach that is intensive and can last for 6 to 20 sessions (3). However, CBT can help patients develop long-term skills (3). There are three components in CBT: thoughts, feelings and behaviours (4). An individual's thoughts and feelings can differ from each other for the same event (3). The main aim of CBT is to assess individuals' problems through different viewpoints, as well as to identify and become aware of distorted thoughts (3). These concepts invest the patient in their therapy and leads to a change of maladaptive behaviours.

This history of CBT is essential in understanding the core principles and skills of this therapy. Dr. Aaron T. Beck, the founding father of CBT, was a psychiatrist and psychotherapist (5). He conducted many experiments examining the psychoanalytic concepts of depression (5). Dr. Beck found that spontaneous negative thoughts existed in depressed patients and labelled these "automatic thoughts" (5). In the automatic thoughts of depressed individuals, Dr. Beck established three categories of negative thoughts: those about their future, themselves and the world (5). With this categorization, Dr. Beck was able to assess these individuals' thought processes and help them form realistic ones (5), helping patients feel better both functionally and emotionally (5). Dr. Beck helped prove that long-lasting changes can occur when there were modifications to an individual's underlying beliefs or ideas of the future, the world and of themselves (5).

The basic theory of automatic thoughts is essential to understand. These thoughts are ideas that pop into an individual's mind that can shape their emotional response (3). These thoughts are described as brief, able to change with awareness, and can have patterns if examined in individuals with mental health disorders (3). Automatic thoughts are influenced by an individual's rules, assumptions and core beliefs (3). The key CBT assumptions are that individuals can assess and evaluate their own core beliefs. Secondly, cognitive deficiencies/distortion of individual thoughts about the world, others, and themselves are the root causes of mental illnesses (3). Dr. Beck identified several illogical thinking processes that lead to cognitive distortion. These include: individuals having selective abstraction, arbitrary interferences, overgeneralization, personalization, magnification, and minimization (6).

In CBT psychotherapy, the environments must be problem-oriented and collaborative (7). Having a strong collaborative relationship between the therapist/provider and the patient will help patients define their problem (7). The problem-oriented approach in CBT can address the patient's state of mind through creating SMART goals that stand for specific, measurable, achievable, realistic, time-limited (7). This approach provides a way for patients to address their concerns systematically.

In CBT, one of the critical cognitive techniques used is the concept of guided discovery (7). This guided discovery is a process that a therapist uses to help their client reflect on the way that they process information. Answering questions or reflecting on the thought process allows a range of alternative thinking to be opened up for each client (7). Clinicians can help these patients comprehend the alternate perspectives that exist (7) through patients figuring out a conclusion without clinicians directly giving them the answer (7). Specifically, tailored questions can help patients find these answers on their own with some guidance. Another cognitive technique is tracking and logging (7). Patients will need to write down and keep track of specific maladaptive thoughts and core beliefs that are exhibited (7). With this, patients have evidence of their core beliefs and maladaptive thoughts.

In CBT, the behaviour techniques include active scheduling and experiments (7). Active scheduling allows patients to have a manageable daily list of tasks to complete, allowing them time to plan (7). This approach produces a pleasurable experience for patients, reducing anxiety throughout the day because of the established plans (7). The behavioural experiments aspect of CBT can tackle patient issues related to anxiety. Patients can track their thought predictions and assess whether a predicted event did happen (7). With time, individual core beliefs will change as more thought predictions are disproven, and new evidence is presented (7).

### **Motivational Interviewing: History, Theory, Principles and Core Skills:**

Motivational Interviewing (MI) is a counselling style that uses a collaborative approach to communicate the concept of change to patients (8). MI fosters and supports commitment and motivation to change in individuals (8). The change processes in MI occurs in an environment that provides empathy, kindness, and acceptance for patients (8). This process is influenced and established by the therapist/clinicians. In MI, the clinician's role is to

help identify change and not to refrain from functioning as an expert by preaching, ordering or blaming patients. Patients have multiple perspectives and should be supported by a clinician who elicits a positive experience (8).

The development of MI started with the work of William R. Miller and Stephen Rollnick on alcoholism (9). These two individuals were clinical psychologists and believed that individuals with drinking problems were in denial (9). In previous instances, some clinicians promoted confrontational approaches and public shaming, but this had little effect on change (9). Miller and Rollnick discussed the importance of having a respectful conversation about the individual's alcohol consumption, stating that it allows patients to decide on their own about the need to change (9). Miller and Rollnick's work discussed MI spirit, core principles and strategies (9).

MI has four "spirits" that are instrumental for this technique to be successful. The four spirits are acceptance, compassion, partnership and evocation (8). Acceptance is one of the essential spirits of MI as it allows clinicians to acknowledge what the patient has brought to the table with no judgements (8). The four components of acceptance are absolute worth, accurate empathy, autonomy and affirmation (8). The three other MI spirits are compassion, which helps patients have a deep understanding of the issues at hand; partnership, which builds a strong relationship between the patient and therapist; and evocation, which establishes why patients want to change (8).

The four processes of MI help clinicians understand how to use this technique. The first process is engagement, allowing both patients and providers to establish a strong and collaborative working relationship (8). Focusing on the concerning issue is the next process (8). Patients can create an agenda with the appropriate direction for each session (8). The third process is evoking, where patients are prompted by their internal motivation to change (8). Clinicians can accomplish this through discussions with patients about their goals. Finally, planning is the process where a strategy is created to accomplish the patients' goals (8). The patients establish these goals through negotiations.

A fundamental assumption in MI is that patient resistance signals the need to alter the clinician's approach (10). Motivation is thought of as a state of mind and can change based on an individual's perspective and mindset (10). Growth occurs within an individual's mindset, and external forces do not fundamentally cause a change in a patient's motivation (10). Having uncertainty is important, as it provides a clear picture of the options available (10). As a provider, it is essential to be a directive advocate and provide autonomy in the MI approach with the patient to help them through this mixed state of ambivalence (10).

Fundamentally, there are five principles of MI that are necessary for appropriate implementation. These are: developing discrepancy, patient resistance adjustments, empathy expression, preventing arguments, understanding values, and supporting self-efficacy (10). For a clinician to invoke an empathy-driven environment, it should be a priority for this clinician to be non-judgemental, supportive, collaborative, and actively listening to their patients (10). It is crucial to create discrepancies with a patient's feelings as these feelings can differ in the future. The recognition of the differences in a patient's present and future goals will help create meaningful arguments and opportunities to discuss the patient's process of change (10). In arguments, patients will not listen to other perspectives. Preventing meaningless arguments is vital, as conflict can cause a power struggle that will negatively affect the relationship between the patients and the providers (10). Clinicians can provide alternative perspectives without a confrontational approach (10). Also, patient/client resistance can occur when a clinician denies, interrupts, ignores or argues with the patient, and should be avoided (10). With the strong support of self-efficacy, patients will choose the path that fits best for them and will see other possible avenues that are available for change (10).

During MI, several clinical skills need incorporation into the approach to therapy. An acronym known as OARS, which stands for open-ended questions, affirmation, reflective listening and summary, is used to remember these skills (11). Open-ended questions allow for good dialogue, build the clinician/patient relationship and help with information gathering (11). As highlighted previously, affirmation is key to the concept of empathy to understand the patient's situation and to validate and build confidence (11). The essential skill for a clinician to master is reflective listening, which allows for patients to establish a robust communicative bond with the provider and improves reflective analysis of their current situation (11). Lastly, summarizing helps clinicians and patients understand the issues discussed, allowing patients to find a solution on their own during the reflective process of listening to what was discussed (11). It also builds a strong relationship with the clinicians.

### **Similarities and Difference between CBT and MI:**

Some researchers have suggested that CBT and MI are distant cousins because some forms of CBT are like MI (12). The similarities between CBT and MI are that both therapies' principles align in a theoretical and practical sense (13). These two therapies require both the active involvement and collaborative approach by providers to create a patient-centred environment (13). Both therapies require discussions to be directive and engage the patients' readiness to change (14). CBT and MI emphasize the importance of patient involvement to apply these learned strategies to their daily lives (15).

Furthermore, the core principles of empathy, active communication, motivation, compassion, align in these two therapies (15). Indirectly discussed in CBT is the importance of motivation in any change discussion. However, the process of applying these therapies by providers is very similar to using the open-ended questions approach regarding patients' thought processes and experiences (15). The guided discovery and evocation techniques used in CBT and MI try to accomplish similar results regarding patients' understanding of their experiences and thought processes (15). Last, CBT and MI do reframe and summarize discussion throughout sessions to help patients feel heard and to focus on the issue at hand (15). Clinicians employing both therapies provide important activities beyond the session to assist patients in this process.

Numerous differences exist between CBT and MI. CBT focuses primarily on the patient's thought process and underlying cognitive distortions (15). This problem-focused approach is goal and solution-oriented, contrary to MI, which assesses patients based on their motivation to change and has both empathy and autonomy as the driving forces (15). With MI, individuals need to know their strengths and must be motivated for change to occur (15). In CBT, providers establish a plan to achieve the patient's goals while in MI, the patient is the driver deciding how to move ahead (15).

These comparisons highlight the essential fact that therapists play a facilitator role in MI through discussions with the patient on their perspectives and internal motivations. This internal motivation is heavily assessed to see the level of commitment to change in the patient (15). MI looks at motivation through the principal components of affirmation and ambivalence (15). With CBT, providers take the lead with discussions on strategies, developing patient skills and through the distribution of educational materials to help the patient achieve these specific goals (15). With this, the patient can apply these skills to other problems.

The concept of change in these two therapies is very different and must be highlighted. CBT identifies issues through the dysfunctional experience and assumptions made from recent events (16). As a psychological-medical model, CBT identifies a patient's automatic thoughts and assesses the negative symptoms that it has on the patient's cognition, behaviour and emotions (16). Finally, in the CBT process of change, meaningful discussions about the patient's perception of the environment and error in their thoughts are conducted in a timely, solution-focused manner (16).

In MI, the concept of change is dictated by the transtheoretical model (17). This humanistic-psychological model has different phases known as pre-contemplation, contemplation, preparation, action, maintenance, and relapse. In pre-contemplation, patients are unaware and not acting on their issues. As a provider at this phase, it is crucial to build trust and not give orders. Contemplation is where the patient wants to start this change. Understanding the reason why the patient wants to change as well as build on the patient's confidence with respect and autonomy (17). The patient's preparations and planning with the therapist's assistance is the next sequences of the model. For this change phase, the concept of reflective thinking and summarization is crucial (17). The Action phase occurs when patients take the initiative to make the needed change, requiring a strong patient-therapist bond to maintain momentum. The maintenance phase occurs when patients use the strategies developed in the MI sessions to continue their progress (17). Lastly, anticipate relapse as another learning opportunity for patients to renew their strategies and try to restart the action phase again (17).

### **A Combined MI-CBT approach**

Research has shown that the integration of both MI and CBT together will provide a healthier and more powerful treatment plan than just providing these therapies separately (15). Some key methods of applying MI-CBT therapy in a clinical setting include using MI to help work through patient issues and tailor the CBT therapy to a goal-oriented manner (15). Using MI before CBT therapy will help create a dialogue about the patient's motivation and what needs to change (15). By engaging and creating a collaborative environment, MI-CBT can play a crucial role in helping patients develop skills tailored to other specific problems (15).

Incorporating MI with CBT will provide a unique counselling style. With the key MI processes of engagement, planning, evoking and focusing incorporated during CBT (15). This approach helps providers have a better visualization of the patients thinking processes during their CBT sessions (15). In the MI process of engagement, there are skills specified not mentioned in CBT that could strengthen the patient-provider relationship (15). The MI process of focusing also touches on not just setting goals but understanding the scope of conversation needed to create patient goals based on their specific thoughts, behaviours and emotions (15). Evoking is another MI process that can help tailor the change discussions from the patient through affirmation and reflection (15). Evoking is supported by an individual's internal drive to change and help CBT providers create more realistic and achievable goals (15). The planning process in MI aligns critically with the CBT principles as the patient's plan to change is driven by commitment and motivation.

Some MI techniques to incorporate into CBT include open-ended questions and reflective statements (15). These techniques will enhance the capabilities of CBT to incorporate the patient's perspective to change and provide a more patient-centred approach.

Although many advantages exist for MI-CBT, there are many disadvantages as both therapies refute one another in some clinical conditions. Significant issues include the need for proper training in both MI and CBT to use the combined approach appropriately (15). Time limitations are another concern, as providers may spend more time understanding the patient's motivation to change and not establish a goal or plan for the patient's issue (15). Without the providers understanding of the patient's motivation to change, implementing any plan may not be helpful (15).

### **Research of Combined MI and CBT Effectiveness**

There have been a few studies that examine the effects of the MI-CBT approach on behaviour changes. The MI-CBT approach has shown effectiveness in substance use disorders such as marijuana, cocaine, and smoking. MI-CBT in the treatment of mental health disorders such as depression, anxiety, weight-related behaviours, and medication adherence issues is also supported (15, 20). There is limited research on whether the MI-CBT approach is better than either MI or CBT therapy alone (15). A small number of studies have shown that

an MI-CBT approach compared to MI alone has a more significant long lasting effect in reducing substance use (14). MI used as a pretreatment before CBT has shown to be more effective than CBT in helping patients with substance use and anxiety behaviours (18). There has not been any clear studies to indicate disadvantages to using a combined MI-CBT approach in helping patient with mental health disorders (12).

Some patient qualitative studies have shown that CBT therapists incorporating the MI spirits had higher patient satisfaction compared to CBT therapists who did not use the MI spirits (19). Patients reported greater involvement and increased their active participation with CBT therapists when MI spirits were incorporated (19). There is a lack of evidence to show CBT alone is less effective than the MI-CBT approach (15). Substantial supportive evidence is found when MI is used as pretreatment with CBT for emotional disorders (19). MI was found to increase the engagement and participation of these patients (19). These studies emphasize the importance of incorporating the MI-CBT approach in primary care.

### Applying a combined MI and CBT therapy into practice

By applying the MI-CBT approach in primary care, it is vital to have adequate training in both treatment modalities. In primary care, all the key MI-CBT components and clinical skills are highly applicable in clinical encounters with patients. The incorporation of the MI spirits would help providers develop strong communication skills and build on the motivation exhibited by patients to change. With CBT, creating a goal-oriented approach will help solidify the provider's approach and help improve the patient's experience. The high variability of patients seen in primary care emphasizes the importance of applying the MI-CBT approach together in an appropriate manner. Only a few studies have laid out what an MI-CBT integrated therapy plan would look like (15). It is crucial to be proficient in both therapies to implement them into practice effectively. With the time restriction that exists in primary care, having an established and tailored approach for each patient benefits all.

### Conclusion

Motivational Interviewing (MI) and Cognitive Behavioural Therapy (CBT) each provide comprehensive approaches for mental health conditions. By combining both therapies, an effective and synergistic method of patient support is created to address the complex clinical needs of patients struggling with mental health and behaviour disorders.

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