COUNSELORS’ EXPERIENCES OF CLIENT AND COUNSELOR LANGUAGE
WHILE USING MOTIVATIONAL INTERVIEWING AND COGNITIVE BEHAVIOR
THERAPY TO FACILITATE CLIENT CHANGE

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Motivational interviewing (MI) is a style of counseling that has diverse applications and can be used in conjunction with other counseling approaches, such as cognitive behavior therapy (CBT). This study used hermeneutic phenomenological method to investigate six licensed professional counselors’ experiences of client language and their own language while using MI and CBT to help facilitate client change. Each participant provided an in-depth narrative account through the course of two individual interviews. Hermeneutic phenomenological analysis procedures resulted in the identification of five main themes, each with at least two sub-themes. Findings also included a therapeutic process of using MI and CBT together to facilitate client change. Findings provide an understanding of these six counselors’ interpretations of client and counselor language which they used to help them make decisions about using MI and CBT together. Findings may have implications for practitioners who wish to incorporate MI and CBT into their counseling practice and for counselor educators who may wish to offer students opportunities to learn and integrate MI and CBT. Future research directions are explored and considerations of the study are presented.
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CHAPTER I
INTRODUCTION TO THE STUDY AND REVIEW OF THE LITERATURE

Individuals who work in the counseling profession are part of a fluid and ever-changing environment. They must adapt to evolving needs of their clientele and remain abreast of advances in the field. Professional development activities, such as continuing education, present opportunities for counselors to be exposed to up-to-date information and to develop skills to help them best serve their clients. Continuing education for members of the American Counseling Association (ACA) is incorporated into the ACA Code of Ethics (2005). Code C.2.f. considers ongoing education essential for counselors in order to be exposed to and benefit from recent research and additional information relevant to the profession. This ethical code also specifies that through continuing education, counselors make efforts to sustain skill proficiency, be receptive to new approaches, and maintain sufficient knowledge related to diverse clientele and specific populations treated. Therefore, continuing education units for counselors may be focused on skill acquisition, improvement, or maintenance; learning about new approaches or methods; or expanding or attaining knowledge based on research findings. This education is provided through a variety of avenues such as professional workshops, online courses, and graduate-level coursework.

In addition to the ACA Code of Ethics (2005), the Council for Accreditation of Counseling and Related Educational Programs (CACREP) specifies that students enrolled in accredited counseling programs “will be exposed to models of counseling that are consistent with current professional research and practice in the field” (CACREP,
Another CACREP standard specifies that students will demonstrate knowledge of evidence-based treatments (CACREP, 2009, p. 34). These CACREP standards require counselor educators to incorporate research-supported therapeutic practices into the training curriculum of counseling students.

Motivational interviewing (MI) is a person-centered yet directive style of counseling that seeks to elicit individuals’ intrinsic motivation to change (Miller & Rollnick, 2002). Since its introduction in the 1980s (Miller, 1983), MI has been recognized in the counseling profession and applied to other helping professions including healthcare and corrections (Arkowitz & Miller, 2008). Individuals are educated about MI through books, journal articles, and professional training workshops and many have incorporated MI into their professional practice (Heather, 2005).

Although MI is a relatively recent counseling approach, a significant amount of outcome research has been conducted over the past 25 years, demonstrating its efficacy and resulting in MI being considered an evidence-based practice (Hettema, Steele, & Miller, 2005; Substance Abuse and Mental Health Services Administration, 2007). Professionals’ interest in MI has grown in recent years, and it has been projected that MI will continue to spread throughout the human services professions of addictions counseling, mental health counseling, health care, and corrections and probation (Motivational Interviewing Network of Trainers, 2008).

As a result of MI’s growth, and perhaps in response to the professional development requirements of ACA and the standards for CACREP-accredited counselor education programs, many professional counselors are pursuing training in MI. Miller
and Rollnick (2009) reported that from the Motivational Interviewing Network of Trainers (MINT) alone, approximately 1,500 people have completed training as MI-trainers. This number has more than doubled since 2005 when 600 individuals were reportedly trained as MI-trainers by the founders of MI (Heather, 2005). Given these statistics, it can be assumed that professional counselors are included in this population and are incorporating this style of counseling into their clinical practice at an increasing rate. Practicing MI, however, requires an appreciation for the “spirit” of MI and adopting behaviors consistent with the approach. This is not to say that one should completely abandon his or her prior methods of working with clients. MI is unique in that it may be used in conjunction with alternative treatment approaches, such as cognitive behavior therapy (Miller & Rollnick, 2002; Miller & Rose, 2009).

The current study used phenomenological design and method of analysis to investigate counselors’ experiences of client and counselor language while practicing MI and cognitive behavior therapy (CBT) to facilitate client change. The use of these two counseling approaches represents a unique type of psychotherapy integration as MI was not created from the basis of a theory (Miller & Rollnick, 2009), but rather as a style of communication that guides interactions between client and counselor. It was projected that counselors might use MI and CBT together in various ways. One possible way is a type of integration called *theoretical integration* in which counselors synthesize or blend MI and CBT to essentially create a new, unique approach (Norcross, 2005). A second type of integration is *assimilative integration* in which counselors are firmly grounded in one approach (MI or CBT) but they selectively incorporate practices from the other.
approach based on client needs (Norcross, 2005). Finally, it was anticipated that counselors might use MI with CBT in a manner that has yet to be defined. Research surrounding psychotherapy integration has focused on the use of two or more theory-based treatments (Norcross, 2005), and it is anticipated that using a counseling style and a theory-based treatment together may result in a unique experience for practitioners. However, the goal of using MI and CBT is consistent with that of integrating two or more theory-based treatments, which is “to enhance the efficacy, efficiency, and applicability of psychotherapy” (Norcross, 2005, p. 4).

Recent research and professional literature supports the idea that MI can positively influence the effectiveness of CBT (e.g., Arkowitz & Westra, 2004; Westra, 2004; Westra & Arkowitz, 2011; Westra, Arkowitz, & Dozois, 2009). For instance, MI was created to guide clients through the exploration and resolution of their ambivalence about change. Therefore, MI can be useful prior to and during treatment to help resolve ambivalence about change itself or about engaging in CBT treatment. Exploration and resolution of client ambivalence will likely enhance counselors’ work with clients due to decreased resistance to change, increasing the likelihood of improved client outcomes (Arkowitz, 2002; Westra, 2004).

Given the potential to improve client outcomes by using these two approaches together, the current study sought to enhance understanding of counselors’ experiences of client and counselor language while practicing MI and CBT. Client and counselor language was the focus of the current study as research has suggested that client language is a salient factor in determining subsequent behavior changes (Amrhein, Miller, Yahne,
Palmer, & Fulcher, 2003; Moyers, Martin, Houck, Christopher, & Tonigan, 2009) and that counselor language influences client language (Moyers & Martin, 2006; Moyers et al., 2007). The research question posed in this phenomenological investigation was: “What are counselors’ experiences of client and counselor language while using motivational interviewing and cognitive behavior therapy to facilitate client change?”

In Chapter 1, a review of MI is offered including a description of the approach, its potential uses and applications, and a summary of outcome research. Following a discussion of MI, an overview of CBT is presented and subsequently a brief comparison of MI and CBT. Next, the contributing factors of MI including the therapeutic relationship and counselor skills are discussed followed by a summary of recent literature describing MI training as well as research pertaining to the effectiveness of such trainings. Finally, the purpose of the current study is further described.

**Motivational Interviewing**

Motivational interviewing (MI) is a directive, person-centered counseling approach designed to resolve client ambivalence and to elicit and strengthen intrinsic motivation for positive change (Miller & Rollnick, 2002). This counseling style emphasizes a way of being with people, and counselors who practice MI facilitate the exploration and resolution of ambivalence in a nonconfrontational, respectful, and collaborative manner (Miller & Rollnick, 2002). MI originated from William R. Miller’s (1983) work with problem drinkers and is described in *Motivational Interviewing: Preparing People to Change Addictive Behavior* (1991) authored by William R. Miller and Stephen Rollnick. This edition focused on addiction counseling, the area in which
MI was developed. Eleven years following its publication, the second edition was published, *Motivational Interviewing: Preparing People for Change* (Miller & Rollnick, 2002), in which MI expanded from addictive behaviors to problem behaviors in general.

The question posed by the originators, “How broad is the horizon?” (Miller & Rollnick, 2002, p. 35), has yet to be answered. Recent MI texts describe applications for the treatment of psychological problems (Arkowitz, Westra, Miller, & Rollnick, 2008), in healthcare settings (Rollnick, Miller, & Butler, 2008), and with offenders in the criminal justice system (Walters, Clark, Gingerich, & Meltzer, 2007). As a result of its evolving nature and broad applicability, MI offers areas for continued investigation in regard to its application, its efficacy, client and clinician speech, learning and training issues, and specific therapeutic elements.

**Principles of Motivational Interviewing**

MI is unique in that it is considered a style of communication and a way of being with people. This counseling style possesses a “spirit [that] lies in understanding and experiencing the human nature that gives rise to that way of being” (Miller & Rollnick, 2002, p. 34). The spirit of MI entails counselor collaboration with clients; honoring client autonomy; and eliciting client knowledge, values, and perspectives. In this manner, the spirit of MI is the foundation for its practice. In an effort to explain or demonstrate the spirit of MI, its founders offered four guiding principles (Miller & Rollnick, 2002): (a) expressing empathy, (b) developing discrepancy, (c) rolling with resistance, and (d) supporting self-efficacy. Counselors who practice MI adhere to these principles in their efforts to assist clients with positive changes.
The first principle involves creating a therapeutic relationship through *expressing empathy*. In order for counselors to communicate their understanding of the client’s world, MI encompasses Rogerian therapeutic techniques including reflective listening (Rogers, 1951). MI utilizes reflective statements to express empathy in critical therapeutic moments (e.g., responding to client resistance or ambivalence) and such skills are essential to effectively implement this approach. In addition to expressing empathy and reflective listening, Carl Rogers’s (1957) concept of unconditional positive regard is present in the therapeutic relationship and supported by Miller and Rollnick’s (2002) belief that overall acceptance of individuals and meeting them where they are in the change process will help facilitate change. Empathy is expressed to convey understanding and acceptance of clients where they are in their process of change.

MI diverges from person-centered counseling in its directive nature in which counselors seek to enhance client motivation to change by exploring and resolving ambivalence. By assisting clients in *developing discrepancies*, the second principle of MI, counselors may guide clients to recognize the implications of their problem behaviors. Making positive changes commonly requires eliminating behaviors that are in some way damaging to the individual. Consider an individual who is contemplating terminating an unhealthy relationship. In developing discrepancy, the counselor might explore the client’s values surrounding relationships and how the relationship might be incongruent with his or her values. As the client verbalizes his or her personal values, the counselor then guides the client to consider the discrepancies that are revealed between the client’s current behavior and his or her values and goals (e.g., client’s values include
fidelity in relationships, yet his or her partner is consistently unfaithful). As the client presents the discrepancies, it is the client rather than the clinician who argues for change and motivates himself or herself to change. Therefore, the argument for change develops within the client as opposed to an argument emerging between client and counselor. As opposed to “installing” motivation in clients, clinicians practicing the MI spirit elicit their clients’ own intrinsic motivations to change by exploring their goals and values and developing discrepancies (Miller & Rollnick, 2002).

Rolling with resistance is the third principle of MI. Confrontation and arguments are avoided by MI counselors and replaced with normalizing ambivalence and resistance about change, which may be expressed as “coming alongside” clients. This idea of “siding with” clients assumes that taking one side of an argument will likely lead to the other person defending the opposite side. In MI, counselors refrain from arguing for change in order to circumvent opportunities for clients to argue against change. The practice of coming alongside or joining with clients in their reluctance to change (i.e., conveying an understanding of client’s circumstances or perspective), is intended to diminish client need for resistance and encourage clients to voice the argument for change (Miller & Rollnick, 2002).

Change and resistance are considered two sides of the same coin in MI (Miller & Rollnick, 2002). Rather than perceiving it as a character defect or a symptom of a difficult client, resistance has been conceptualized as ambivalence about change (Arkowitz, 2002). Ambivalence is considered a natural aspect of change, something to be expected and explored rather than opposed. Arkowitz (2002) characterized resistance
as a source of information to clinicians. He suggested that resistance may be functional for clients, and the reasons for resistance should be respected and explored in order to understand what is preventing the client from pursuing change.

Arkowitz (2002) further noted that resistance may emerge intrapersonally (i.e., client experiences a conflict within himself or herself) or interpersonally (e.g., counselor behavior may evoke client resistance within the therapeutic relationship). In practicing MI, clinicians must recognize their role in eliciting interpersonal resistance and alter their behavior to mitigate such resistance. To further illustrate how MI clinicians think about resistance on an interpersonal level, Moyers and Rollnick (2002) likened clinicians confronting client resistance to a person paddling a canoe upstream. Instead of paddling upstream or working against clients, they suggested that MI clinicians use their energy to steer the interpersonal interaction and guide clients to explore and resolve their ambivalence and move towards positive behavior change.

The current phenomenological study investigated the experiences of counselors who practice MI and CBT. Arkowitz and Miller (2008) discussed the potential for clinicians who have practiced CBT to struggle with the third MI principle of rolling with resistance because it conflicts with some CBT conceptualizations of resistance. Resistance is frequently considered synonymous with noncompliance in CBT, which may include not completing homework assignments, not following through on behaviors discussed in session, interrupting the clinician, and placing unreasonable demands on the clinician (Newman, 2002).
Cognitive behavior therapy encompasses a broad range of practices that focus on clients’ cognitions and behaviors to produce desired changes (Corey, 2009). Aaron Beck, founder of cognitive therapy, labeled the therapeutic relationship in his counseling approach *collaborative empiricism* because the client and clinician co-investigate the client’s distress and jointly determine the goals of therapy. The objective of cognitive therapy, however, is to expose the client’s biased thinking, investigate client cognitions, and use relevant empirical evidence to confirm or reject client cognitions (A. T. Beck & Weishaar, 2005). Clinicians who use cognitive behavior approaches often consider resistance an indication of irrational thoughts that need to be identified and reconstructed, such as believing an easy solution to problems exists instead of working to change oneself (Ellis, 2005). This approach to therapy and managing resistance is often direct and didactic and the clinician is considered the one who educates the client (J. S. Beck, 1995). This conceptualization of resistance conflicts with MI’s third principle of rolling with resistance because in MI, the counselor joins or comes alongside the client (rather than challenging forthrightly the client’s resistance) and then subtly guides (rather than overtly directing or pushing) the client toward change. In the current phenomenological study, recognizing and responding to client language that suggested resistance and ambivalence were part of participants’ experiences when practicing MI and CBT.

The fourth and final principle of MI is *supporting self-efficacy*. This includes emphasizing the personal choice of clients, promoting their autonomy, and believing the responsibility to change lies with the client. MI recognizes that the client is the one responsible for change and that the client must believe he or she is capable of change.
This principle also emphasizes that counselors must believe their clients are capable of change and express this belief to clients. Messages expressed to clients should emphasize that they and only they can make the decision to change and the counselor’s role is to assist clients with the process of change, not to force or “trick” them into change or to coerce them into change by imposing uninvited consequences (Miller & Rollnick, 2002).

**An Emerging Theory of MI**

MI is a dynamic and evolving counseling method that has been refined over time as researchers have discovered more about its applications and contributing factors. For example, the focus on client speech in predicting subsequent behavior change illustrates the evolution of MI in research and in practice. Miller and Rollnick (2004) presented four themes of MI: client-centeredness, addressing ambivalence, directiveness, and focus on client speech. Recent research has demonstrated the salience of the fourth theme of MI, an emphasis on client speech (Amrhein et al., 2003; Moyers & Martin, 2006; Moyers et al., 2007; Moyers et al., 2009). Further, Hettema et al. (2005) offered three hypotheses to express an emerging theory of MI, each including a focus on client speech: (a) use of MI will increase change talk and decrease resistance compared to alternative approaches that use more confrontation or overt directiveness; (b) an inverse relationship exists between counter-change talk (i.e., arguing against change) in session and subsequent behavior change; and (c) a positive correlation exists between clients’ level of change talk in session and subsequent behavior change.

More recently, Miller and Rose (2009) proposed a theory of MI that has two components: relational and technical. The relational component is demonstrated in the
expression of empathy and the spirit of MI whereas the technical component focuses on the directiveness of MI—counselors’ use of MI-consistent behaviors to reduce client sustain talk (i.e., language that speaks for the status quo or against change) and increase client change talk in-session to increase the likelihood of subsequent behavior changes. An outline for an emerging theory of MI was presented by Miller and Rose who also discussed several areas in which more research is needed in order to understand the contributing factors that allow MI to be an effective therapeutic method and to fully formulate a theory of MI.

Investigations of client language during MI sessions have contributed to the maturation of MI. The findings therefore guide the practice of MI as well as future research. The current study sought to contribute to this line of research by investigating counselors’ experiences of client language while practicing MI and CBT as well as their experiences of counselor language used to strategically guide clients towards change.

**Motivational Interviewing and the Stages of Change**

The five stages of change proposed by Prochaska and DiClemente (1984) in the TransTheoretical Model of change (TTM) represent a sequential process of behavior change. When using MI with the TTM, MI counselors elicit the client’s intrinsic motivation in order to travel through and accomplish the tasks involved in each stage of change (DiClemente & Velasquez, 2002). Although MI is a counseling style separate from the TTM, these two approaches can be used in concert to help clients move towards positive behavior change (Miller & Rollnick, 2002).
MI was originally conceptualized as an approach to assist clients who presented in the precontemplation or contemplation stages of change move into preparation for change and ultimately action (Miller, 1983). MI can also be helpful in maintaining and strengthening motivation throughout the change process, including the later stages of action and maintenance (DiClemente & Velasquez, 2002).

**Stages of Change**

*Precontemplation* is the earliest stage of change in which the individual is unaware or underaware that a problem exists or lacks readiness to address and change problem behavior. Resistance to change is common in precontemplation due to the benefits of the status quo seeming to outweigh those of changing (DiClemente & Velasquez, 2002). Therefore, MI counselors facilitate an exploration of the client’s perception of the problem to decrease resistance to the counseling process and to foster a respectful, collaborative therapeutic relationship.

The tasks required of individuals to move from precontemplation to the next stage of change are increased awareness of the need to change, increased apprehensions about consequences of the problem behavior, and considering the possibility of change (DiClemente, 2003). MI-consistent interventions used to assist clients in completing these tasks include reflective listening, providing feedback in an empathic style, exploring values and personal goals to develop discrepancies, and presenting clients with a menu of options to encourage clients to consider possible choices (DiClemente & Velasquez, 2002; Miller, 1999). As a result of encouraging clients to talk about their perception of the problem behavior (in addition to using other MI-consistent
interventions such as providing feedback in an empathic manner, exploring values, developing discrepancies), increased awareness of the problem is likely to develop. Willingness to acknowledge the problem, however, does not equate with readiness to change. Rather, the client will likely experience ambivalence about change, resulting in movement from precontemplation to the stage of contemplation.

Contemplation is the second stage of change in the TTM and is characterized by ambivalence. Although clients in this stage have identified the problem and may begin to think about it seriously, they struggle with changing their behavior. That change and resistance are “opposite sides of a coin” suggests that ambivalence is a normal aspect of change (Miller & Rollnick, 2002, p. 43). The goal of the contemplation stage of change is to arrive at a decision to change which requires the individual to complete the task of evaluating the costs and benefits of change as well as the costs and benefits of the status quo (DiClemente, 2003). Miller (2008) cautioned that although both sides of ambivalence are explored, the dialogue between the client and a counselor who is practicing MI should be in the direction of resolving ambivalence and towards change.

In order to assist clients in moving from contemplation to the next stage of change, MI-consistent interventions include developing discrepancies, using decisional balances that explore the costs and benefits of both change and remaining stagnant (with more emphasis given to supporting client reasons to change), emphasizing personal choice, and eliciting and strengthening change talk (DiClemente & Velasquez, 2002; Miller, 1999).

The third stage of change, preparation, involves developing a plan for change and preparing for action. As clients progress through contemplation, clinicians must be
skilled in using appropriate timing when transitioning from resolving ambivalence and eliciting and strengthening change talk to creating a plan for action, the goal of the preparation stage (DiClemente, 2003). If a clinician discusses a plan for change before the client is ready, resistance may be evoked and commitment to change may subside, resulting in a decreased likelihood of behavior change (Amrhein et al., 2003). Therefore, it is important to emphasize that clinicians must be aware of client signals of readiness (e.g., sufficient frequency and strength of commitment language) to begin plan development and only then should clinicians work towards assisting clients into the preparation stage of change. MI-consistent interventions to facilitate this transition include consolidating and solidifying client change and commitment language, offering a menu of options, anticipating and lowering barriers to action, educating clients about what to expect in their action plan (e.g., expectations for treatment), and enhancing social support (DiClemente & Velasquez, 2002; Miller, 1999).

Once a plan of action is developed and clients are prepared to make the desired change, clients move into the action stage. This stage requires the most time and energy from the client as observable behavior changes are made and clients attempt to sustain these changes. Clinicians can help clients in this stage by boosting their self-efficacy and assisting clients in modifying their change plans as necessary (DiClemente & Velasquez, 2002). The goal of the action stage is to establish a new pattern of behavior for a significant period of time (e.g., 3–6 months), and once this goal is achieved, individuals move to the final stage of change, maintenance (DiClemente, 2003).
*Maintenance* implies that the individual has sustained changes over time. During the maintenance stage, motivation must be sustained in order for clients to maintain their commitments to the behavior change and prevent relapse or the re-occurrence of the problem behavior (DiClemente & Velasquez, 2002). Tasks of this stage include avoiding relapse of problem behaviors, sustaining changes in precarious situations, and integrating changes into the individual’s life (DiClemente, 2003). To aid in the transition from action to maintenance, MI-consistent interventions include helping clients identify and prepare for risky situations; rehearse new, healthy coping skills; and identify and use social support (DiClemente & Velasquez, 2002; Miller, 1999). These interventions may be helpful throughout the maintenance stage that may continue for years (DiClemente, 2003).

**MI and TTM in Concert**

Although MI and the TTM are independent of each other, the theoretical framework offered by the TTM can be a useful tool for MI clinicians when assessing clients’ readiness to change and selecting appropriate, effective interventions to assist clients in traveling through the process of change. MI and the TTM share a philosophy of how people change in that both approaches (a) recognize that the client is responsible for change, and (b) consider change to be a process that occurs over time.

The TTM, however, has been conceptualized as a lengthy change process and MI was developed as a brief intervention. Given that human change may be a lengthy process, it is reasonable to question whether MI (an approach directed towards eliciting and strengthening intrinsic motivation to change) is sufficient as a stand-alone
intervention to help clients initiate and maintain behavior changes long-term. Therefore, MI has been added to standard treatments (e.g., CBT) to increase client involvement and retention in treatment and maintain positive changes (DiClemente & Velasquez, 2002).

MI can be useful in guiding clients through the TTM’s five stages of change (DiClemente & Velasquez, 2002; Miller, 1999). However, clinicians must assess each client’s current status in the process of change and implement interventions appropriate for the client’s level of readiness to change. In the current study, it was anticipated that participants’ experiences would include listening to client language to assess client readiness to change. It was also anticipated that this experience of client language may have influenced participants’ decisions about their own language when implementing appropriate interventions. Thus, it was anticipated that counselors’ experiences of their own language used in session might be what they say influences and is influenced by client language.

**Applications of Motivational Interviewing**

Although it was originally conceptualized as a precursor to formal treatment, MI has since demonstrated positive effects through various applications. Recent research offers empirical support for MI as a prelude to treatment, a stand-alone treatment, and as a method used in conjunction with alternative treatments (Burke, Arkowitz, & Menchola, 2003; Hettema et al., 2005).

**MI as a Prelude to Treatment**

MI was intended as a prelude to standard treatment services and can be especially useful in situations when there is a time limit, such as third-party payer restrictions, or
with specific populations (e.g., clients who are dependent on alcohol or drugs) for whom treatment adherence is typically a challenge (Miller & Rollnick, 2002). Research has shown MI to have a positive effect when used prior to standard treatment (e.g., Aubrey, 1998; Hettema et al., 2005, McKee et al., 2007), and MI has been found to significantly enhance client engagement in treatment and increase intention to change (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Of the 72 studies using MI included in Hettema et al.’s (2005) meta-analysis, seven investigated the effects of adding MI at the beginning of standard treatment. Analysis of these seven studies found that the effects of MI were significant and appeared to be maintained or even improved at a one-year follow-up (effect size maintained at approximately 0.60). This application of MI, an addition to “treatment as usual,” appears to increase treatment retention and adherence resulting in favorable outcomes (i.e., behavior change).

Aubrey (1998) investigated the effects of a single, 30- to 60-minute session of MI prior to standard treatment with adolescents who presented for outpatient substance abuse treatment. In her study, 77 participants completed an initial 3- to 4-hour intake session and were then randomly assigned to one of two groups. The experimental group received feedback from their intake session in the MI style, and the control group did not receive feedback prior to beginning treatment. The MI feedback session emphasized a collaborative exploration of possible connections between substance use and the clients’ struggles in several areas of life, a positive attitude toward change, and clients’ personal choice and control. Aubrey found that participants who received the MI feedback session engaged in nearly three times more outpatient treatment sessions compared to the control
group. In addition, participants who received the MI session reduced their use of substances by two-thirds from baseline and reported being abstinent 70% of days at 3-month follow-up (baseline = 18% days abstinent) whereas the control group reported abstinence 43% of days at 3-month follow-up (baseline = 37% days abstinent).

Despite these positive findings, MI as a precursor to treatment has demonstrated some inconsistent results. For example, Miller, Yahne, and Tonigan (2003) randomly assigned 208 participants equally to either a treatment group that received a single MI session prior to engaging in treatment, or to the standard care group. Contrary to the findings of prior investigations, Miller et al. found no significant differences between the groups in regards to treatment attendance, motivation to change, or substance use behaviors. Amrhein et al.’s (2003) analysis of the same data set found that clinician flexibility in responding to client signs and signals that they were ready to create a plan for change was essential for positive changes to occur. Therefore, clinicians who strictly follow an MI manual (as was the case in Miller et al.’s study) may sacrifice a certain level of flexibility and move the client too quickly toward planning change, resulting in decreased motivation to change and continued substance use. These findings may help explain the lack of positive outcome in MI investigations in which clinicians used a manual to determine how, and perhaps more importantly when, to proceed to plan development rather than focusing on cues offered by the client indicating his or her level of readiness.

McKee et al. (2007) compared two treatment conditions for participants diagnosed with cocaine abuse or dependence. Thirty-eight participants were randomly
assigned to treatment that included a single Motivational Enhancement Therapy (MET) session prior to two CBT sessions. MET is an adaptation of MI wherein personalized feedback from formal assessment measures is offered in the MI style (Miller, Zweben, DiClemente, & Rychtarik, 1995). Clinicians trained in MI conducted the MET session in addition to maintaining the MI style throughout the subsequent two CBT group sessions. The control group \((n = 36)\) only received three CBT treatment sessions. Results indicated that the participants who received MET attended more treatment sessions, reported a greater desire for abstinence and a greater expectation of success, and expected greater difficulty in maintaining abstinence. However, no significant differences were found between the treatment and control groups in terms of cocaine use and commitment to abstinence. Several limitations may help explain the lack of behavior follow-through, including implementing an insufficient standard treatment (two or three CBT sessions) to result in significant behavior change, a small sample size for inadequate power, and a lack of control over some aspects of treatment delivery (e.g., consistency of CBT delivery, variations in clinician experience level). In addition, differences in the delivery of MI (e.g., variations in MI training, treatment procedures, site and therapist characteristics) may have influenced its effect and outcomes (Hettema et al., 2005).

**MI as a Stand-Alone Intervention**

In general, stand-alone applications of MI have demonstrated efficacy when compared to no-treatment control groups and, when compared to the effects of viable alternative treatments (e.g., CBT), MI has produced equal or superior positive outcomes (Burke et al., 2003). MI used as a stand-alone intervention hinges on the notion that
strengthening the client’s intrinsic motivation to change is sufficient to facilitate change in some cases. Therefore, MI can serve as an impetus for change without subsequent interventions, granting this approach the potential to be used as a free-standing, brief intervention (Miller & Rollnick, 2004). Although formal or standard treatment may be unnecessary for some individuals after an initial dose of MI (e.g., one- to two-hour MI session), recent research has demonstrated a greater likelihood of sustained effects of MI when used as a stand-alone treatment followed by brief booster sessions (e.g., 15-30 minute telephone sessions delivered incrementally after the initial dose; Hettema et al., 2005).

Monti et al. (2007) examined the usefulness of MI as a stand-alone intervention for young adults who struggled with problem drinking and presented at a medical emergency department (ED). In this study, 165 participants who ranged in age from 18 to 24 years were randomly assigned to one of two treatment groups. Participants assigned to the feedback-only condition completed and received feedback on several alcohol-related assessments while in the ED, whereas participants assigned to the MI condition received feedback about their problem drinking in the style of MI. Participants needed to register a blood alcohol content (BAC) of .01% or higher upon admission, report consuming alcohol in the 6 hours prior to admission, or score an 8 or higher on the Alcohol Use Disorders Identifications Test (AUDIT). Baseline measures were assessed and included number of days drinking, number of heavy drinking days, and average drinks per week for the 30 days prior to the ED admission. Results of assessment
measures were provided to participants of both treatment conditions in a computer-generated report.

Participants in Monti et al.’s (2007) study who were assigned to the feedback-only group received a 1–3 minute session in the ED in which feedback from the assessments was offered. Participants assigned to MI received a 30- to 45-minute session which included personalized feedback, support for self-efficacy, and a conversation about the participant’s alcohol use. Clinicians using MI sought to establish rapport as well as assess and enhance the participants’ motivation to change by exploring the participants’ goals for change. Participants in both treatment groups received a telephonic booster session with a counselor at one month (20 minutes in duration) and three months (25–30 minutes in duration) following the initial ED session. Follow-up assessment measures were gathered by research assistants who were blind to the treatment conditions at 6 and 12 months following the ED admission.

Results of Monti et al.’s (2007) study showed that the MI group reported significantly lower alcohol consumption rates at both the 6- and 12-month follow-up assessments on both within-group and between-group measures. For example, at the 12-month follow-up assessment, participants who received the single MI session reduced their consumption from baseline measures by 45% to 53% on the three measures of consumption whereas the feedback-only group reported only an 11% to 18% reduction in consumption. This study supports the efficacy of MI as a stand-alone intervention to facilitate positive change in young adults’ problem drinking behaviors when used in an emergency medical setting. However, certain aspects of this study warrant commentary.
First, the inclusion criterion of participants having at least 0.01% BAC is minimal which may suggest participants were not “problem drinkers.” Second, comparing a 1- to 3-minute feedback session to 30- to 45-minute MI session falls short of comparing equivalent treatments, yet it may speak to MI’s superiority over a minimal intervention in an ED setting.

Cleary, Hunt, Matheson, and Walter’s (2009) systematic review of 54 studies (one meta-analysis, 30 randomized control trials, and 23 non-experimental studies) also supported the use of MI as a stand-alone treatment to reduce substance use. Cleary et al.’s review compared studies of various treatments for people with co-occurring disorders. Treatments reviewed included MI, CBT, MI plus CBT, group therapy, residential programs, integrated Assertive Community Treatment (ACT), intensive case management and non-integrated ACT, and contingency management. Cleary et al. reported that MI was the most effective treatment for substance use reduction compared to the alternative treatments. In addition, studies that paired MI with CBT demonstrated improvements in mental health symptoms as well as substance use reduction, suggesting a benefit of using MI in conjunction with CBT.

**MI in Conjunction With Standard Treatment**

In addition to serving as a prelude to treatment and as a stand-alone intervention, MI can be used in conjunction with other interventions. The communication style of MI, for example, can be used in assessment interviews, when offering feedback from objective assessment measures, and throughout the therapeutic process. The versatility of this counseling style is particularly useful when clients become stuck in ambivalence or
experience a decrease in intrinsic motivation (Miller & Rollnick, 2002). In appropriate situations, MI can be introduced into the counseling process to elicit intrinsic motivation and resolve ambivalence. The current study sought to capture counselors’ experiences of listening to client language while practicing MI with CBT.

To illustrate how MI can be used with alternative treatment methods, Westra (2004) provided three case studies. Each of the three clients was diagnosed with anxiety and depression and presented a type of resistance to either standard CBT treatment or to change itself. Westra described her use of MI to create a therapeutic environment that encouraged clients to work through their ambivalence about change or about engaging in CBT treatment.

In the first case study, MI was implemented as a precursor to CBT treatment for depression and multiple anxiety disorders after a female client expressed resistance to engaging in treatment. Through the course of five individual MI sessions, the client’s ambivalence about treatment was resolved and she subsequently completed 10 sessions of CBT. Her depression and anxiety were reduced significantly post-treatment, from a baseline score of 24 on the *Beck Depression Inventory* (BDI) to a score of 6 on the BDI post-treatment. Her symptoms were reduced somewhat after the MI sessions, but the significant improvements occurred after the CBT treatment. Had the client not been given the opportunity to work through her initial ambivalence about treatment in the course of five MI sessions, she may have continued to resist treatment and experienced limited improvement or perhaps she simply would have dropped out of treatment altogether (Westra, 2004). In this example, Westra outlined the potential benefits of
implementing MI in conjunction with CBT and the importance of the clinician being able to recognize ambivalence and shift the focus from behavior change to exploring and resolving ambivalence.

In her second case study, Westra (2004) implemented MI as an alternative to standard treatment after a female client participated in group CBT sessions for depression and generalized anxiety disorder with little to no positive change. After five sessions of MI, however, the client had changed her problematic behaviors and was able to sustain the changes with three monthly, face-to-face booster sessions. Westra suggested that in such cases, clients may experience increased frustration and demoralization when CBT treatment is continuously prescribed with limited success and that for these clients, MI emerges as a desirable and effective alternative.

In the third case study, Westra (2004) described a female client who experienced social anxiety and depression. This client had some success with CBT treatment, but reached a barrier when she refused to engage in further exposure therapy. After participating in a CBT group and 10 individual CBT sessions, the client was noncompliant and frustrated with treatment. Again, Westra recognized the signs of resistance and altered her focus from behavior change to exploring the client’s ambivalence about change and CBT treatment. After four MI sessions, the client began to make significant changes. The MI sessions were followed by five individual sessions in which Westra incorporated MI into CBT treatment, resulting in further progress and success for the client.
In the first case example, Westra (2004) illustrated the effectiveness of MI as a precursor to CBT treatment for a client who was initially resistant to treatment. In the second case, Westra used MI as an alternative to CBT when CBT treatment was failing to produce desired outcomes. Finally, in the third case, Westra used MI and CBT together. As stated by Miller and Rollnick (2002) and demonstrated by Westra, resistance is not considered a fault of clients, but rather a signal to counselors that they must refocus the path of treatment. Counselors must also meet clients where they are in their experience of change and interact with clients accordingly by exploring and resolving ambivalence.

MI offers versatility in its application and therefore, clinicians who incorporate MI in their practice must be skilled in effectively applying MI and knowing when it is appropriate to use. Contingent upon client needs, MI clinicians must be aware of and have the skills to recognize when MI can be useful. Westra’s (2004) case studies described client outcomes when MI was used with CBT, and in the first case, Westra also alluded to her experience as the clinician. Westra recalled enthusiastically applauding her client’s new behaviors to which the client responded that she was unsure if she would continue the behavior change. In response to the client’s retreat from change, Westra adjusted her behavior from outwardly promoting change to facilitating the client’s exploration of the effects of her new behaviors. Thereafter, Westra refrained from using language that obviously directed the client toward change and instead offered subtle guidance by eliciting the client’s own ideas about how she might benefit from continuing the behavior change. After five sessions of MI, the client resolved her ambivalence about
change and went on to complete 10 sessions of CBT which resulted in reduced symptoms of depression and anxiety.

Westra’s (2004) brief account of her experience demonstrated her ability to assess the influence of her own language on the language of her client and to then adjust how she approached her client, including the language she used, to reduce resistance and facilitate client behavior change. The purpose of the current study was to seek counselors’ descriptions of their experiences of client and counselor language while using MI and CBT to facilitate client change.

**Motivational Interviewing’s Emphasis on Language**

Although MI is a person-centered counseling style, its directive component is integral. Four of the five basic methods used when practicing MI are largely borrowed from person-centered counseling: open-ended questions, affirmations, reflective statements, and summarizations (Miller & Rollnick, 2002). MI diverges from Rogerian counseling with its use of the fifth method—focusing on client language—intended to elicit clients’ intrinsic motivation so as to resolve ambivalence and initiate positive change (Miller & Rollnick, 2002).

In order to cultivate and elicit intrinsic motivation, MI clinicians explore client ambivalence about change and focus their attention on client change talk or language about the desire, need, ability, reason, and commitment to change. Clinicians differentiate between client language that speaks for and against change, and then they intentionally reinforce and strengthen client talk that favors change (Amrhein et al., 2003).
Research has shown that the intensity of language that speaks of commitment to change (Amrhein et al., 2003) and change talk in general (Moyers et al., 2009) are linked to subsequent behavior changes. Therefore, MI clinicians venture to elicit and solidify client language in support of change to increase the likelihood of subsequent behavior changes (Amrhein et al., 2003; Moyers et al., 2009). Skilled MI clinicians differentiate between language that speaks for the status quo (or against change; sustain talk) and language that speaks for change (change talk), and then clinicians reinforce, elicit further, and strengthen client language for change (Miller & Rollnick, 2002).

Client language about change has been categorized as either preparatory language or commitment language. Preparatory language includes utterances that give voice to the client’s desire (e.g., “I really want to change”), ability (e.g., “I believe I could change”), reasons for (e.g., “If I do not change, my relationship will end”), and need to change (e.g., “I need to do this for my family”; Amrhein et al., 2003), and is commonly noted by the acronym DARN (Miller & Rollnick, 2004). Commitment language is heard when the client promises or vows to change (e.g., “I will stop smoking”; Amrhein et al., 2003).

The MI clinician will deliberately and skillfully alter his or her behaviors in response to client language (Miller & Rollnick, 2002). For example, if preparatory change talk is recognized, the clinician may attempt to reinforce and strengthen this direction by inviting the client to elaborate on the statement, provide an affirmation, summarize the change talk, or reflect the statement back to the client. If commitment language is heard, the clinician will work to strengthen the commitment to change and develop a collaborative plan for change. Conversely, the clinician may not attend to
sustain talk or language that speaks for the status quo (i.e., against change) in an attempt to direct the client away from arguing for the status quo and to avoid reinforcing resistance to change.

Amrhein et al. (2003) investigated how client speech within one MI session corresponded to behavior changes following that session. Eighty-four adults who presented for treatment for illicit drug use at either a public inpatient or outpatient facility agreed to participate in a single session of MI that lasted 45 to 90 minutes. Each session transcript was coded for preparatory language (DARN) and commitment language (e.g., “I am,” “I will”). First, the study revealed that preparatory language failed to predict changes in behavior, as did frequency of commitment language. The strength of commitment language, particularly towards the end of the MI session, however, was found to significantly predict subsequent behavior change, which in this study was abstinence from illicit drugs. For example, statements that contained a strong commitment, such as, “I promise to stop using” or “I will definitely stop using” were more likely to lead to change than a statement containing a weaker commitment such as “I will try to stop using” (Amrhein, 2004). In this study, the strength of client commitment language appeared to be related to client preparatory language (desire, ability, and need, \( p < .01 \); reasons, \( p = .001 \)). For example, clients’ strength of wanting to change (desire talk) or believing that they were capable of change (ability talk) was related to the strength of their statements of commitment to change.

Although Amrhein et al.’s (2003) study found only commitment language to predict behavior change, Moyers et al. (2009) found change talk in general (i.e.,
preparatory and commitment language) to lead to subsequent behavior change. In this study, Moyers et al. coded client and counselor behaviors in 63 recorded MET sessions from the Project MATCH study (see Project MATCH Research Group, 1997), and then this data was analyzed with data collected on participants’ drinking behaviors. Moyers et al. found that clinicians’ use of MI-consistent behaviors predicted client change talk and that change talk was linked to subsequent changes in drinking behavior. Furthermore, Moyers et al. found that change talk was often “sandwiched” by sustain talk, and the authors recommended that clinicians regard sustain talk as normal and avoid challenging it, and instead focus on eliciting and strengthening client statements that are in support of change.

In a preliminary investigation of how change talk and counterchange talk effect areas of the brain that respond to alcohol cues, Feldstein, Filbey, Sabbineni, Chandler, and Hutchison (2011) conducted functional magnetic resonance imaging (fMRI) scan with 10 individuals diagnosed with alcohol dependence. Participants completed an MI session with a counselor and were then shown alcohol cues after seeing change talk and counterchange talk statements that originated during their MI session. Results of this study found that the reward regions in the brain were stimulated when a counterchange talk statement was shown followed by an alcohol cue. However, no significant activation occurred in the reward region of the brain when participants were shown their change talk statements and then an alcohol cue. According to Feldstein et al., these findings suggest that change talk may hinder reward activation in the brain regions that respond to alcohol
cues, and the authors emphasized the role of change talk in assisting individuals change their alcohol use behaviors.

Amrhein et al.’s (2003) and Moyers et al.’s (2009) studies of linguistics in MI sessions and Feldstein et al.’s (2011) study of the effects of change talk on the brain reinforce the need for MI clinicians to remain attentive to clients’ verbalizations, to interpret client language as a possible indicator of their readiness to change, and to respond to change talk in a manner that might help facilitate change. Based on the findings of these studies, client change talk has the potential to mature into stronger language for change that may then lead to actual behavior change, and change talk may have an impact on specific regions in the brain to help individuals make behavior changes. The current investigation focused on counselors’ experiences of and responses to client language (e.g., DARN, commitment talk, sustain talk) when practicing MI and CBT to facilitate client change.

**Counselor Behavior and Client Language**

Moyers and Martin (2006) investigated the influence of clinician behaviors on client language. The researchers coded 30 therapist behaviors and 16 client behaviors from 38 randomly selected recorded sessions from the Project MATCH study (see Project MATCH Research Group, 1997). Clinician behaviors that Moyers and Martin coded as MI-consistent were clinicians’ use of language consistent with MI such as emphasizing personal choice and control, seeking permission prior to giving advice, offering affirmations, and providing support. MI-inconsistent behaviors included counselor
language that conflicted with the style and principles of MI such as giving advice without permission, confronting, and being overtly directive.

Client language was coded into six categories of change talk: desire, ability, reason, need, taking steps, and commitment. Results showed that client change talk followed clinicians’ MI-consistent behaviors more frequently than expected by chance and that counter-change talk (or language that speaks against change and for the status quo) occurred at a lesser rate than expected by chance. For example, change talk was elicited 17% of the time following a MI-consistent behavior whereas counter-change talk occurred only 2% of the time. In addition, it was found that MI-inconsistent behavior preceded counter-change talk more commonly than anticipated by chance.

Moyers and Martin (2006) found a significant relationship between clinician behaviors and clients’ movement toward change. These findings encourage MI clinicians to use language consistent with MI such as frequently providing affirmations, emphasizing clients’ personal choice and control over their decisions and processes of change, and seeking client permission prior to making suggestions or giving advice. In addition, Moyers and Martin identified behaviors that clinicians should avoid so as not to elicit client talk that speaks for the status quo and against change. Their suggestions were to refrain from confronting, prescribing how to go about changing, giving advice without client permission, and warning clients about the possible consequences should they choose not to change.

Results from Moyers and Martin’s (2006) study demonstrate the impact of counselor behaviors and language on client language, and inform practitioners that in
order to facilitate client change talk and subsequent behavior changes, MI counselors should implement MI-consistent interventions and diminish behaviors inconsistent with MI. Furthermore, counselors must consistently monitor their inclinations to confront, argue, persuade, give advice without permission, or warn (Moyers & Rollnick, 2002). However, many counselors have established a style of practice prior to being introduced to MI that may or may not be consistent with MI. In learning MI, counselors not only need to attain or improve skills used in MI, but they may also need to temper the use of previous behaviors and interventions that are inconsistent with MI (Miller & Mount, 2001).

The current study investigated the experiences of counselors who practice MI and CBT. Counselors who practice MI and CBT will likely need to be intentional about using language that is MI-consistent and temper the use of language that may promote certain aspects of CBT but are MI-inconsistent. The intent of the current study was to better understand counselors’ experiences of listening to client language and making decisions about their own language in counseling sessions, specifically when practicing MI and CBT.

**Efficacy of MI**

MI is now practiced by a variety of professionals in their work with various populations and problem behaviors. MI has expanded beyond the field of addictions to various helping professions including mental health, medicine, and corrections. As a result of its application potential and increasing popularity, an impressive amount of
outcome research has been conducted to assess the efficacy of MI including more than 200 published clinical trials in addition to several meta-analyses (Miller & Rose, 2009).

Changes within U.S. healthcare policies have influenced professionals in the fields of mental health, addictions, and medicine to focus on empirically supported treatments that are cost-effective as well as produce positive outcomes (Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001). Therefore, analyses of the efficacy of MI in treating specific problem issues and populations are necessary in order for MI to be considered a viable counseling method, not only by counselors, but also by third-party payers, funding sources, and training agencies.

After reviewing MI clinical trials, the Substance Abuse and Mental Health Services Administration (SAMHSA) included MI in its National Registry of Evidenced-Based Programs and Practices (NREPP). Inclusion in the NREPP signifies that MI has been scientifically tested through quality research and found to be an empirically validated approach that can be readily disseminated into practice (www.nrepp.samhsa.gov).

MI has been most researched in the treatment of substance use disorders; however, MI has been applied to additional target behaviors including diet and exercise, gambling, eating disorders, treatment compliance, HIV/AIDS prevention and management, and the treatment of psychological problems (e.g., Arkowitz & Westra, 2004; Hettema et al., 2005; Lundahl et al., 2010). MI has also been applied to various age groups such as adolescents (e.g., Knight et al., 2005; Peterson, Baer, Wells, Ginzler, & Garrett, 2006), ethnic groups including African American and Native American
populations (e.g., Befort et al., 2008; Hettema et al., 2005), and special needs groups such as people diagnosed with diabetes (e.g., West, DiLillo, Bursac, Gore, & Greene, 2007), co-occurring disorders (e.g., Martino & Moyers, 2008), and obese people (e.g., Befort et al., 2008). MI has also been considered applicable to group therapy formats (e.g., Walters, Ogle, & Martin, 2002) and couples therapy (e.g., Burke, Vassilev, Kantchelov, & Zweben, 2002).

When investigating the effects of MI, controlled clinical trials are regarded as the best method of determining treatment efficacy (Arkowitz & Miller, 2008). Three meta-analyses of MI research have been conducted in recent years. Burke et al. (2003) reviewed 30 controlled clinical trials, Hettema et al. (2005) reviewed 72 trials, and Lundahl et al. (2010) reviewed 119 trials. Although much of the findings from these meta-analyses and additional individual research efforts offer empirical support for the positive effects of MI on behavior change, there are inconsistencies among these findings. For example, Burke et al. found MI produced no significant effect in altering HIV-risk behaviors, yet Hettema et al. found a rather large effect of MI for the same problem area (average effect size = 0.71).

These meta-analyses found that MI produced moderate effect sizes in the areas of alcohol and drug abuse, gambling, public health, treatment adherence (i.e., treatment engagement, retention and follow through with behaviors related to treatment), and diet and exercise. Hettema et al. (2005) found that at follow-up, the initial effects of MI typically were found to be somewhat diminished, with the exception of treatment adherence and diet and exercise in which the effect size increased from moderate to high.
(effect size > 0.70). The initial effects of MI also appeared to endure when MI was added to another treatment (e.g., CBT; Hettema et al., 2005). Lundahl et al. (2010), however, found that client changes were maintained overall when assessed three months to one year following treatment. In general, the effects of MI were found to be lower when a manual-guided approach was used (Hettema et al., 2005; Lundahl et al., 2010). This finding may be a result of clinicians moving to develop a plan for change prior to clients reaching a sufficient level of readiness (Hettema et al., 2005).

Knowledge of evidence-based practices is important in order for counselors to make educated decisions about implementing empirically tested and validated interventions and counseling approaches with their clients. Therefore, knowledge of MI research likely influences counselors’ decisions of when and with whom to implement MI. Consider a counselor who is informed of research reporting that MI has had positive effects when used with individuals who experience problems with alcohol abuse and who are not considering changing their behavior (i.e., precontemplative about change). This information would likely influence a counselor’s decision to use MI when the individual has entered counseling in response to an employment mandate because alcohol was detected on the individual’s breath at a job site. In the current study, participants’ knowledge of the efficacy of MI in working with specific populations and presenting concerns is likely to have influenced their decisions about when and how MI and CBT are implemented with specific clients. For the current study, this knowledge and decision making process were anticipated to be part of the participants’ experiences of client and counselor language when practicing MI and CBT.
MI With Ethnically Diverse Populations

Multicultural considerations may also influence counselors’ experiences of client and counselor language when using MI and CBT to facilitate change. MI has demonstrated efficacy when used with non-majority populations (Hettema et al., 2005; Lundahl et al., 2010). In their meta-analyses of 119 MI-related studies, Lundahl et al. (2010) found that MI outcomes were positively related to studies with higher percentages of participants who were of minority ethnicity with the exception of African Americans. In their review of 72 clinical trials using MI, Hettema et al. (2005) used multiple regression analysis to determine if study sample characteristics were significantly related to effect size. Tested characteristics included age, gender, ethnicity, and problem severity. Findings showed that only ethnicity was significantly related to effect size, accounting for 19% of variance ($B = 0.434, p < 0.05$).

Perhaps the greatest strength of MI in working with multicultural clients is the emphasis on counselors gaining an accurate understanding of the client’s unique perspective and experiences (Arkowitz & Miller, 2008). For example, Native American participants in the Project MATCH study experienced more favorable outcomes following four sessions of MET when compared to 12 sessions of CBT or Twelve-Step guided treatment (i.e., Alcoholics Anonymous; Hettema et al., 2005). This may be due to the similarities between the nonconfrontational, person-centered style of MI and traditional Native American style of communication (Hettema et al., 2005). Venner, Feldstein, and Tafoya (2007) gathered qualitative data from a focus group of six Native American adults (four females, two males) from southwestern tribes in order to create a
treatment manual specific to using MI with Native American clients. Similarities found between MI and the participants’ views of change included humanistic beliefs (e.g., everyone possesses positive qualities), non-judgmental attitudes, and seeking positive motivations to change.

MI counseling may also be consistent with values of Latino cultures. According to Anez, Silva, Paris, and Bedregal (2008), three values common in Latino culture—personalismo, respeto, and confianza—are recognized and practiced in the MI approach. Personalismo refers to communication that emphasizes relationships with individuals that include an overall tone of warmth and friendliness; respeto refers to respect within relationships and mutual deference that is contingent upon the hierarchical structure that influences social interactions; and confianza, translated as trust in English, speaks to the level of intimacy and closeness developed in relationships. Each of these values of the Latino culture is present in the spirit of MI, and in working with Latino populations, these values can be explored from clients’ perspectives and understood in regards to how they may influence clients’ treatment for problem behaviors. In the current study, it was anticipated that client ethnicity may have influenced participants’ practice of MI and CBT in counseling sessions.

**Cognitive Behavior Therapy**

CBT encompasses a wide range of practices that incorporate both cognitive and behavioral conceptualizations and interventions, including Aaron Beck’s cognitive therapy, Albert Ellis’s rational emotive behavior therapy (REBT), and Donald
Mechinbaum’s cognitive behavioral modification (Corey, 2009). At the time of this study, participants reported practicing both MI and CBT.

Cognitive behavior counselors assume that individuals’ behaviors and emotions are determined by how they perceive and structure experiences (J. S. Beck, 1995). Psychological distress such as anxiety and depression are considered a result of dysfunctional cognitive processes, and therefore, change is believed to occur by identifying and restructuring irrational beliefs or distorted ways of thinking. Cognitive behavior counselors attempt to identify the automatic thoughts and assumptions (A. T. Beck & Weishaar, 2005) or irrational beliefs (Ellis, 2005) contributing to or causing distress. Throughout the counseling process, counselors encourage clients to be introspective in regard to their internal dialogue in order to access information about their cognitive processes. Once maladaptive thoughts and assumptions are identified, the meanings and implications of clients’ cognitive processes are examined. In this process, counselors educate clients about the dysfunction of certain cognitions and assist clients in restructuring their self-statements and altering cognitions so that changes in affect and behavior can be made and sustained (A. T. Beck & Weishaar, 2005).

In addition to focusing on clients’ cognitions, CBT also targets behaviors. Behavioral interventions such as guided relaxation, exposure therapy, activity scheduling, behavior rehearsal, and role-playing are often implemented (A. T. Beck & Weishaar, 2005). The use of CBT is often desired by third-party payers (e.g., health insurance companies) because it is an evidence-based practice; it is time limited; and specific, observable, and measurable objectives are established in treatment plans. The principles
and practices of CBT are commonly disseminated in treatment manuals. Manual-guided treatment programs can be beneficial in order to decrease the gap between research and practice as well as provide consistent treatment between counselors and agencies (Lamb, Greenlick, & McCarty, 1998; Morgenstern et al., 2001).

CBT is one of the most extensively researched therapeutic approaches, resulting in hundreds of published outcome studies. Results of these studies have often found CBT to be superior to or equal to alternative treatments for a broad range of problems (Butler, Chapman, Forman, & Beck, 2006). For example, CBT has been found to be effective when applied to group and individual treatment of substance use disorders, mood disorders (e.g., major depressive disorder), anxiety disorders (e.g., obsessive-compulsive disorder, post-traumatic stress disorder), and eating disorders (Nathan & Gorman, 2007). Various interventions and CBT programs have been deemed evidence-based practices by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidenced-Based Programs and Practices (NREPP; www.nrepp.samhsa.gov).

In the current study, participants had been working with diverse clientele seeking counseling for a range of presenting issues. Efficacy studies of counseling methods or treatment approaches with specific disorders may guide counselors’ decisions about which interventions or methods to use. Both MI and CBT have demonstrated efficacy with a variety of problems, and so it may be assumed that counselors who use both approaches will be thoughtful about which approach to implement (MI, CBT, or a combination of the two), that is, when and how to implement it. By investigating the
experiences of counselors who are using MI and CBT, it was anticipated that such decision-making processes would be illuminated.

**Using MI and CBT Together**

A discussion pertaining to using MI with CBT to enhance client outcomes for various mental health problems has emerged in professional literature. For example, a special series of *Cognitive and Behavioral Practice* included articles that examined the applicability and usefulness of integrating MI and CBT when working with people who experience mental health problems (Westra & Arkowitz, 2011). The series included articles that examined the use of MI and CBT together to treat generalized anxiety disorder (Kertes, Westra, Angus, & Marcus, 2011), depression (Flynn, 2011), eating disorders (Geller & Dunn, 2011), suicidality (Britton, Patrick, Wenzel, & Williams, 2011), obsessive-compulsive disorder (Simpson & Zuckoff, 2011), and substance abuse (Moyers & Houck, 2011). This series emphasized that although CBT has demonstrated effectiveness in treating a number of problem issues, many clients do not reach their desired outcomes at treatment completion or drop out of treatment prematurely, and suggested that MI may be useful in fostering client engagement, enhancing client readiness to change, and resolving client ambivalence about change to improve client outcomes. Although the articles included in the series as well as other research (Westra et al., 2009) support the idea that MI and CBT provide a synergistic effect on client outcomes, it has been noted that components of MI and CBT have the potential to conflict (see Moyers & Houck, 2011). Whereas Kertes et al. (2011) investigated client experiences of MI and CBT, the current study sought to explore counselors’ experiences
of practicing both approaches, including how counselors make decisions about how to implement the components of MI and CBT that have potential to conflict.

**Contrasting MI and CBT**

Although MI and CBT may be used together to facilitate client change, these two methods represent two very different therapeutic approaches (Miller & Rollnick, 2009). Differences include the type of method each represents (e.g., counseling style vs. theory-based treatment); the focus of the therapeutic process, including ideas about how to facilitate client change; the type of therapeutic relationship; and approaches to and degree of emphasis on addressing and managing client ambivalence and resistance.

**Type of Therapeutic Method**

MI is “a collaborative, person-centered form of guiding to elicit and strengthen motivation for change” (Miller & Rollnick, 2009, p. 137). It is fundamentally a humanistic style of counseling that was conceived as William Miller learned from his clients how to be effective in guiding them towards change. The approach developed from Miller’s reflections on his behaviors with clients and therefore, MI was not derived from a pre-existing theoretical base (Miller & Rollnick, 2009). Instead, MI was created as a flexible approach that requires “a creative integration” of MI-consistent methods to assist each client in their unique process of change (Miller & Rollnick, 2002, p. 140). MI is therefore malleable to meet each client’s degree of readiness to change and to work harmoniously with each client’s strengths and challenges.

CBT seeks to teach people how to identify, evaluate, and alter dysfunctional cognitions (J. S. Beck, 1995) and behaviors by using specific therapeutic tools. CBT is
based on cognitive and behavioral principles and theories about how people change. It is often a structured approach that includes specific steps required for treatment and structured counseling sessions (J. S. Beck, 1995). Due to its standard format, CBT is commonly disseminated through the use of structured manual-guided programs that offer specific treatment regimens. In contrast, research has demonstrated that using manual-guided MI has led to reduced positive outcomes. It has been speculated that this is likely due to clinicians allowing the manuals, instead of the client, to indicate client’s readiness to change (Hettema et al., 2005) and suggests a need for the MI approach to remain flexible whereas CBT is well-suited for the structured format offered by treatment manuals.

As a method of communication, MI has the potential to be used in conjunction with a variety of interventions and treatment methods such as CBT. Based on the findings of recent MI meta-analyses (Burke et al., 2003; Hettema et al., 2005), Miller and Rose (2009) noted that when MI was used with other treatment methods, the outcome was often larger, more enduring effect sizes compared to when MI was used alone. MI offers a way to be with people that guides them toward positive changes whereas CBT offers specific techniques to facilitate changes in cognitions and behaviors. When used together, the combined effect of MI and CBT may be greater than either approach used separately. Although the differences between MI and CBT allow the two approaches to be used together, counselors who choose to do so must effectively manage the differences that may conflict.
Focus of the Therapeutic Process

MI and CBT focus on varying aspects of the change process (Burke, Dunn, Atkins, & Phelps, 2004). MI targets the “why” of change and seeks to cultivate and elicit clients’ intrinsic motivation to change, whereas CBT focuses on the “how” of change and attempts to identify and alter clients’ dysfunctional cognitions and behaviors and provide clients with what the therapist perceives to be lacking (e.g., coping skills, education; Burke et al., 2004; Miller & Rollnick, 2009).

These differences reflect varying perspectives, and therefore different foci of the therapeutic process. CBT counselors believe people experience distress as a result of maladaptive, dysfunctional cognitions and behaviors and therefore, they focus on altering cognitions and behaviors in order to create change related to clients’ presenting problems (J. S. Beck, 1995). MI counselors believe that people essentially talk themselves into change when they verbally explore and express their desires, abilities, reasons, needs, and commitments related to change (Arkowitz, Miller, Westra, & Rollnick, 2008). Thus, MI counselors focus on client language that speaks for change (Miller & Rollnick, 2004) and use their own language to guide clients toward change by evoking, reinforcing, and strengthening client’s verbal commitments to change (Moyers & Martin, 2006).

The Therapeutic Relationship

MI and CBT can vary in their approaches to the therapeutic relationship and therefore, demonstrate contrasting therapeutic styles and roles within the relationship. Expression of empathy is one of MI’s core principles and rolling with client resistance is another, which may differ from components of the therapeutic relationship emphasized in
CBT. However, the therapeutic relationship will vary depending on the type of CBT practiced and some CBT approaches may be more consistent with MI’s approach to the therapeutic relationship than others. For example, Aaron Beck’s cognitive therapy encourages a strong therapeutic alliance that includes the expression of empathy, trust, rapport, normalization of client struggles, and instillation of hope (J. S. Beck, 1995), whereas Albert Ellis’s REBT did not prioritize a warm therapeutic alliance, including the expression of empathy, based on the belief that it is neither necessary nor sufficient for change to occur (Ellis, 2005). Expression of empathy is integral to MI, yet its importance varies among CBT practices. In the current study, it was anticipated that participants would have mitigated potentially conflicting ideas about therapeutic constructs such as the expression of empathy when practicing both MI and CBT.

MI and CBT may present contrasting ideas in regard to how the responsibility for change is addressed within the therapeutic alliance. MI counselors emphasize that the responsibility for change lies with clients. They are trained to highlight clients’ personal choice and control and promote client autonomy to assert that clients are capable of change and that only the client can decide to change and make the change, though the counselor can assist him or her with this if the client chooses (Miller & Rollnick, 2002). Often in CBT, counselors assume the role of a teacher, educating clients to be their own therapists and therefore, some responsibility for change is placed on the counselor who must help clients become aware of and test their irrational beliefs and dysfunctional behaviors and teach clients skills to modify their thoughts and behaviors (Arkowitz & Westra, 2004; J. S. Beck, 1995).
Burke et al. (2004) described the therapeutic style of CBT approaches as “collaborative but assertively instructive” (p. 316). CBT practitioners frequently assume a teacher role when educating clients about dysfunctional cognitions and behaviors and when implementing CBT techniques and interventions (J. S. Beck, 1995). The teacher-student relationship common in CBT may be inconsistent with the relationship promoted in MI that is based on client evocation and subtle guidance. The teacher role assumed by CBT counselors infers that the counselor has knowledge about what clients need to do in order to make desired changes and therefore, clients are in a position of not knowing and needing the knowledge held by the counselor. Counselors using CBT commonly teach clients what they know about what they determine the client is lacking (e.g., coping skills, thought monitoring) so that clients may apply the knowledge to make positive changes. MI counselors, on the other hand, prioritize the elicitation of clients’ own ideas about change and only offer advice after receiving clients’ verbal permission.

In contrast to the therapeutic style of CBT, MI has been described as “quiet and eliciting” (Rollnick & Miller, 1995, p. 326). Miller and Rollick (2002) compared client and counselor interactions to dancing wherein two people move together in the direction of change. Which partner (i.e., client or counselor) has the lead in the dance is subtle, possibly unobservable, and may alternate. For example, the client may take the lead by educating the counselor about his or her experiences and perceptions related to the problem behavior as well as his or her values, goals, and challenges. The MI counselor may then assume the lead by responding to the client in a manner that guides him or her further in the direction of change (i.e., using reflective listening; developing discrepancy;
recognizing, reinforcing, and strengthening client change talk). In this covert fashion, MI counselors focus on client language and use their own language to strategically assist the client toward change.

MI and CBT can be effective when used together to facilitate client change, yet each has a unique therapeutic style that may conflict with the other. Therefore, counselors who choose to use MI and CBT must make decisions about which therapeutic style to implement or how to blend the contrasting styles to effectively meet client needs.

**Ambivalence and Resistance**

There are significant variations between MI and CBT in regard to addressing client ambivalence and resistance. Arkowitz (2002) conceptualized client resistance in MI as ambivalence about change and therefore, he considered resistance as an indication that further exploration is needed in order to understand the client’s obstacles to change. According to MI, ambivalence is a natural aspect of the change process and MI counselors focus on guiding clients through the exploration of both sides of ambivalence (Miller & Rollnick, 2002). Miller (2008) recommended that when doing so, however, the counselor must emphasize client change talk in order to guide the client in the direction of resolving ambivalence and toward change and to avoid reinforcing the client’s ambivalence causing him or her to become stagnant in the change process.

Miller, Moyers, Amrhein, and Rollnick (2006) distinguished sustain talk (or client language that favors the status quo) from resistance. Miller et al. suggested that “sustain talk” be used to describe client statements of desire, ability, reasons, need, and commitment to the status quo whereas “resistance” defines in-session client behaviors.
such as interrupting or disagreeing with the counselor and changing the conversation to avoid talking about change. MI counselors use the third principle of MI and roll with client resistance. By coming alongside clients and not arguing for change, the counselor may allow intrapersonal resistance to arise (i.e., client experiences a conflict within himself or herself; Arkowitz, 2002) and clients to assume the argument for change (Miller & Rollnick, 2002).

CBT counselors may attribute client resistance to underlying irrational beliefs or cognitive distortions that are interfering with change (Arkowitz & Westra, 2004; Ellis, 2005). Therefore, in order to resolve client resistance, CBT counselors often identify and restructure the disturbances in clients’ cognitive processes that are causing the resistance (Arkowitz, 2002). How MI and CBT conceptualize resistance and ambivalence explains the variety of interventions used to mitigate resistance. When encountering client ambivalence or resistance to change, MI counselors roll with resistance and encourage clients to explore their ambivalence whereas CBT counselors’ conceptualizations and interventions vary depending on the type of CBT practiced.

In CBT literature, Leahy (2008) discussed factors that have the potential to create an impasse in the therapeutic relationship and identified several interventions to help resolve impasses. Among them were interventions focused on altering the cognitive schemas of clients or correcting errors in their thinking, resulting in the therapist educating the client about his or her dysfunctional cognitive processes that created the impasse. Although similarities may exist between CBT and MI in that the therapist has the responsibility to become aware of dissonance in the therapeutic relationship and
implement interventions to mitigate this, CBT interventions often contrast with those of MI. Rather than educating clients about their cognitive distortions and working with clients to change them, MI therapists elicit and enlist the client’s own wisdom to help diminish interpersonal resistance within the therapeutic relationship. To do this, MI counselors develop discrepancies and encourage the client’s own exploration of the costs and benefits of change, using the client’s own language to reinforce and strengthen client change talk.

Albert Ellis’s REBT offers the theory of Low Frustration Tolerance (LFT) to explain clients’ lack of motivation to make changes (Ellis & Dryden, 1987). This theory claims that although people have tendencies to move towards positive growth, there is also an opposing internal force toward avoiding the discomfort of change. REBT therapists believe that clients can reduce their LFT and move towards change, but that clients need to be taught by their therapists that they would benefit from minimizing LFT and shown how to do so (Weinrach et al., 2006).

Reactance is a term used in CBT literature to describe the lack of motivation clients experience when they perceive their freedoms to be lost or threatened (Brehm & Brehm, 1981). According to Seibel and Dowd (1999), reactance refers to client behaviors that establish boundaries between client and therapist, such as arguing, distancing, and limit-setting, which they considered to be client attempts to control or reduce the therapist’s influence. In contrast to MI literature, Seibel and Dowd focused on the conceptualization of client reactance and how it may affect client outcomes, rather
than on how therapists might alter their behaviors or language to assist clients in working through their lack of motivation.

In an earlier article, however, Dowd and Sanders (1994) suggested the use of paradoxical interventions—symptom prescription and positioning—to manage client reactance. A paradoxical intervention is a technique in which the client is instructed by the counselor to engage in the problematic behavior. This intervention presents the client with a predicament that he or she must comply and assume control over or resist the directive and cease the behavior (Corsini & Wedding, 2005). Such techniques are typically used in family therapy approaches, but Dowd and Sanders applied it to managing reactance in CBT.

Symptom prescription occurs when the therapist instructs the client to engage in the problem behavior which ideally leads to the client becoming aware that he or she can control the behavior and therefore choosing to reduce or eliminate the behavior. Positioning occurs when the therapist agrees with or even exaggerates the client’s stated perception of the problem behavior. This intervention might appear to be similar to MI’s coming alongside the client that occurs when rolling with resistance, yet the two approaches vary in that Dowd and Sanders (1994) noted that positioning should be done with caution because it may be perceived by the client as sarcastic. Dowd and Sanders, however, did not offer suggestions about how the intervention should be implemented. Coming alongside and rolling with resistance are done in the spirit of MI to promote collaboration, evocation, and client autonomy. Therapeutic paradoxes were included in Miller and Rollick’s first edition of the MI text (1991) but were eliminated from the
second edition due to the authors’ belief that paradoxes are often used to “trick” clients into change thus conflicting with the respectful, collaborative spirit of MI (Miller & Rollnick, 2002).

There is little consistency within CBT literature in regard to managing client resistance or lack of motivation to change. Therapists practicing REBT apply the theory of LFT and believe clients can be taught that they would benefit from minimizing LFT and shown how to do so whereas CBT counselors who perceive clients to be reactant may implement paradoxical interventions. Some CBT sources briefly discuss people’s natural hesitancy or reluctance to change and promote therapists’ use of reflective listening and expression of empathy (J. S. Beck, 2005), whereas other sources encourage education and discussion about what the client may expect from the CBT process (Leahy, 2003) or restructuring client’s cognitive schemas that may be creating resistance to change (Leahy, 2008). It becomes evident that across the scope of CBT practices, some approaches appear to be more consistent with MI than others with respect to addressing and managing client resistance and ambivalence.

Although there is some discussion in the literature about client resistance, reactance, and LFT, in the practice of CBT, resistance and ambivalence are typically not of any special focus (Arkowitz & Miller, 2008). It is commonly assumed that clients presenting for treatment are ready to change and therefore, neither readiness to change nor ambivalence about change are considered or addressed in much detail (Arkowitz & Westra, 2004). This presents a sharp contrast to MI in which meeting clients where they are in the process of change and aiding clients in their exploration and resolution of
ambivalence are defining characteristics and considered a cornerstone in the therapeutic process. In the current study, it was anticipated that counselors’ conceptualizations and strategies to manage client resistance and ambivalence would be part of their experiences of client and counselor language while practicing MI and CBT.

The differences described thus far are but a sample of what may be the differences between CBT and MI. Although these two methods are distinctively different, they have the potential to be used together to enhance treatment effectiveness (see Westra, 2004). Counselors who practice both MI and CBT must use sound clinical judgment to determine how to implement both approaches to best suit the needs of each individual client.

**Contributing Factors of MI**

Despite the amount of MI outcome research to date, little is known about what contributes to the effectiveness of MI. Further research is therefore needed to identify the contributing factors and specific components of MI that influence client outcomes (Hettinga et al., 2005). The purpose of the current study was to add to this body of research by gaining an understanding of counselors’ experiences of client and counselor language while using MI with another treatment approach. By investigating this phenomenon, counselors’ skills and cognitive processes were anticipated to be revealed so as to illustrate what may be required of counselors to implement MI when used in conjunction with another counseling approach.
Therapeutic Relationship

Research has demonstrated that a positive therapeutic relationship is associated with positive outcome in counseling and the relationship accounts for approximately 30% of the variability in client outcome (Lambert & Barley, 2002). In addition to the therapeutic alliance, clinicians’ strong interpersonal skills (e.g., warmth, empathy, genuineness, support, affirmation, supporting self-efficacy) are associated with more positive outcomes whereas negative emotions experienced by clinicians (e.g., hostility, depression, feeling overwhelmed) and negative behaviors (e.g., controlling, blaming, rejecting, withdrawing) are related to poorer outcomes (Najavits & Weiss, 1994). Although these findings are from psychotherapy research in general, it is apparent that the spirit of MI and the style in which MI clinicians work with clients would likely elicit positive outcomes based on the therapeutic alliance (grounded in collaboration and respect) and behaviors of the clinician (focused on expressing empathy and supporting client autonomy).

Miller, Benefield, and Tonigan (1993) investigated participants who were interested in receiving feedback about their alcohol use, but who were not necessarily interested in treatment for an alcohol problem. Forty-two participants were randomly assigned to three groups. Each group completed assessment measures and received one session of individualized feedback. The first group received feedback in a directive counseling style in which the clinician confronted participants about their alcohol-related problems and provided direct advice, the second group received feedback in a person-centered counseling style, and the third group received delayed feedback and
served as a wait-list control group. Participants returned for follow-up measures to assess their alcohol use behaviors six weeks following the feedback session and again at 12-months. Miller et al. found that a person-centered, nonconfrontational style resulted in lower alcohol consumption rates compared to a confrontational/directive style in working with problem drinkers. In addition, participants who experienced confrontation demonstrated increased behaviors of resistance and elevated consumption rates. Miller et al.’s study supports the effectiveness of the respectful, nonconfrontational therapeutic approach encouraged by MI.

**Counselor Skills**

In an effort to understand what contributes to MI’s effectiveness in changing problem behaviors, Moyers, Miller, and Hendrickson (2005) investigated specific interpersonal skills of MI clinicians and the effects of these skills on client involvement in counseling sessions. Audio-recorded counseling sessions were submitted by clinicians \( n = 103 \) four months following their completion of a two-day MI training. The first 20 minutes of each recorded session were reviewed and analyzed on clinician measures (e.g., empathy, acceptance) and client measures (e.g., affect, cooperation). Interpersonal skills assessed using the *Motivational Interviewing Skills Code* system (MISC; Miller, Moyers, Ernst, & Amrhein, 2003) included acceptance, egalitarianism, empathy, warmth, and overall MI spirit. Each of these skills was found to be positively related to client involvement in sessions based on client variables of affect, cooperation, and disclosure. Moyers et al. found that clinicians’ interpersonal skills that were congruent with MI significantly increased the level of client involvement in session.
Moyers et al.’s (2005) study supports the style of MI as a “way of being” as opposed to a set of techniques, and counselor interpersonal skills consistent with the spirit of MI positively influenced client involvement. Miller and Moyers (2006) suggested that clinicians who understand and practice the spirit of MI will be able to implement the essential skills of MI more easily and will use them more proficiently. Acquiring these MI-consistent interpersonal skills is therefore considered a prerequisite to learning additional MI skills.

Training of MI Counselors

Training clinicians to practice MI proficiently has been a topic of discussion in recent years. According to Hettema et al. (2005), the manner in which MI is delivered has potential to significantly impact treatment outcome. Variations in MI delivery may explain the inconsistent findings of MI outcome research. Therefore, sufficient training and a level of consistency between MI trainings are necessary for consistent practice among MI clinicians that may then translate into positive client outcomes. MI requires clinicians to be proficient in specific skills in order to use MI effectively and appropriately. In-depth training, or training that includes the eight stages of learning MI (Miller & Moyers, 2006) and coaching or feedback following an initial training in MI (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004), is recommended to transfer an understanding of the spirit of MI, knowledge of the principles, and proficiency of essential skills.
Stages of Learning MI

Miller and Moyers (2006) structured the learning of MI in eight specific stages. The goal of the first stage is to gain an understanding of the spirit of MI. In this stage, counselors adopt a specific way of being with clients that serves as a foundation for their interactions and work with clients. The spirit of MI involves a collaborative relationship, eliciting intrinsic motivation from clients, and promoting client autonomy (Miller & Rollnick, 2002). The collaborative relationship establishes a partnership between client and counselor in that the counselor values the experiences and perspectives of the client. In this therapeutic relationship, the counselor creates an environment that is conducive to change but is not coercive. MI counselors elicit motivation to change from within the client by evoking his or her own knowledge and experiences instead of imposing ideas on clients or “installing” motivation from “an expert” perspective (which may be CBT-consistent). Practicing in the spirit of MI also focuses on promoting client autonomy. Counselors cannot “make” their clients change; only clients can choose to change and act on their choices. The responsibility for change, therefore, lies with the client who may receive or refuse assistance in his or her process of change. Respect and affirmation of client autonomy is necessary for counselors to practice the spirit of MI.

Counselors who are new to MI and who have traditionally practiced CBT may be accustomed to the role of the “teacher” and therefore, understanding and practicing the spirit of MI and transitioning to the role of a “quiet and eliciting” guide towards change may be a challenge. Miller and Moyers (2006) identified a connection between the extent to which clinicians practice the spirit of MI and how readily they acquire skills.
essential to MI. Therefore, learning about and gaining an understanding of the MI spirit is considered the first step to becoming proficient in MI, and in the sequence of learning MI, the first stage establishes a foundation for the remaining seven stages (Miller & Moyers, 2006).

The second stage of learning MI is the acquisition of person-centered counseling skills (Miller & Moyers, 2006). Such skills include asking open-ended questions and using statements of affirmation, reflective statements, and summarizations. Although these skills are not specific to MI, they are considered essential to MI.

The third stage of learning MI introduces a skill that differentiates MI from person-centered counseling and represents the technical component of MI (Miller & Rose, 2009)—the focus on client language. This skill requires counselors to recognize and reinforce client change talk. As previously noted, research has shown that client language expressed in session that is in favor of change is linked to subsequent behavior changes (Amrhein et al., 2003), and that counselor behaviors that are MI-consistent are more likely to be followed by client change talk (Moyers & Martin, 2006). Counselors in the third stage of learning MI are trained to recognize and reinforce client language that speaks for clients’ desires, abilities, reasons for, need for, taking steps towards, and commitment to change.

The fourth stage of learning MI branches off the third and introduces skills used to elicit and strengthen client change talk. In stage three, clinicians learn to differentiate change talk from sustain talk and focus on client language that speaks for change. Stage four takes this skill a step further as trainees learn to encourage change talk and then use
specific skills to enhance and solidify clients’ verbal commitments to change. This skill is not only knowing how to elicit and strengthen such language (e.g., asking for elaboration, providing affirmations, reflecting change talk, summarizing client’s language), but also knowing when to use this skill. In the course of therapy, once change talk is recognized, the counselor learns to shape his or her own language to facilitate the client’s use and maturation of change talk. The skills acquired in stages three and four characterize the directive component of MI, or the counselor’s strategy used to assist clients in their movement towards change, as the counselor works to recognize and reinforce, elicit and strengthen the client’s language that argues for positive changes.

Stage five is characterized by learning how to roll with resistance. This skill is essential for counselors due to its impact on client outcomes (see Miller et al., 1993). The presence of resistance decreases the likelihood of behavior change and therefore, counselors learn to come alongside or join with clients and refrain from arguing with clients to reduce resistance. Specific skills acquired in this stage include offering accurate empathy through the use of reflective statements, emphasizing personal choice, and reframing.

Rolling with resistance is a skill that may conflict with some CBT practices. For example, CBT practitioners are often trained to dispute cognitive distortions or irrational beliefs of their clients that they believe are causing client resistance. This can be done in a confrontational style in which the therapist argues for the client to recognize that the belief is irrational and dysfunctional (Arkowitz & Westra, 2004). The MI style, however, contends that disputation of client arguments will likely only reinforce them. Arguing
with clients to change often causes clients to assume the opposite side of the argument which results in the reinforcement of client counter-change talk, no movement toward change, and potentially a damaged therapeutic alliance due to the frustration of both client and counselor (Arkowitz & Westra, 2004; Miller & Moyers, 2006). MI therefore offers an alternative counselor response that allows the client to argue for both sides of ambivalence while the counselor intentionally and purposefully reinforces and strengthens the argument for change by using skills learned in stages three and four. The outcome of rolling with resistance is likely a strong therapeutic alliance, decreased level of client resistance, and further movement toward change. For counselors whose prior practices relied heavily on confronting resistance, however, this skill may be difficult to acquire and effectively incorporate into practice.

The sixth stage of learning MI involves knowing when to transition to a change plan. Counselors must assess client readiness and recognize the appropriate time to transition from building motivation to change and strengthening commitment to change to developing a plan for change. Counselors learn to summarize clients’ change talk and encourage clients to consider how to proceed to action. The responsibility for plan development is with the client, although the counselor may offer suggestions when permitted by the client.

The learning of MI that occurs in stage six requires counselors to be aware of client readiness to change and to respond in a timely manner. If counselors attempt to transition to plan development prior to the client being ready, resistance is often evoked resulting in diminished change talk (Amrhein et al., 2003). Amrhein et al. found that
clinicians who attempted to implement manual-guided MI allowed the manual rather than client indicators to determine when this transition should occur. In cases when clients were not at a sufficient level of readiness to develop a plan for change, and the clinician attempted to do so, client commitment language diminished resulting in limited behavior changes. For example, Miller et al. (2003) conducted a clinical trial in which MI was compared to a “treatment as usual” control group in inpatient and outpatient settings. Results showed no significant differences between the groups, suggesting that MI had no effect on client outcomes. A therapist manual that “prescribed and proscribed procedures for MI sessions” (Miller et al., 2003, p. 757) was used to train clinicians and this likely guided them in making decisions about when to transition to developing a plan for change instead of assessing for client readiness. Many CBT approaches use and encourage manual-guided therapy to bridge research and clinical practice and ensure consistency of practice (Morgenstern et al., 2001). Taking cues about when to transition to plan development from a manual, however, has shown to decrease client movement towards change (Amrhein et al., 2003).

The seventh stage of learning MI involves solidifying and strengthening client commitment to a change plan. This stage may mimic stage four in that the counselor will elicit and strengthen language expressing commitment to the change plan. The eighth and final stage of learning MI includes the skill of alternating between MI and other counseling methods and knowing when MI is an appropriate approach to implement. Miller and Moyers (2006) noted that MI is not necessarily appropriate for clients who have resolved ambivalence or who are currently in the action or maintenance phases of
change. Such clients may benefit more from an approach with readily applicable tools and techniques such as CBT to assist clients in how to make changes. CBT and MI can complement one another to improve client outcomes if clinicians are able to strategically use MI to resolve ambivalence about change, solidify commitment to change, and create a plan for change and use CBT to give clients tools and techniques to successfully implement change. MI can be helpful to clients in answering the question, “Will I change?” whereas CBT might answer the question, “How do I change?” (Burke et al., 2004).

Learning to effectively implement MI is a complex task that requires specific training. MI training is similar to counselor training in other treatment methods in that the most common method for counselors to learn MI is through professional training workshops (Miller & Mount, 2001). Such trainings typically last one to three days and include an introduction to the spirit of MI and its principles, demonstrations of MI, and practice using MI-consistent skills and diffusing them in practice (Miller & Mount, 2001). The current study investigated the experiences of counselors who (a) reported having completed at least 20 hours of training in MI and 20 hours of training in CBT and (b) currently practice MI and CBT to facilitate client change.

MI Training Effectiveness

Miller and Mount (2001) investigated the effectiveness of a two-day, 15-hour MI training in regard to the acquisition of counselor skills related to MI. Twenty-two corrections counselors and probation officers participated in the study. The MI training consisted of didactic education and demonstration as well as experiential learning in
which participants practiced their skills in small groups with guidance from the trainers. Participants’ skills were assessed prior to training, immediately after training, and at a 4-month follow-up. At each assessment, participants completed a self-report measure, provided a recorded sample of their work for analysis using the MISC system (Miller et al., 2003), and completed the Helpful Responses Questionnaire (Miller, Hedrick, & Orlofsky, 1991) which required participants to write out their responses to six hypothetical client statements.

Results of Miller and Mount’s (2001) study showed that counselor skill proficiency in MI varied across assessment measures and across time. Self-report measures indicated that the participants perceived themselves to be competent in MI, Helpful Responses Questionnaire analysis showed that participant behaviors were modified to be more consistent with MI, and the analysis of counselor behaviors using the MISC indicated statistically significant changes in behavior that were MI-consistent. Although participants altered their behaviors to be more MI-consistent when evaluated two days following the training, at the 4-month follow-up evaluation, some behaviors returned to nearly baseline levels. In addition, participants’ use of MI-inconsistent behaviors (e.g., confronting, directing, warning, giving advice without permission) did not decrease significantly immediately following the training nor at the 4-month follow-up assessment. Overall, client responses (e.g., change talk, sustain talk) to counselor participants of Miller and Mount’s study failed to change. These findings suggest that a two-day MI training was insufficient to produce an adequate level of
sustained behavior change in counselors (practicing MI-consistent skills and eliminating MI-inconsistent behaviors) in order to influence client outcomes.

Miller et al. (2004) conducted a study of four methods for learning MI. Data were gathered from 140 substance abuse counselors who were randomly assigned to four treatment groups (workshop only, workshop and practice feedback, workshop and individual coaching sessions, and workshop plus practice feedback and individual coaching) or a waitlist control group. All participants assigned to treatment groups completed a two-day workshop similar in format to the professional training described by Miller and Mount (2001). The first treatment group participated in the training workshop only. Practice feedback was provided to participants in the second treatment group in which they submitted recorded sessions and received comments about their work from an MI expert. Individual coaching was offered to participants in the third treatment group who received up to six coaching sessions by telephone with an MI expert who did not review samples of the counselors’ practice. The fourth treatment group received each of the three methods (training workshop, practice feedback, and individual coaching).

Miller et al. (2004) assessed counselor skills by using the MISC to analyze participants’ recorded sessions at 4, 8, and 12 months following the two-day workshop. Although the assessments indicated that each of the five groups (four treatment, one wait-list) improved their MI skills over time, the groups who received feedback and/or coaching demonstrated the greatest gains in MI proficiency. Miller et al.’s study found that as clinicians used more MI-consistent skills they decreased their use of MI-inconsistent behaviors (e.g., confrontation). This finding reinforced Miller and
Mount’s (2001) notion that when conducting MI training, it may be as important for trainers to emphasize a reduction of preexisting practice behaviors that are inconsistent with MI as it is to increase the use of MI-consistent skills.

Miller et al.’s (2004) study of how clinicians learn MI suggested that follow-up training (e.g., practice feedback, coaching) is necessary in order to gain proficiency in practicing MI. There are challenges, however, to conducting and participating in such follow-up training. Miller and Mount (2001) discovered that for the most part, participants chose not to engage in six follow-up training sessions offered by the facilitators (average attendance was less than one follow-up session). Without a method of follow-up training such as practice feedback or coaching, skills acquired in training tend to diminish over time (Miller & Mount, 2001). In the current study, participants completed at least 20 hours of MI-specific training including varying degrees of practice feedback and coaching.

**Purpose of the Study**

Although it was originally developed as a prelude to treatment for addictions, MI has evolved in its applications and has demonstrated effectiveness in assisting individuals in changing a wide range of problem behaviors. Currently, MI offers a variety of applications including its optional use with the TransTheoretical Model of Change, its use as a prelude to treatment, as a stand-alone intervention, and in conjunction with other treatment methods, such as CBT. As a result of MI’s demonstrated efficacy in clinical trials and increasing popularity in the helping professions, it may be assumed that professional counselors have been trained in MI and have integrated it into their clinical
practice. However, MI trainings vary and recent research and literature suggest that in order to practice MI competently, training should include the eight stages of learning MI (Miller & Moyers, 2006) and additional practice feedback or coaching (Miller & Mount, 2001; Miller et al., 2004).

Currently, little is known about how counselors use MI with other treatment approaches. As a result of CBT’s popularity as a theory-based treatment and an evidenced-based practice and MI’s growth and recognition as an evidenced-based practice in substance use disorders treatment, a discussion about the benefits of using MI and CBT together to improve client outcomes has emerged in the literature (e.g., Arkowitz et al., 2008; Arkowitz & Westra, 2004; Burke et al., 2004; Westra & Arkowitz, 2011). In addition to investigating counselors’ experiences using of MI and CBT together, the current study sought to focus on a defining component of MI that has not been well-researched—counselors’ experiences of client and counselor language (Miller, 2008).

Client language in MI counseling sessions is considered an indicator of subsequent behavior changes (Amrhein et al., 2003; Moyers et al., 2009) and this language is perceived to be influenced by clinician behaviors (Moyers & Martin, 2006; Moyers et al., 2007). The current study anticipated that counselors who practice MI and CBT listen to client language in order to increase their awareness of client needs and to help them decide what language they will use in assisting clients’ movement towards change, specifically how they will implement elements of MI and CBT in counseling sessions. Therapeutic constructs such as the stages of change, resistance, ambivalence,
multicultural considerations, and efficacy of each approach may influence counselors’ decisions about their language in session and which interventions to implement. The current study investigated counselors’ experiences of client and counselor language while practicing MI and CBT. The purpose of the current study was thus to learn how counselors perceive and interpret client language as well as how they use their own language to facilitate client change. 

By investigating counselors’ experiences of client and counselor language, the current study intended to provide information about how counselors experience client language and make strategic decisions about their own language in counseling sessions in order to facilitate client change while practicing MI and CBT. Findings may have implications for counselors who wish to integrate MI and CBT in their own practice as well as for counselor educators who may wish to promote the integration of two evidence-based practices with counseling students and counseling professionals. Findings will also have implications for future lines of inquiry.

**Chapter I Summary**

Chapter 1 introduced the counseling style of motivational interviewing including its core principles, applications in the counseling profession, emphasis on language, efficacy demonstrated in clinical trials, and use with ethnically diverse populations. A brief overview of CBT was provided followed by a discussion of the contrasting components between MI and CBT. The contributing factors of MI were then presented including elements of the therapeutic relationship and specific skills and characteristics of MI clinicians. A discussion of MI training followed including the stages of learning MI
and components of effective MI trainings. Finally, the purpose of the current phenomenological study was described as an investigation of counselors’ experiences of client and counselor language while practicing MI and CBT to facilitate client change.

Chapter 2 presents the research question along with the phenomenological design and method for the current study. Methodological processes explained include sample recruitment and screening of participants, data collection, data analysis, and measures used to ensure credibility and trustworthiness of the study.
CHAPTER II

METHOD

Motivational interviewing (MI) is a person-centered, directive counseling style that represents a method of interacting with people, and cognitive behavior therapy (CBT) is a well-established theory-based treatment approach. Given that MI is a style of counseling or a method of interaction, it can be used with other therapeutic approaches such as CBT. As discussed in Chapter 1, MI and CBT may be used together to optimize client outcomes, yet specific characteristics and components of the two approaches have the potential to conflict. Counselors who choose to use both MI and CBT must therefore decide how to use these approaches together to best meet client needs and facilitate desired client changes.

Although it is a person-centered approach, MI is directive in that counselors assist clients in resolving ambivalence and in moving in the direction of change. Salient components of the directiveness of MI include the language used by both counselor and client. Counselors who use MI will listen for client language that speaks for change (change talk), use their own language to elicit additional change talk, and use the client’s own reasoning to reinforce and strengthen change talk. Counselors’ experiences of counselor and client language in counseling sessions were the focus of the current study.

The current hermeneutic phenomenological study sought to investigate counselors’ experiences of client language and their own language while using MI and CBT to facilitate client change. Specifically, the purpose of this study was to enhance understanding of how counselors interpret client and counselor language when making
decisions about how to use both MI and CBT in counseling sessions. The research question posed in the current study was, "What are counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change?"

In Chapter 2, the phenomenological design and method of the current study is presented. The researcher’s preparation for the study is described and followed by descriptions of the current study’s sample size and characteristics, procedures for sample recruitment, data collection and data analysis, and strategies used to ensure the credibility and trustworthiness of the study.

**Design**

**Phenomenology**

Phenomenological method was chosen for the current study in order to enhance understanding of counselors’ lived experiences of client and counselor language while practicing MI and CBT. Phenomenological research seeks information about what is the essence of the lived experience of the phenomenon (Creswell, Hanson, Clark, & Morales, 2007). The current study investigated: “What are counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change?” The purpose of the investigation was to gain an understanding of the meaning attributed to counselors’ lived experiences of client and counselor language when practicing MI and CBT by investigating the “lifeworld” of the participants, or their lived experiences as they occur in everyday clinical settings (Giorgi & Giorgi, 2008). The meaning of the phenomenon was negotiated between the researcher and the participants during data collection and further developed by the researcher through data analysis.
In the early 20th century, Edmund Husserl founded phenomenology as a philosophical movement (Ashworth, 2008). Derived from his philosophy that research investigations should start with the human experience (Ashworth, 2008), Husserl created a phenomenological research method to investigate how events and objects are presented in one’s consciousness (Giorgi & Giorgi, 2008). Phenomenological research seeks to gain a greater understanding of the meaning or nature of everyday experiences (i.e., counselors’ routine practice of using MI and CBT) and differs from other scientific methods in that it seeks descriptions of how people experience the world prior to reflecting upon such experiences (van Manen, 1990). Phenomenological research begins with the examination of the lifeworld, which Husserl described as the natural, pre-reflective world. The phenomenological investigation is then aimed towards discovery in that the desired outcome is to bring about awareness as a result of reflection and to elicit insights—from the researcher and participants—into everyday experiences that foster a profound understanding of the meaning or nature of such experiences (van Manen, 1990). Although phenomenological studies do not result in theories, they aim to offer insights into the meaning of lived experiences, and therefore more direct contact with the world (van Manen, 1990).

Several forms of phenomenology are used in qualitative research, and each is based on unique philosophical underpinnings and traditions of inquiry. Types of phenomenology include empirical phenomenology, transcendental phenomenology, and hermeneutic phenomenology (Patton, 2002). In the current study, hermeneutic phenomenology was used because of its focus on interpretations of everyday experiences.
Hermeneutic Phenomenology

When conducting phenomenological research, it is necessary to understand the philosophical underpinnings of the method of the investigation when presenting its findings (Debesay, Naden, & Slettebo, 2008). The current hermeneutic phenomenological study was based on the philosophy of Hans-Georg Gadamer who believed that humans are naturally interpretive beings. Hermeneutic philosophy assumes that individuals interpret experiences (e.g., client and counselor language) in an effort to understand them (Gadamer, 2004).

The term *hermeneutic* is derived from the Greek verb *hermeneuein*, which translates as “to make something clear, to announce or unveil a message” (Thompson, 1996, pp. 360-361). In order to “make clear” or “unveil a message” of human experience, hermeneutic phenomenology combines interpretive and descriptive methods to examine individuals’ lived experiences (Hatch, 2002). Phenomenology describes the lifeworld and lived experiences whereas hermeneutic describes an interpretation of such lived experiences (van Manen, 1990). According to van Manen, a distinction may be made between descriptive/transcendental phenomenology or a “*pure description* of the lived experience,” and hermeneutic phenomenology which is an “*interpretation* of experience” (p. 25). The emphasis of hermeneutic philosophy is an interpretive understanding of the phenomenon wherein the interpreter is the researcher who seeks a thorough analysis and an explanation of textual data, or the language spoken by participants turned into text by the researcher through transcription (Schwandt, 2000).
The purpose of a hermeneutic phenomenological investigation is to describe and interpret the lived experience under investigation, which does not exhaust the entire phenomenon; rather, it offers a reflection on how humans experience the world and the essence of such experiences (van Manen, 1990). As van Manen stated,

To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal. (p. 18)

The current study intended to offer an interpretive description of counselors’ experiences of client and counselor language when using MI and CBT in counseling sessions.

When conducting a hermeneutic phenomenological investigation, the researcher works within the context of the hermeneutic circle in his or her pursuit of a descriptive interpretation of the phenomenon. The hermeneutic circle consists of a reflexive, circular method of thinking used to facilitate understanding and the acquisition of new knowledge about the phenomenon by transferring focus from the whole to the individual parts and then from the individual parts to the whole (Debesay et al., 2008). The hermeneutic circle, however, is not meant to turn into a vicious cycle wherein the researcher becomes trapped traveling in the same places. Instead, it has been argued that the hermeneutic circle may be better represented as a spiral wherein the researcher progresses to attain new knowledge while moving in the circular process between the parts and the whole (Gilje & Grimen, 1993, as cited in Debesay et al., 2008).
Within the hermeneutic circle, the researcher engages in two arcs, or dimensions of activity: the *arc of projection* and the *arc of reflection* (Sandage, Cook, Hill, Strawn, & Reimer, 2008). The *arc of projection* is based on Gadamer’s philosophy that humans (i.e., researchers) project their interpretations of life experiences from their frame of reference including their preconceived ideas that may be rooted in their own historical contexts (Sandage et al., 2008). Although prejudgments exist, they are not to be considered a negative aspect of interpretation, but rather an inevitable reality of an individual’s history and worldview. However, preconceived ideas about the phenomenon under study can impede data analysis if they remain unexamined. Researchers conducting hermeneutic phenomenological research must therefore be mindful of their own prejudgments through the *arc of reflection*, or the dimension of activity that requires researchers to reflect on their projections, interpretations, and preconceived ideas rooted in their historical contexts (Sandage et al., 2008). Commonly referred to as *reflexivity* in qualitative research, the arc of reflection conveys the need for the researcher to be self-aware and to question and make explicit his or her perceptions and assumptions to inform the study’s credibility (Schram, 2006). Reflexivity requires the researcher to strive for balance of ownership of his or her own perspective, including attending to and questioning *what he or she knows and how he or she knows it*, and constructing an authentic understanding of the phenomenon (Patton, 2002). The arc of reflection in the current study began prior to data collection and continued throughout data collection and analysis in tandem with the arc of projection.
Preparation

Prior to data collection, the phenomenological researcher must assume a perspective and attitude appropriate for gathering data from participants’ descriptions of their lived experiences (Giorgi & Giorgi, 2008). Husserl introduced “bracketing” to assist phenomenological researchers prepare for their investigations (Giorgi & Giorgi, 2008). Bracketing is a process required of transcendental phenomenological researchers prior to engaging in and throughout a phenomenological investigation. This process encourages the researcher to increase his or her awareness of and set aside his or her preconceived ideas, beliefs, and expectations about the phenomenon. The purpose of bracketing is to ensure that the experiences of participants are not misinterpreted by the researcher.

In hermeneutic phenomenology, the idea of bracketing is considered and practiced differently than in alternative forms of phenomenology. Arriving at an understanding of the phenomenon does not require the researcher to displace, to suspend, or to “free ourselves [researchers] of all prejudice, but to examine our historically inherited and unreflectively held prejudices and alter those that disable our efforts to understand others and ourselves” (Garrison, 1996, p. 434). According to Gadamer, biases and prejudices are unavoidable and researchers’ interpretations arise from their historical contexts that shape their worldviews (Sandage et al., 2008).

The philosophy that informs hermeneutic phenomenology states that objectivity does not require the researcher to set aside his or her preconceptions, but rather objectivity lies in reflexivity and the honesty of the researcher’s thinking and reasoning,
thoroughness and rigor of intellectual thought, and guarding against failure to acknowledge evidence that counters his or her preexisting beliefs or expectations (Lindstrom, 1990, as cited in Armour, Rivaux, & Bell, 2009). Although interpretation is a primary task of hermeneutic phenomenology, it also can be its weakness (Armour et al., 2009). In order to remain open to the phenomenon and capture the essence of and interpret the meaning of participants’ experiences of the phenomenon under study, researchers must engage in the arc of reflection and continuously acknowledge and reflect on their preconceptions about the phenomenon.

In order to facilitate scientific rigor, prior to beginning the investigation, I reflected on my experiences and beliefs about the phenomenon under investigation in order to increase my awareness of their existence and to enhance understanding of my own experiences that comprise my historical context related to this phenomenon. In order to do this, I followed suggestions of Debesay et al. (2008) and an example provided by McGrath (2008), and I used memo writing to reflect on and document my preconceptions and personal experiences related to the phenomenon under study (see Table 1). I continued a similar process throughout data collection and data analysis in that I continued to reflect on and document through the use of memos how these conditions may have had potential to influence my interpretations of participants’ experiences. Memos written throughout the investigation (i.e., during preparation, data collection, and data analysis) were collected in an audit trail to enhance the study’s credibility including minimizing bias and maximizing authenticity (Lincoln & Guba, 1985; Patton, 2002).
Table 1

Reflections on My Beliefs About the Phenomenon and My Experiences Related to the Phenomenon

Based on my experiences, it is my belief that:

MI and CBT can be very effective when used together and the counselor is in tune with client language to assess his or her needs and then shape his or her own language to interact with the client and implement interventions to best meet client needs.

Assessing client readiness to change is done by listening to client language.

When I heard a client blame others for her problems, yet describe an extensive history of similar problems, I interpreted this to mean that the client had little to no awareness of the problem and little to no intention of making changes herself to resolve the problem. When listening to the client describe her situation, I assessed that she was precontemplative about change.

Expressing empathy is essential regardless of the therapeutic approach used and is done through the use of counselor language.

Counselor language may be shaped and molded by client language, including the counselor’s assessment of client needs.

This client came to the college counseling center as a walk-in appointment after her experience of anxiety related to social situations caused her to flee from a class and miss an exam. The client described the professor’s behavior as the problem causing her to leave class, and she failed to take any ownership of the problem. The client described her present circumstances as “needing” to graduate next semester, but an extensive history of missing classes throughout her four and a half-year college career because of symptoms of social phobia has repeatedly delayed her graduation. As the client described her desire, reasons, and need to graduate, I was able to guide the client to develop discrepancies between her stated goals and her current behaviors, thus developing client’s awareness of the problem and a need to change. My language—using reflective statements to develop discrepancies

(table continues)
Reflections on My Beliefs About the Phenomenon and My Experiences Related to the Phenomenon

using client’s own words—was my reaction to the client’s stage of change and her needs as I perceived them through her description of her current conflict.

Client language—including language that suggests resistance, sustain talk, and change talk—may be shaped by counselor language.

In working with the client described above, when I used open-ended questions and reflective statements about the client’s desire, needs, and reasons to change, she continued to disclose more about her circumstances which included cultural and family components and relationship issues with her boyfriend. Through my use of MI-consistent language, additional client disclosure was elicited. By supporting client’s self-efficacy and reflecting her own presentation of discrepancies between her needs and desires and her current behaviors back to her, the client’s awareness of the problem increased and she began to acknowledge that it was, indeed, her problem. The client then began to express ambivalence about making changes.

Client language informs the counselor about what counseling approach and interventions (including counselor language) might be helpful—MI or CBT or a combination.

I was using CBT to conceptualize the client above who was just beginning to contemplate change. I provided education to the client on cognitive errors and about how her thoughts may be influencing her behaviors. The client responded by stating that her problems were not that simple and that her thoughts were not the problem. I had introduced a therapeutic tool that the client was not ready for, resulting in the client rejecting it. I interpreted this as the client informing me that she was not ready for CBT. I then resumed using MI (e.g., rolling with resistance, focusing on evocation, expressing empathy) to gain a better understanding of how the client conceptualized her problems which led to the client moving further into acknowledging her problems as her own and being more open to considering change.

(table continues)
Table 1 (continued)

Reflections on My Beliefs About the Phenomenon and My Experiences Related to the Phenomenon

Counselors must not be rigid in their own agendas in session, but must adjust to the changing needs of the client throughout the therapy process by being versatile in their implementation of MI, CBT, or a combination of the two.

I was using CBT to conceptualize the client as I perceived cognitive distortions to be evident in client’s descriptions of her problems. Therefore, I introduced CBT work to the client due to my belief that this would be helpful to her. However, when I introduced a CBT concept to the client (e.g., identifying errors in thinking), I evoked resistance. I then adjusted my agenda to using MI to elicit additional client motivation to change and I planned to move into CBT work when I perceived the client to be ready to move into the action phase of change.

Both MI and CBT can be effective alone, yet with some populations/problem behaviors, a combination of the two might be necessary in order for clients to make and sustain desired changes (i.e., a client must resolve his or her ambivalence about change and learn skills in order to make and sustain the change).

Using both approaches is somewhat of an art and requires a skilled clinician, yet there is no one way or right way to use both approaches.

It takes a good deal of self-awareness, awareness of the client, and awareness of the dynamics within the therapeutic relationship to strategically use both approaches.

Clients may react positively and experience positive outcomes with the MI approach (expression of empathy, developing discrepancies, promoting autonomy, focusing

(table continues)
Reflections on My Beliefs About the Phenomenon and My Experiences Related to the Phenomenon

on exploration and resolution of ambivalence, emphasizing change talk), as well as with the education and therapeutic tools offered in CBT.

When using both approaches, I believe the spirit of MI is pervasive, even when implementing CBT interventions (e.g., education may be offered to a client about cognitive distortions but is followed by the counselor eliciting how the information fits for the client and inviting the client to educate the counselor on how he or she related to the information or how he or she may apply it; the counselor continues to interact with the client in a way that retains the spirit of MI).

MI may be used as an antecedent to CBT when initiating a therapeutic relationship. For example, MI may be used to assess readiness to change and explore and resolve any ambivalence a client may be presenting prior to implementing CBT.

Feeling comfortable and competent in practicing both approaches requires practice and happens over time.

Receiving supervision and feedback while learning to use both MI and CBT is extremely helpful, especially in learning to retain MI consistency while using CBT methods.
Procedures

Hermeneutic Phenomenological Research Activities

Van Manen’s (1990) ideas helped shape the current study’s design to be consistent with hermeneutic phenomenology. According to van Manen, hermeneutic phenomenological method consists of six interplaying research activities, activities I engaged in prior to, during, and after data collection. The first activity was initiated prior to data collection and required the researcher to *turn to the nature of the lived experience* and commit to thinking about the phenomenon fully or as a whole. Thoughtfulness about the lived experience was my primary task as the researcher. In order to complete this task, I conducted the above reflective inventory of my own beliefs and experiences related to the phenomenon (see Table 1), and then I became thoughtful about other possibilities and factors that may have influenced this lived experience for other professional counselors.

The second research activity in which I engaged was *investigating experience as it was lived*. Within this activity, thorough, in-depth individual interviews were conducted with participants during which I sought to connect with the lived experiences of each participant as they were occurring, including specific details, to produce a rich narrative account. The current study implemented suggestions of van Manen (1990) and McCracken (1988) so that I might access participants’ everyday experiences as well as their lifeworlds through interviews in the data collection process (further described in the Data Collection section).
The third research activity was reflecting on essential themes. After transcribing each participant’s narrative account in full, I examined the content of participants’ lived experiences and became thoughtful about and reflected on the significance and meaning of the described events to identify the essential themes of this phenomenon (further described in the Data Analysis section). In this activity, van Manen (1990) noted a distinction between the appearance and content of narrative accounts of the experience (e.g., data in the form of interview transcriptions) and their essence (e.g., essential themes of the phenomenon identified from the data), that which serves as the foundation for the experience.

The fourth research activity I conducted was the art of writing and rewriting which required me to “bring speech” to the participants’ lived experiences and to articulate my thoughts about the significance and meaning of the participants’ experiences through the development of essential themes (further described in the Data Analysis section). According to van Manen (1990), this activity is a process in which the researcher is not following instructions to “write-up research findings” but rather conducting research and expressing thoughts in language that describes and gives meaning to the lived experiences of the participants.

Maintaining a strong and oriented relation to the research question of the study was the fifth research activity. In this activity, I remained faithful to the primary research question and refrained from becoming side-tracked, distracted, or disinterested in the phenomenon under investigation. Van Manen (1990) noted the discipline required of the researcher in order to remain oriented to the fundamental question of the study. To do
this, I used memo writing throughout data collection and analysis to assist me in organizing my thoughts and to remain focused on the phenomenon under investigation. In addition, a peer reviewer was employed on two occasions during data analysis to ensure I remained oriented to the research question.

Finally, the sixth research activity was balancing the research contexts by considering parts and whole. In this activity, which occurred in data analysis, I intermittently removed myself from the detailed aspects of the experience to examine the experience as a whole (see Identifying Themes in Data Analysis for a full description). Van Manen (1990) considered this activity necessary to refrain from getting lost in the details of the experience and encouraged the researcher to reflect on the significance of each of the parts of the experience in the context of the overall structure of the entire experience.

Participants

Sample size and characteristics. Participant selection was purposeful (Polkinghorne, 2005). According to Creswell (2007), small, purposeful samples are often used in phenomenological studies in order to elicit the essence of a phenomenon from information-rich data sets. Wertz (2005) suggested that the number of participants in a qualitative study should be guided by the nature of the research question and the potential of the findings to inform this question. McCracken (1988) suggested that saturation, or the state in which data become redundant in satisfying the research question (Lincoln & Guba, 1985), can be achieved after gathering in-depth data from six to eight participants. As Patton (2002) suggested for qualitative studies, purposeful sampling was chosen for
the current study to gather information-rich data sets and facilitate an in-depth understanding of the phenomenon under study.

Participants in the current study were six professional counselors licensed in their state of practice in the United States. Age of participants ranged from 30 to 66 years and all participants were White. Three participants were male and three were female. All participants held a master’s degree, one was a doctoral candidate in a doctor of philosophy (Ph.D.) degree program, and one had already earned a Ph.D. degree. Participants’ number of years experience as a professional counselor ranged from 2 to 30 years.

All participants were given pseudonyms and are referred to by their pseudonyms in this and in subsequent chapters. Participants reported working in a variety of clinical settings with a broad range of populations and problem behaviors, and four of the six participants reported working in more than one clinical setting. Debra reported working with adolescents on a range of issues in a high school setting as well as working with a broad range of clients and presenting concerns in private practice. George reported working with adults diagnosed with substance use disorders in a university department clinic. Flor reported working with a variety of populations and presenting problems in private practice and non-profit outpatient settings. Evelyn reported working with children and adolescents and their families in an outpatient clinic specific to weight management. John reported working with homeless men in an inpatient setting as well as various populations and presenting problems in a private practice setting. Finally, Chris reported working with adults diagnosed with substance use disorders in an intensive
outpatient modality as well as working as a substance abuse counselor in a community health care clinic.

**Sample recruitment.** Following approval from Kent State University’s Institutional Review Board (see Appendix A), the researcher posted an invitation to participate in the current study on the Motivational Interviewing Network of Trainers’ (MINT) professional listserv. The MINT is a professional and international network of over 1,000 individuals who have completed the MI Train the New Trainer seminar, a 3–4 day training that focuses on how to train other professionals in MI (MINT, 2008). In addition to posting an invitation on the MINT listserv, the researcher created a participant pool by generating a list of individuals who the researcher anticipated would meet the participant inclusion criteria for the current study based upon her own professional interaction with them or the recommendation from another professional that they would be a candidate for this study (e.g., a licensed professional counselor). An email was sent directly to these individuals, inviting them to participate in the current study (see Appendix B).

Invitations to participate stated that the researcher was seeking participants who were licensed professional counselors, who had been trained in CBT and MI, and who self-identified as using MI and CBT together in their customary practice (see Appendix B). Potential participants invited via the listserv or personal email reported their interest to participate in the current study by directly notifying the researcher by email or telephone. They then received a telephone call from the researcher and were screened for inclusion to participate in the current study. Invitations to participate also requested that
recipients forward to the researcher names and contact information of their colleagues who they believed would meet inclusion criteria and might be interested in participating in the study. These referrals contributed to the participant pool derived from the snowball strategy (Polkinghorne, 2005).

**Participant screening.** Per Creswell’s (2007) recommendation for phenomenological studies, the current study used criterion sampling (Patton, 2002) to ensure all participants would be willing and able to offer information-rich data. Participant screenings were conducted via a telephone interview that lasted approximately 15 minutes (see Appendix C). Questions posed during the screening interview addressed potential participants’ training and clinical experiences in MI and CBT. The current study sought to investigate the experiences of counselors who use MI and CBT to facilitate client change in their customary practice. Therefore, training in and consistent practice of both counseling approaches was necessary in order for participants to offer information-rich and in-depth accounts of their experiences using these approaches.

Currently, CBT trainings lack consistency and vary in duration, content, and intensity (Ryan, Cullinan, & Quayle, 2005). The standard for CBT training established in the current study was guided by Sholomskas et al. (2005). It was determined that participants had to have completed at least 20 hours of coursework or seminars specific to CBT, which ideally included didactic learning paired with supervised practice, considered the “gold standard” of clinician training (Sholomskas et al., 2005). The standard for training in MI was that participants had to have completed at least 20 hours
of coursework or seminars specific to MI. Similar to the practice of supervision in CBT, it was ideal for participants to have had follow-up supervision or coaching in MI as recommended by Miller et al. (2004); however, as noted by Miller et al., such follow-up training infrequently occurs. In the current study, participants’ engagement in practice supervision, practice feedback, or coaching varied and ranged from less than 15 hours of CBT only supervision to extensive (ongoing for more than 6 months) MI feedback on recorded counseling sessions or MI coaching to extensive supervision specific to using CBT and MI together.

Inclusion criteria of the current study required participants to have been practicing MI and CBT for a minimum of one year. In the current study, participants’ experience practicing MI ranged from three years and 10 months to 10 years, and their experience practicing CBT ranged from 4 to 30 years. In regard to clinical practice requirements, participants conducted a minimum of five individual counseling sessions per week. In phenomenological investigations, participants must experience the phenomenon in “daily life” rather than sporadically or minimally. By screening the amount of client contact in a typical work week, counselors were included who lived the phenomenon as a part of their routine clinical experience.

The last four screening questions followed the suggestions of Moustakas (1994) to establish criteria for participation in a phenomenological study. In order for individuals to have been considered for participation, they had to (a) be familiar with the phenomenon (i.e., have attended to client and counselor language while using MI and CBT to facilitate client change); (b) be interested in understanding the nature of the
phenomenon and its meanings; (c) be willing to engage in a lengthy interview (approximately 60 minutes) and a follow-up interview; and (d) consent to interviews being audio recorded. Screening questions (see Appendix C) were posed to potential participants and were followed by probes and clarifying questions as needed to determine if participant inclusion criteria were met.

Six individuals responded to the researcher’s invitation posted on the MINT listserv. Four of these respondents did not qualify for the current study—two because they were licensed psychologists and not licensed professional counselors, and the remaining two because they practiced counseling in countries other than the United States. Using the snowball strategy, the researcher contacted 12 individuals by a personal email. Eight of these individuals did not qualify for the current study—three did not use CBT in their customary practice, two were not seeing at least five individual clients per week, one was not licensed in her state of practice, one did not have at least 20 hours of training specific to MI, and one was not interested in understanding the nature of the phenomenon and its meanings. Individuals who did not meet the inclusion criteria for the current study were thanked for their time, but were not asked to participate in this study. Individuals who reported their training and practice experience met the participant inclusion criteria were invited to participate in the current study at the close of the screening interview. Two individuals who were recruited via the snowball strategy and who met inclusion criteria were MINT members, and therefore, four of the six participants of the current study were MINT members. Participant recruitment and selection procedures are presented in Figure 1.
Following participants’ verbal commitments to participate in the study, a consent form (see Appendix D) and a demographic questionnaire (see Appendix E) were sent to each participant through electronic mail. Both forms were completed by the participant and returned to the researcher prior to the data collection interview. The primary
interview question (see Appendix F) was also given to participants prior to the data collection interview so that they might be mindful of the phenomenon under investigation in their work with clients prior to the interview and have a specific experience in mind to discuss during the data collection interview.

Data Collection

Phenomenology requires in-depth, intensive exploration of participants’ experiences of the phenomenon, and it assumes that language is the main conduit through which the meaning of the experience is conveyed (Polkinghorne, 2005). Therefore, counselors’ experiences of client and counselor language while using MI and CBT were revealed through dialogue between the researcher and the participants in individual interviews. The purpose of the interviews was to gain a thorough description, or a narrative account (van Manen, 1990), of the participants’ experiences of client and counselor language while using MI and CBT to facilitate client change.

Interviews were conducted face-to-face when distance between the researcher and participant permitted. Although face-to-face interviews were the preferred method for data collection, the researcher lacked resources to travel extensive distances and therefore conducted five of the six main interviews via telephone (a method Rubin & Rubin, 2005, regard as acceptable). Interviews were semi-structured and primarily flowed from the dialogue offered by the participant. The researcher elicited detailed descriptions of participants’ experiences of client and counselor language so that she could interpret and describe this account through data analysis (Polkinghorne, 2005). The interview process consisted of a main data-gathering interview and a follow-up interview to add detail or
depth to the participant’s data set. All follow-up interviews were conducted by telephone. All interviews were audio-recorded and transcribed in full by the researcher. The main data collection interview lasted approximately 45 to 60 minutes and subsequent follow-up interviews were approximately 20 to 30 minutes in duration.

During the interview process, the researcher considered the following suggestions from van Manen (1990): (a) keep the question as well as the meaning of the phenomenon open, (b) keep the researcher and the participant oriented to the phenomenon of experiencing client and counselor language while using MI and CBT to facilitate client change, (c) ask questions that provide opportunities for additional questioning, and (d) regard each participant as a co-investigator of the study.

The purpose of the main data-gathering interview was to focus on the experience under investigation in depth, to allow time for the participant to explore events they recalled, and reflect on the meaning and nature of those events and offer such descriptions. The objective of this interview was to facilitate participants’ sharing of their own stories and experiences in their own terms (McCracken, 1988). It was the task of the researcher to use her judgment to facilitate the interview while creating an environment in which participants felt safe to disclose their experiences and where they were open to the meaning revealed in their recalled experiences (van Manen, 1990) as negotiated in the dialogue between researcher and participant (Schwandt, 2000).

Prior to beginning the main data-gathering interview, the researcher reviewed each participant’s signed consent form and asked if the participant had any questions. The researcher then summarized information gathered during the participant’s screening.
The interview did not commence until the participant confirmed accuracy of this information. The researcher then informed the participant that the interview recording device was being turned on. The researcher then followed van Manen’s (1990) recommendation and encouraged participants to describe their experiences from their internal vantage point including their emotions, thoughts, and behaviors. Participants were encouraged to describe their experience as they lived it and to avoid generalizations. The researcher informed participants that she would be asking clarifying questions throughout the interview to facilitate depth and detail.

To begin the interview, the researcher asked each participant to briefly describe the client he or she would be discussing in the interview (e.g., demographic information, presenting problem) without reporting any identifying client information, and to briefly describe the work the participant had done with this client (e.g., number of sessions together). During the interview, the researcher posed the primary interview question to each participant (who was given this question prior to the interview) and asked secondary questions as necessary to create a rich data set (see Appendix F). Secondary questions as well as probes and clarifying questions were used as needed to facilitate participants’ in-depth accounts of their experiences, and it was anticipated that these accounts would include topics identified in the literature review (McCracken, 1988). These topics included client ambivalence, resistance, client readiness to change, efficacy of CBT and MI, multicultural considerations, and managing the use of MI and CBT together.

Following the main data collection interview, the researcher reviewed each transcription and formulated questions for each participant as needed to clarify or add
detail to the participants’ narrative accounts. These questions were posed in follow-up
interviews which lasted approximately 20 to 30 minutes. In addition to the researcher’s
follow-up questions, participants were invited to share any additional information about
their experience that came to mind following the main interview.

Prior to launching the current study, the researcher engaged in a practice
interview with a colleague who was trained in MI and CBT, who used both approaches in
her customary practice, who had experienced the phenomenon under investigation, and
who was willing to share her experiences with the researcher in a semi-structured
interview. Based on the process of the practice interview and the feedback of this
interviewee, the researcher made some adjustments to the interview process including
revising secondary questions of the interview (e.g., adding the fifth question in Appendix
F) and modifying the structure of the interview (e.g., beginning the interview with a brief
introduction of the client without disclosing any identifying information). Revisions
made to the interview process as a result of the practice interview were implemented in
each participant interview during data collection.

**Data Analysis**

Gadamer (2004) preferred to view hermeneutics as a philosophical approach to
interpretation instead of a specific research method used to obtain new knowledge
(Debesay et al., 2008). Specific procedures, however, are necessary to maintain integrity
when analyzing data from hermeneutic phenomenological studies. The purpose of data
analysis is to transform participant descriptions of lived experiences into
phenomenological descriptions and interpretations that grasp the essence of the
phenomenon and offer an understanding of the meaning of the lived experience (van Manen, 1990). In hermeneutic phenomenology, the researcher’s primary analytic task is reading and reflecting on participants’ accounts of their lived experiences (Armour et al., 2009) and interpreting participants’ constructions of their lifeworlds (Ashworth, 2008). In the current study, the methods of van Manen (1990) were applied to offer appropriate structure to the hermeneutic phenomenological analysis of the textual data.

Defining and Generating Themes

Themes generated from participants’ accounts of lived experiences serve as structures of the experience, the pillars around which the phenomenological description is created (van Manen, 1990). According to van Manen, themes have four defining qualities. First, themes attempt to answer the question, “What is the meaning of this experience?” or “What is the point of this?” Second, themes capture specific aspects of the phenomenon under investigation. A theme is an attempt to describe a component of the structure of the lived experience as a step to gain a greater understanding of the experience. Third, themes are simplifications of the phenomenon. A theme offers an oversimplified summary of an aspect of the lived experience. Fourth and finally, themes are not objects or things grounded in the text of participant descriptions, but are verbs that describe complete actions.

Generating themes from participants’ descriptions of lived experiences is essential to the phenomenological method for several reasons (van Manen, 1990). Themes aid the process of discovering the meaning or the essence of lived experiences and guide the researcher to make sense of the phenomenon under investigation. Themes also
demonstrate openness to the data and to the meaning of the experience embedded in the data.

Theme generation requires the researcher to reflect on the data and the emerging structures of the lived experience which ideally results in the researcher gaining insights to the phenomenon, creating new descriptions of the experience, and discovering various interpretations of the data. Thoughtfulness required of researchers in theme generation is exemplary of phenomenological reflection, or the process of determining and explicating what is the phenomenon. Throughout this process, the understanding of the phenomenon is maturing from the pre-reflective understanding to the reflective understanding that includes the meaning and essence of the lived experiences (van Manen, 1990).

The interpretative process of hermeneutic phenomenology requires the researcher to go beyond the descriptive data provided by participants and consider the meaning and significance of participant responses, make sense of the data, offer explanations, and make inferences about the phenomenon under study (Patton, 2002). To accomplish this, I engaged in the arc of projection in tandem with the arc of reflection within the hermeneutic circle. Theme generation is the researcher’s means to arrive at a description and an interpretation of the phenomenon and offer shape to the shapeless data set (van Manen, 1990).

**Identifying Themes**

Following van Manen’s (1990) methods, three approaches to identifying themes were used in the current study: wholistic, selective, and detailed. Each approach was used to analyze each participant’s descriptions of the lived experience in a reflexive,
circular process. When employing the wholistic approach, the researcher attended to the text as a whole and formulated a phrase that captured the fundamental meaning of the text in its entirety. When using the selective approach, the researcher read multiple lines of text and highlighted statements that appeared to be particularly essential to the experience or revealing about the phenomenon. The detailed approach required the researcher to examine each sentence or sentence cluster in the text and question what the sentence or sentence cluster revealed about the phenomenon. As the researcher conducted wholistic, selective, and detailed analysis, she identified 26 codes for thematic statements, or re-occurring constructs (e.g., counselor assessment of client readiness to change, implementing CBT to help client build skills), from participants’ data sets. The approaches described by van Manen offer guidelines to engage in the hermeneutic circle so that understanding is enhanced by alternating focus from the whole to the individual parts and from the individual parts back to the whole while engaging in the arcs of projection and reflection (Debesay et al., 2008).

After each of the three approaches was applied to each participant’s descriptions of his or her lived experience to identify themes, the themes were then analyzed between each participant to identify the essential structures that comprise counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change. This process of analysis resulted in eight themes and the therapeutic process of using MI and CBT being identified from 26 coded thematic statements. In order to understand the essence of this phenomenon, distinctions were made between essential themes and incidental themes and the essential themes were consolidated and modified. In
phenomenology, the method of free imaginative variation is used to verify whether the themes are essential to the phenomenon (van Manen, 1990). When using this method, the researcher identifies possible alternative meanings by using imagination, alternative frames of reference, examining the idea from an opposite or reverse perspective, and approaching the experience from varying roles or positions (Moustakas, 1994). Using free imaginative variation, the researcher examined each identified theme and the therapeutic process and inquired whether or not the phenomenon would be the same if the theme under investigation were to change or be deleted. Each theme was scrutinized as to whether or not the phenomenon would retain its fundamental meaning without the theme. Five main themes, each with at least two sub-themes, were identified as essential to the phenomenon as well as a therapeutic process of using MI and CBT.

A peer reviewer (Creswell, 2007; Lincoln & Guba, 1985) who assumed the role of a “devil’s advocate” was invited to question the researcher on her determination of the five main themes and their sub-themes and the therapeutic process. This practice is recommended in qualitative research (Creswell, 2007; Lincoln & Guba, 1985). The essential themes of the phenomenon of experiencing client and counselor language while using MI and CBT and the therapeutic process were written and re-written by the researcher to elicit further reflections and insights (van Manen, 1990). Throughout the writing process, the researcher strived to remain oriented to the life experiences described by the participants while assuming the role of a researcher and to produce text that was rich and deep to express the essence of the phenomenon under study. The researcher used memo writing and employed the peer reviewer a second time during this writing
process to assist her in remaining oriented to the research question and to continue to reflect on her interpretations. Figure 2 depicts the data analysis procedures of the current study.

**Credibility and Transferability of the Study**

The current study employed recommendations of Lincoln and Guba (1985) and Creswell (2007) to establish credibility and trustworthiness. Transferability is also a noteworthy construct mentioned by Lincoln and Guba, and I considered this construct as it applies to the findings of the current study.

**Credibility**

Measures taken to ensure credibility of the current study included clarifying researcher bias (Creswell, 2007), establishing an audit trail (Lincoln & Guba, 1985; Patton, 2002), employing a peer reviewer (Creswell, 2007; Lincoln & Guba, 1985), and member checking (Creswell, 2007; Lincoln & Guba, 1985). As previously mentioned, in preparing for hermeneutic phenomenological studies, researchers are not required to “set aside” their preconceptions but rather practice honest, thorough reflections to enhance awareness of their previous experiences related to the phenomenon that may influence their projections and interpretations. In the current study, efforts to clarify researcher bias began prior to data collection and continued throughout the investigation. Such efforts included reflecting on and documenting in memos my own experiences and preconceptions about the phenomenon under investigation (see Table 1) as well as my experiences throughout the research investigation (i.e., during preparation, data collection, and data analysis). The purpose of this task was to heighten my awareness of
Read and reflected on textual data.

Engaged in wholistic, selective, and detailed approaches to analysis and identified 26 thematic statements.

Compared thematic statements across participant accounts to identify eight emerging themes.

Reflected on data and emerging themes. Eight themes modified into five themes. Therapeutic process was identified.

Reflected on evidence for themes and therapeutic process. Engaged in free imaginative variation. Themes, sub-themes and therapeutic process were refined. Employed a peer reviewer.

Implemented changes based on first peer review session. Continued to reflect on and rewrite themes and therapeutic process. Employed a peer reviewer for a second time.

Employed member checking with each participant to verify findings with participants’ experiences.

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Figure 2. Data analysis procedures
my own preconceptions and biases that might influence my interpretations as well as inform consumers of research findings of my position. Memos written throughout the investigation were collected in an audit trail to enhance credibility of the study including minimizing bias and maximizing authenticity (Lincoln & Guba, 1985; Patton, 2007).

Through the process of peer review, the researcher exposed the data analysis procedures and the essential themes and the therapeutic process that emerged from the data to a peer who was familiar with phenomenological research. The peer reviewer was employed on two occasions in the final stages of data analysis. This person assumed the role of “devil’s advocate” to assist the researcher in remaining honest to the data and exploring the meanings of the findings and bases for interpretations. The peer review process was also purposeful in granting the researcher the opportunity to use an external source to question themes and to disclose thoughts and feelings that may be clouding judgment or hindering progress in the data analysis process.

Member checking was completed by asking each participant to verify whether or not the findings—the main themes and the therapeutic process of using MI and CBT (further described in Chapter 3)—represented his or her lived experiences. This strategy was employed during data analysis after the essential themes and the therapeutic process were generated from all participants’ data. The findings were presented to each participant to give him or her an opportunity correct any misinterpretations of the researcher; however, each responded that the tentative findings were consistent with his or her experience.
Transferability

As qualitative research findings are unique to their participants, Lincoln and Guba (1985) suggested that it is the responsibility of the individual seeking to transfer the information from qualitative studies to determine the level of transferability as “inferences cannot be made by an investigator who knows only the sending context” (p. 297). However, it was my responsibility as the researcher in the current study to produce credible and trustworthy findings from which others could make judgments and transfer the findings of the current study as they might seem useful.

The current study focused on counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change. Although it is my hope that findings of the current study contribute to the literature, the responsibility for transferring these findings is that of the individuals who wish to use the information. For example, a counselor who hopes to help facilitate client change in his or her clinical practice by using MI and CBT may benefit from learning about the experiences of others who have used the approaches together. Determining how the findings of the current study pertain to such a person is the task of that individual. In a second example, MI-trainers may transfer the findings of the current study to help inform them of the possible experiences of their trainees who are attempting to use both MI and CBT. The task of transferring the information, however, pertains to those who wish to use it. This hermeneutic phenomenological study offers one interpretation and description of this phenomenon which will never exhaust the possibilities of additional (possibly richer) interpretations to be made in regard to the same or similar experiences (van Manen, 1990).
Chapter II Summary

In this chapter, the research question of the current study was presented and the study’s design and method, hermeneutic phenomenology, was described. The researcher’s preparation for the study was described followed by the sample size and characteristics and procedures used for data collection and data analysis. Finally, a discussion of the efforts made to ensure a credible and trustworthy investigation was presented. In Chapter 3, the findings of the current study are presented.
CHAPTER III

RESULTS

The current study investigated counselors’ experiences of client and counselor language while using motivational interviewing (MI) and cognitive behavior therapy (CBT) to facilitate client change. Hermeneutic phenomenological method was used to analyze data collected from six participants who were licensed professional counselors. Each participant completed two individual interviews. The main interview was semi-structured (see Appendix F) and lasted 45–60 minutes, and the follow-up interview was comprised of questions derived by the researcher from the first interview and lasted approximately 20–30 minutes (see Chapter 2 for a full description of data collection procedures).

Findings of the current study included the identification of five main themes and a therapeutic process of using MI and CBT. During member checking, each participant verified that the five main themes and the therapeutic process were part of his or her experience of client and counselor language while using MI and CBT to facilitate client change.

In this chapter, the themes are described and supported by excerpts from participants’ narrative accounts. The therapeutic process of using MI and CBT is also described and further explained with examples from each participant’s account. Information from participant accounts is presented here as it was described by participants. However, when participants did not explicitly state that they were using MI or CBT with their clients, the researcher interpreted their reported behaviors as consistent
with MI, consistent with CBT, or a blending of MI and CBT. These researcher interpretations are embedded as bracketed comments in the following section.

**Synopses of Participants’ Narrative Accounts**

The current study gathered data from six participants in the form of in-depth narrative accounts (see Chapter 2 for a summary of participant demographic information). Each participant is referred to here by his or her pseudonym. Descriptions of participants include demographic information, number of years experience as a licensed professional counselor, number of years experience using MI and CBT, and supervision received in either MI or CBT as part of or in addition to the study’s inclusion requirement of at least 20 hours of training specific to MI and at least 20 hours of training specific to CBT. The following synopses also provide a summary of each participant’s narrative account including an overview of each participant’s work with the client he or she chose to discuss.

**Participant One: Debra**

Debra described herself as a White female in her 50s who had 30 years of experience as a licensed professional counselor. Debra reported practicing CBT for 30 years and MI for seven years at the time of the current study. In addition to completing the training requirements for the current study, Debra reported that for the past five years she engaged in MI-specific supervision that included practice feedback.

Debra described her use of MI and CBT with an adolescent White male who was referred to counseling by his high school after the client was found consuming alcohol at a school function. Debra reported she worked with this client for approximately two
years in a private practice setting and that their work together ended over one year ago (at the time of her interviews for the current study) when the client graduated high school. Debra saw this client on a weekly basis except during the summers when they met every other week.

Upon their first meeting, Debra interpreted the client as “guarded” after hearing the negative language he used to describe his previous therapists and his feelings about counseling. She decided to use “straight MI” to roll with resistance, engage the client in the counseling process, and build a therapeutic relationship. She described her work with the client to be very challenging initially in that the client used violent, offensive language to describe his White supremacist beliefs, and Debra believed the client was capable of acting violently towards others. Debra explained that she sought consultation to help her address her own personal responses to the client so that she could maintain her role as helper. She also described how she addressed her concerns in consultation and with the client’s parents pertaining to the client’s propensity for violence [consistent with CBT].

After approximately four months of practicing MI with this client, Debra heard the client verbalize his discontent with the lack of diversity among his friends, specifically pertaining to differences in race, ethnicity, and socioeconomic status. Debra interpreted the client’s language to indicate that he was ready [consistent with MI] to begin challenging and modifying his beliefs about others [consistent with CBT]. Debra used CBT to assist the client in making these changes, but she retained the MI style to
ensure she was moving toward change at the client’s pace and that he remained engaged in the counseling process.

In addition to modifying the client’s beliefs about others, Debra and the client collaborated on what issues to address and how to go about addressing them when they met with his parents to work on family issues [blending MI and CBT]. Debra used CBT to focus on the behaviors of the client and his parents to improve the functioning of the family unit. By the time she terminated treatment with this client, Debra reported he had made significant changes, including improved relationships with his parents and abstaining from substance use. Debra also conveyed that his aggressive language and racist beliefs diminished, transforming him into a “relaxed” and “comfortable” young man.

**Participant Two: George**

George described himself as a White male in his 40s who had a Ph.D. degree and who primarily worked as a faculty member at a university. George reported being a licensed professional counselor for 12 years, practicing CBT for 15 years, and practicing MI for 10 years. In addition to meeting the training requirements for the current study, George reported he participated in several MI trainings that often included practice feedback and coaching.

George described his use of MI and CBT when counseling a graduate student in the university setting. The client was a married White female in her late 20s who was referred to George by a faculty member at the university. The client was struggling to balance her roles as a new mother and a doctoral student. George had had two
counseling sessions with the client at the time of this study and he anticipated their work would continue.

By listening to the client’s language as she described her presenting concerns, George interpreted the client to be ambivalent about remaining in her doctoral program while being a mother of an infant child [conceptualization consistent with MI]. George, therefore, decided to use MI to guide the client to explore and resolve her ambivalence. George expressed empathy to the client and normalized the challenges she was experiencing. It became evident to George that the client had resolved her ambivalence when she made the decision to remain in the doctoral program. The client then took the lead in their discussion of specific behaviors the client might engage in to use her time more effectively to better manage both roles [consistent with CBT].

In this dialogue, George heard the client disclose some of her beliefs about being a mother as well as negative self-talk about her performance as a student. George described how he believed the client’s language illustrated “irrational or quasi-irrational beliefs” that were likely causing the client unnecessary distress [consistent with CBT conceptualization]. George then began to focus their work on identifying and challenging the client’s beliefs and ways of thinking by using reflective statements and open-ended questions [blending MI and CBT]. George reported that he intended to continue thought modification in future counseling sessions to help the client be content and successful in her decision to continue the doctoral program while being a new mother.
Participant Three: Flor

Flor described herself as a White female in her 60s who had been a licensed professional counselor for eight years. Flor reported using both MI and CBT for the past eight years. In addition to the study’s training requirements, Flor noted she engaged in approximately 13 hours of CBT training supervision specific to post-disaster distress.

Flor described her work with a married White male in his late 30s. The client was affected by a natural disaster that resulted in he and his family needing to relocate. The client presented for counseling almost one year after the disaster for help addressing his anger and alcohol use.

Flor had been trained to use a 10-session CBT program developed specifically for survivors of a natural disaster and she used this program throughout her 10 sessions with this client. Flor described how she listened empathically to the client’s story [consistent with MI] and encouraged him to express his emotions related to his difficult situation. She also described how she used the client workbook included with the CBT program to help this client identify how his thoughts and beliefs were contributing to the intensity of his anger. Flor reported that although it was difficult for the client to identify his thoughts initially, he eventually made progress becoming aware of how his thoughts influenced his feelings, resulting in him experiencing less intense anger than when he presented for counseling [consistent with CBT].

Based on the client’s language, Flor believed the client wanted to change his drinking behaviors, but she also heard him describe the purpose of his drinking (e.g., to escape) and the difficulty he anticipated in stopping drinking. The client, however, was
sober for two years prior to the disaster. Therefore, Flor elicited from the client his beliefs about the benefits of sobriety and how he was able to achieve sobriety in the past [consistent with MI]. She learned that attending Alcoholics Anonymous (AA) meetings had been helpful for the client in the past, but he had not been attending meetings since he relocated. With Flor’s encouragement and information about specific meetings in the area, the client began attending AA meetings and he stopped drinking.

**Participant Four: Evelyn**

Evelyn described herself as a White female in her 30s. She reported being a licensed professional counselor for two years, practicing CBT for six years, and practicing MI for four years. Evelyn reported she engaged in MI “intensive coaching” on a weekly basis for six months and she continued to receive ongoing feedback and coaching on a monthly basis.

Evelyn described her work with an adolescent White female who she had seen for five monthly counseling sessions in an outpatient clinic for weight management. The client’s goals were to lose weight and then maintain a healthy weight, but she experienced weight cycling in that she would lose and then regain weight. Evelyn described her most recent session with this client during which the client had realized she had gained a significant amount of weight since their last meeting. Evelyn interpreted from the client’s language and nonverbal presentation that the client was feeling surprised and discouraged and was also having difficulty identifying what could have contributed to the weight gain. Evelyn also interpreted the client’s confidence to be low and that the client felt a lack of control over the weight gain.
Based on her interpretations, Evelyn guided the client to identify her strengths and what she was doing well with regard to managing her weight in order to enhance the client’s confidence and to assist the client in identifying what changes she could make to help her reach her goals [consistent with MI]. From this dialogue, the client decided she needed to increase her amount of physical activity. Evelyn then elicited a plan from the client for how she could go about doing this [consistent with MI and CBT]. At the close of this session, Evelyn reported that the client’s confidence rating for following through with the plan she developed was a 9 on a 10-point scale [confidence rating is consistent with MI]. In addition to the client’s confidence rating, Evelyn recognized a change in the client’s language and nonverbal presentation that she interpreted as the client feeling in control of her situation as she left the session.

**Participant Five: John**

John described himself as a White male in his 30s. He reported being a licensed professional counselor for three and one-half years, using CBT for six years, and using MI for three years and 10 months at the time of the current study. John reported that he engaged in extensive, ongoing CBT supervision for six years and supervision specific to MI and CBT combined for almost four years.

John described his work with a homeless man who was in his 50s and who immigrated to the United States in the 1980s. Their work together lasted eight months, and John saw the client three or four times per week as his case manager and counselor. The client had several psychiatric diagnoses including bipolar disorder with psychotic features, posttraumatic stress disorder, and alcohol dependence. The client mistrusted
Americans as he believed American culture was very materialistic. When he was assigned to John’s caseload, the client was living in temporary housing of poor condition located in an area known for drug activity.

John worked with this client on many issues including alcohol dependence, psychotic delusions, medication compliance, poverty, and homelessness. From the client’s language, John interpreted that the client lacked trust in the housing and mental health systems and in Americans in general and that autonomy was important to the client. John intentionally worked to develop trust with the client by expressing empathy and eliciting information from the client about his goals, culture, and strengths [consistent with MI]. John used the client’s terminology to communicate with the client and to work on stabilizing the client. For example, the client was prescribed psychotropic medications to diminish his delusions, persecutory type, but he disliked taking “medication.” Therefore, the client and John used a different term when referring to his psychotropic medications which led to the client increasing his medication compliance.

John described a number of challenging situations in his work with this client. John conveyed that he used MI to guide his interactions with the client including rolling with resistance, expressing empathy, developing discrepancy, and exploring ambivalence, and that he used CBT to conceptualize the client’s delusions and to help the client modify his problematic behaviors (e.g., alcohol use). John’s account was unique from other participants in the current study in that he described the challenges he faced in remaining MI-consistent when working with such complex client issues. Prior to learning MI, John used a directive form of CBT as his primary counseling style, and he described how he
became aware that he had regressed to using his previous, directive style of counseling when resistance emerged in the therapeutic relationship. During his work with this client, John received supervision specific to using MI and CBT together to help him refrain from being overly directive with the client and to continue to meet the client in his readiness to change for each of his issues.

John’s work with this client came to an unfortunate close when the client stopped taking his psychotropic medications. John reported his work with this client was terminated approximately three years prior to the current study and that the client has continued to make significant progress on each of his issues with another counselor.

**Participant Six: Chris**

Chris described himself as a White male in his 30s. Chris reported being a licensed professional counselor for two years, practicing MI for eight years, and practicing CBT for four years at the time of this study. Chris reported he had participated in two years of supervision specific to MI and four years of supervision specific to using MI and CBT together that included practice feedback.

Chris described his work with an adolescent Hispanic male who was referred to counseling after being suspended from school for using cannabis at school and for anger outbursts. Chris used the Cannabis Youth Treatment (CYT; Sampl & Kadden, 2001) protocol to guide his work with this client. The CYT was designed to incorporate CBT with motivational strategies. This program consisted of two individual sessions that used MI to enhance motivation to change followed by three CBT group sessions. The two MI sessions took place within the same week and were each 30 to 40 minutes long. The
three CBT group sessions began the week following the MI sessions, occurred on a weekly basis, and were each 75 minutes long. An in-person follow-up assessment was conducted 90 days following the final CBT group session. Chris reported his work was terminated with this client after the 90-day follow-up which occurred approximately one and one-half years prior to the current study.

Based on the client’s initial presentation (e.g., closed posture) and language (e.g., using expletives to describe referral sources), Chris interpreted the client to be “precontemplative” and “resistant” to the idea that he had a problem with cannabis and would benefit from counseling. Chris described how he used MI in the two initial individual sessions to roll with resistance including expressing empathy to the client and eliciting from the client what he saw as potential problems with his cannabis use. By the end of the second MI session, the client was engaged in the counseling process and he had identified problems with his cannabis use, including conflicts with his girlfriend and school suspensions.

Chris interpreted peer pressure to use cannabis at school to be a challenge for the client, especially considering Chris understood the culture of the client’s inner-city school to be accepting of or even promoting cannabis use. Chris believed that refusal and assertiveness skills [consistent with CBT] would help the client achieve his goal of reducing cannabis use, especially at school, to avoid additional suspensions and problems with his girlfriend. Based on the goals identified by the client, Chris and the client collaboratively developed a plan [consistent with MI and CBT] for the client to engage in the CBT group sessions which focused on developing refusal and assertiveness skills.
Chris was a co-leader in the CBT group sessions and witnessed the client learning new skills and practicing his skills with other group members. At a 90-day follow-up assessment, the client informed Chris that he had maintained a reduction in cannabis use, he had not been suspended from school again, and his relationship with his girlfriend had improved.

Themes

Five main themes were identified in the current study. The researcher identified each theme as an essential component of participants’ experiences of client and counselor language while using MI and CBT to facilitate client change, and participants verified this during the member checking process. The five main themes are as follows:

1. Counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs.
2. Counselors interpret client language specific to readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change.
3. Counselors interpret client language that suggests problematic thinking or a need for behavior change and then respond with the use of CBT when clients are determined to be ready to change.
4. Counselors are intentional about their use of language, including having an awareness of what they are not saying.
5. Counselors’ responses are guided by their interpretations of client factors (e.g., psychopathology, sociodemographic information, personal resources).
Theme identification occurred through the course of a multi-phase process consistent with hermeneutic phenomenology (van Manen, 1990). As described in Chapter 2, the researcher used wholistic, selective, and detailed analysis with each of the transcribed interviews. While engaging in the three types of analysis, the researcher created codes for specific thematic statements, resulting in a total of 26 codes (e.g., using MI for engagement, using CBT to learn new behaviors); however, one code was eliminated because there was only one example of the concept by one participant.

The researcher then listed the 25 thematic statements, reread the coded transcripts, and pulled excerpts from the transcripts that provided evidence for each thematic statement. This process allowed the researcher to examine the evidence for the statements across participants’ accounts. The researcher used memos to help her reflect on the evidence for the 25 statements which resulted in the reorganization of some concepts and consolidation of similar concepts to create eight preliminary themes. For example, the researcher initially had “counselor listens to client language to assess needs and readiness for change” as a thematic statement beneath which sub-categories emerged including “needs for the relationship” and “readiness for change.” Another thematic statement was “counselor listens to client language and then adjusts his or her own language accordingly” beneath which sub-categories emerged including “pertaining to the therapeutic relationship” and “pertaining to the client’s movement toward change.” The researcher consolidated and reorganized these concepts to form the preliminary thematic statements “counselor language is based on his or her interpretation of client’s needs in the relationship” and “counselor’s interpretations and responses to client’s
language speaking for motivation for change.” The researcher again used memos collected in an audit trail to track and clarify her understanding of the developing themes and to assist her in organizing the thematic statements to gain an understanding of how they fit together and related to one another as a phenomenological description. Memos were also used to help the researcher reflect on her interpretations and maintain awareness of her historical context and biases related to the phenomenon (as described in Chapter 2). After further reflection, rereading of participants’ accounts, and consultation with a peer reviewer, these statements were modified further to be as they are listed above as Themes 1 (counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs) and 2 (counselors interpret client language specific to readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change).

Rereading participants’ accounts and further reflection using memo writing led the researcher to consolidate some preliminary themes and to modify others into sub-themes because they were not present in all participant accounts, but appeared to be an important element of a broader, already existing theme. For example, preliminary themes of “counselors’ interpretations and responses to client’s problematic thinking” and “counselors’ interpretations and responses to client’s need for skills or to try new behaviors” were consolidated to create Theme 3—counselors interpret client language that suggests problematic thinking or a need for behavior change and then respond with the use of CBT when clients are determined to be ready to change. Also, the preliminary
themes of “counselors’ interpretations and responses to client language speaking for motivation to change” and “counselors’ interpretations and responses to ambivalence” were consolidated to create Theme 2—counselors interpret client language specific to their readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement towards change—which includes Sub-theme 2.2—resolving ambivalence.

The consolidation and rewriting of themes resulted in the identification of five main themes, each with at least two sub-themes. Sub-themes were identified and written beneath the umbrella of each main theme to further deconstruct the components of participant experiences and to describe participants’ experiences in more depth and detail. The sub-themes were derived from participant accounts, but were not necessarily present in each participant’s account as were the main themes.

The researcher then transferred her focus from the details of the phenomenon to the experience as a whole in the arcs of projection and reflection by using free imaginative variation (Moustakas, 1994; van Manen, 1990). The researcher used free imaginative variation to examine each identified theme and inquire whether or not the phenomenon would be the same if that particular theme were to change or be deleted.

Peer review—or discussions used to examine the relevance of the themes to the research question, the clarity and comprehension of the themes and sub-themes, and the rigor and quality of the data analysis process from which the findings emerged—occurred in the final stages of data analysis, but before member checking. During the peer review sessions, the peer reviewer questioned the researcher on how the findings responded to
the research question and how the themes were generated from the data. The peer reviewer also inquired as to how well the sub-themes fit beneath the main themes and how the themes were written-up. As a result of the two peer review sessions, the researcher modified the wording of two main themes and eliminated a sub-theme from Theme 3 that did not qualify as a sub-theme. The five main themes were verified by each participant during member checking.

**Theme 1**

Theme 1: Counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs.

Participants in the current study described how they listened to client language to gain an understanding of what was needed in the therapeutic relationship. These needs varied contingent on client factors (e.g., presenting problem, cultural components) and histories (e.g., past counseling experiences). Following their interpretations of the needs within the therapeutic relationship, participants adapted their language in counseling sessions to meet those needs.

Evelyn’s account of her work with an adolescent female in weight management treatment exemplified this first theme. Evelyn understood the client to be surprised and discouraged by her weight gain, and she interpreted the client to need a guide to help her move toward her goal of sustained weight loss after experiencing the set-back. Evelyn described how she experienced the client’s reaction to her weight gain at the beginning of the counseling session:
She had come in [and] the energy was low and...just felt deflated. ... At least for me it seemed like she sort of felt overwhelmed, like, “Oh my gosh. I thought I was doing okay, but I’m not. I’m really doing terribly here and I don’t know what to do.” So I sensed her feeling of overwhelmed. ... She was feeling discouraged. And it was difficult for her to identify what may have been some contributing factors to her weight gain. ... I think that she was so surprised by what her weight change had been that she was ... shocked and kind of like, “Oh my gosh I need to do something about this,” but feeling a little bit overwhelmed and not knowing what to do or how to do it.

In order to assist the client in moving toward her goal of sustained weight loss, Evelyn assumed the role of a guide. Consistent with MI, Evelyn began by eliciting from the client what the client believed she was doing well and what the client believed she might benefit from doing differently. Evelyn then used open-ended questions to ask the client what she wanted to do. As Evelyn described:

We did some collaborative sort of agenda setting of the areas that she could make improvements in. And you know, then asking her that question, “Well out of all of these areas, where do you feel the most confident that you can make a change or make an improvement?”

After guiding the client to evaluate what she was already doing well and what changes would help her reach her goal, Evelyn recounted that the client quickly decided she needed to increase her physical activity in order to be successful in losing weight.
After collaboratively developing a plan for how to go about doing this, Evelyn observed the client’s response which she described as:

I noticed that the energy [was] increasing when she put that specific plan on paper. Because it was like she felt a sense of control again. Because I think that when we first looked at her weight and she saw the change, there was . . . this overwhelmed, a little bit out of control. But by the end of the session, it was like she had gained some of the control back because she had this concrete plan to work with.

In Evelyn’s account, she described how she approached the therapeutic relationship as the client’s guide towards change after interpreting that the client was overwhelmed by the surprise of her set-back. The client had been successful in losing weight in the past and therefore, Evelyn believed the client would be able to identify what she needed to do differently in order to reach her goal. Evelyn’s approach was consistent with MI, and at the close of the session, Evelyn reported the client expressed confidence that she would implement the change plan.

Within Theme 1, participants described three sub-themes: expressing empathy and normalization, developing trust, and diminishing resistance. Although expressing empathy is the first sub-theme, it should be noted that all participants described expressing empathy to their clients in the current study and the expression of empathy was not exclusive to sub-theme 1.1.

**Sub-theme 1.1. Expressing empathy and normalization.** Within the therapeutic relationship, several participants identified the need for empathy and
normalization of clients’ reactions to stressors. Flor described her interpretation of this need in her work using a 10-session CBT program with a client who was affected by a natural disaster:

It [the natural disaster] was such a life changing event . . . It’s got so many things you can touch on in a person’s life and it precipitated so many things, and . . . I saw several of the clients through that program and all of them were just, they were just so relieved to just come in and talk to somebody and felt like somebody was going to listen to them . . . and there was a lot of that; nobody was listening to them.

Flor also described how she responded to her client with empathy and normalization:

Every time I would ask something, it was like I would hit the button and he would go on the rampant about everything and this is so unfair and it’s affecting this, this, this, and this and you know, “How are we going to be able to get out of this?” . . . In a way I would let him go there because . . . [the natural disaster] was such a devastating event . . . To kind of be there with him to be empathic and to listen to his story. . . . I was able to . . . make some reflective statements with him and, you know, recognize that none of the things are fair and it’s really unfortunate and also helping him to feel that he’s not the only one going through this and . . . many people feel like he does, so that he doesn’t feel so . . . all alone or “How can I fight this all by myself?”

In George’s account, he described his work with a doctoral student who was struggling with her roles of being a new mother and a doctoral student. Specifically, the
client was ambivalent about sacrificing time with her child in order to produce academic work that met her high standard as a student. George described his interpretation of the client’s needs as: “I think she was also looking for, approval is probably overreaching, but support in that having these feelings is okay and that it’s normal for a graduate student going through a transition.”

George’s interpretation of the client’s needs led him to respond to her in the following ways:

Giving her some feedback on how that’s normal and so on and so forth. I did some self-disclosure there. In talking about being a new parent in graduate school, I can relate to that, so I did some self-disclosure. And I think she resonated with that as well. In terms of having these stresses and problems, I think she resonated with again that it’s okay and it’s normal. There’s going to be bumps like this even a professor or a counselor that you’re seeing has a similar experience.

Following George’s expression of empathy and normalization of the client’s experience, he assessed the client’s response:

She was most at ease or most relaxed in the conversation when we talked about how this was normal to the doctoral student experience and how, you know, it’s okay if you turn in work that you think is less than what you can do. It seemed to help her relax the most at that juncture. And from there it was less intense; she seemed to be breathing easier.
Sub-theme 1.2. Developing trust. Some participants identified trust as a primary need within the therapeutic relationship, and they described how they were deliberate in their use of language in counseling sessions to develop trust with clients. In the following excerpt, Debra described how she listened to her client’s language and interpreted a need for honesty in order to develop trust within the therapeutic relationship:

He had had a couple of other therapists and he hated his other therapists because [he said] they lied to him. And that was something I really had to be careful about, not not lying, but not having him think that I’m lying. . . . And I was really very cognizant of that, he didn’t want to be lied to, ever.

At the end of their work together, the client asked Debra if she was Jewish. After hearing the client’s racist remarks and language that spoke of White supremacy, she found it difficult to respond to him, but she believed she needed to respond with an honest answer:

And so when he asked me that question, I had to answer it. There was no way I could avoid it. I had to answer that question to be really honest and to honor the relationship we had built.

John identified several areas of mistrust for his client who was homeless, experienced psychotic delusions, and who had immigrated to the United States. In his account, John described his understanding of the client’s mistrust in the housing system, his previous case managers, and the people of the United States:
I realized that the system had pretty much forced him to [a major metropolitan city] against his will to begin with, so we had to begin with the premise of trust. . . The mistrust that [clients] have . . . isn’t in the mistrust of the counselor, it’s mistrust in the system. The system has put the recipes for their success together and says you have to do it this way or you’ll never succeed but it has very little insight into what a person goes through.

He had a lack of trust. I was his fifth case manager in a one-year period. Paranoid delusions, delusions of persecution mostly, but hence forth the reason we had to switch the case managers as often as we did. . . He had given me a play by play, blow by blow of absolutely everybody that had wronged him. . . . He had given me the names, dates, specifically what other case managers had tried to do with him, what he felt they were trying to do, and . . . it was going into his delusional complex where he thought that they were after . . . his demise.

There was a lot of mistrust because we [Americans] were so into material things. There was a complete utter mistrust because we ran free. Just as much as you would think that that would give him more autonomy, it actually decreased his autonomy . . . In a sense there were so many choices, he had none.

John described his efforts to build trust with this client and how he perceived the client to respond to his efforts. He also described how he approached the therapeutic relationship as a team and empathized with the client:

I used the motivational interviewing to kind of give him an opportunity to build trust. . . . He began to disclose more thinking again that I fully understood where
he was coming from and can empathize with him. . . . So he was kind of more apt to listen to me, more conversationally, and it would kind of change his impression of me again, not of a therapist, but kind of a comrade. Which was the only way [I was] going to garner his trust. . . . I often call the client and I, when I’m working with motivational interviewing, “a team.” Symbolically in motivational interviewing it’s like jumping on the couch with them.

In order to foster trust within their relationship and address the cross-cultural issues, John elicited information from the client about his culture and took the position of a learner to gain an understanding of the client’s mistrust of Americans. John perceived that, “It bred tons of trust when he saw I was actually curious.” John was also intentional about being genuine with the client on the issues of homelessness and the culture of poverty. As he described, “I can pretend like I know a culture of poverty, but that’s going to come across as rather insincere. If motivational interviewing is ever effective it’s when that counselor is sincere and trying to understand their clients.”

Finally, John affirmed the client and acknowledged his strengths. As he described:

I trumpet a lot of what I think it takes to survive homelessness. There’s a fabric in a human being of survival that a lot of people who have never had to live without never have to have, and when you compliment their wherewithal, their ability to survive the worst environments man has to offer . . . you use that to empower them.
Affirming the client and acknowledging the strength it requires to survive homelessness served as another way John honored the client in order to enhance the trust in their relationship.

Sub-theme 1.3. Diminishing resistance. Some participants in the current study interpreted client language to indicate resistance within the therapeutic relationship. These participants then responded in ways to diminish resistance and establish a working therapeutic relationship. For example, Debra described her interpretation of resistance in the relationship and her response to diminish it:

When he first came he was very guarded, very angry, frustrated it was a mandated assessment from the school. He had other experiences with therapists and he related them to me saying all therapists were idiots, and he used a different term, and I’m not going to say that term, but he was very negative about the counseling experience. And so I just thought I had to do straight engagement. MI is the most effective because I’m just going to honor where he is at and not push anything else on him. . . . Because I knew that if I did anything that was in any way confrontative or me leading the conversation, he would’ve run away.

Given her interpretation of resistance within the therapeutic relationship, Debra decided to use MI in an attempt to reduce resistance and engage the client in the counseling process. Debra described her use of MI-consistent language and the client’s response to her efforts to diminish resistance within their relationship:

Every time that I put it back in his lap, he physically would relax. . . . Every time I would reflect back his statements or even ask him open-ended questions about
what he just talked about, it was “She hears me,” “She gets me,” “She hears me,” and he would come in tightly wound and sitting very straight and by the end of the session he would always be a little bit loungy, more like an adolescent draping himself on furniture. . . . He would always give me a little bit more every session. A little bit more about the full story. And so it was almost like unwrapping an onion with him in that he gave me the rough terrible outside, that prickly paper that was really caustic, and I unwrapped it with him and he gave me little pieces here and there.

Similar to Debra’s account, Chris described his interpretation of resistance in his relationship with a male adolescent client who was referred to counseling after being suspended from school for cannabis possession and use at school:

Very closed posture. And, you know, the answer to the question, “So you’ve been referred by this person, this person, that person, how do you feel about this referral?” He’d talk in his dictionary of curse words he would use, is how he’d refer to them. . . . Very, “You’re not going to break me” kind of type of mentality. . . . So there was a good amount of resistance up front. . . . He was very precontemplative, very resistant to the fact that . . . he even had a problem let alone needing to change anything. . . . The reason for the referral stemmed from the fact that people were kind of forcing him to do stuff that he didn’t want to or telling him that he had problems where he didn’t believe that he did. . . . He, of course, did not believe any of it was a problem. [He] really didn’t see any point to . . . talking about marijuana use or learning anything about it.
Again similar to Debra, Chris described using MI to diminish resistance:

Kind of just talking to him and kind of processing the fact that he was angry at everybody, you know. One, reflecting just how it was normal and validating that it was normal to be very upset about other people or people forcing him to be somewhere that’s uncomfortable. . . . And using motivational interviewing and the skills of motivational interviewing were very helpful that being and having a different approach with him and actually having someone ask him . . . “What do you enjoy about smoking marijuana?” but also validating that yes, it is enjoyable and it’s normal to like that kind of stuff. . . . [I said] “Help me understand better . . . What works with the marijuana and what are some issues you’re having?” So then he opened up. . . . He didn’t need to defend himself. He was just kind of free to talk, you know, and [I was] there to support him regardless of what he was doing.

Chris reported that by the close of two MI sessions, the client had identified problems with his cannabis use as he saw it, developed his own goals for counseling, and committed to engaging in three CBT group sessions to attain refusal and assertiveness skills to help him reach his goals.

**Summary of Theme 1.** Theme 1 described how participants interpreted client language and nonverbal presentations in order to make decisions about how to respond to clients to develop a working therapeutic relationship. Needs of the therapeutic relationship varied and participants responded by expressing empathy and normalizing clients’ responses, developing trust, and diminishing resistance. According to participant
accounts, MI-consistent language constituted the majority of participant responses (e.g., focusing on evocation, rolling with resistance) to address needs identified within the therapeutic relationship.

**Theme 2**

Theme 2: Counselors interpret client language specific to readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change.

Each participant described interpretations of client language specifically to help them understand client readiness or motivations to change. Once the therapeutic relationship was established, participants then described how they intentionally used their own language to meet clients in their current place in the change process and to assist clients in their movements toward change.

Debra described her work with an adolescent male who used bigoted language and referred to White supremacy when he presented for counseling. Debra interpreted the client’s language and his guarded presentation to mean that the client was not ready to consider making a change. Based on her interpretation, Debra decided to use MI with this client to engage him in the counseling process and to establish a therapeutic relationship. She described how she chose her words carefully when responding to the client in that she used non-prejudiced language when describing different types of people. After months of this type of work, Debra described a change in the client’s language: “He started talking about at that point how he didn’t like his friends because they were all so ‘vanilla.’ And he used that terminology.” Debra interpreted the client’s language as
change talk, and therefore, she responded by exploring his notion of “vanilla friends” by eliciting more information about the client’s desire to change this component of his life. As Debra described:

And I said, “‘Vanilla’, that’s an interesting word to use. What does that mean for you?” And he said, “They’re all White, they’re all from the same socioeconomic [status] and there’s not a lot of variety” . . . It was really, okay he has vanilla friends, so what does he mean by that and what does he want to do with that, and does he want to change it? And I really asked him that . . . “So you have vanilla friends, what does that mean for you? Is that something you like, not like? What would you like to do about that?” I put it right back into his lap . . . “Is that something you want in your life? Variety?” And he said, “Well, yeah, if they were more exciting I probably wouldn’t be so depressed.”

After hearing that the client wanted to make this change, Debra began using CBT methods to explore, challenge, and modify the client’s thinking about people different than him. As Debra described, “That opened up the door for us to really start talking about how he really, truly felt about other races versus what he said at the beginning of treatment . . . And so we started looking at, ‘What are benefits from [interacting with diverse] people?’” Debra’s use of CBT to help the client modify his thoughts about others is further described in Theme 3.

Within Theme 2, three sub-themes were identified: raising problem awareness, resolving ambivalence, and enhancing confidence in ability. Each sub-theme describes
how participants interpreted client language pertaining to their readiness and motivations to change and assisted clients in their movement toward change.

**Sub-theme 2.1. Raising problem awareness.** Two participants, John and Chris, described their interpretations of clients as unaware of or choosing to ignore the existence of a problem. These participants then described their intentional use of language to raise client awareness of the problem and how the clients responded.

John described how he conceptualized the drinking habits of his client who was alcohol dependent and who experienced psychosis:

> When I talked to him about alcohol, he said that alcohol was healing for him and then he contemplated not drinking, but he hadn’t really gotten to the point where he wanted to do very much about that. . . . The alcohol he would always find an excuse for: helped his breathing, helped him think better, it helped wake him up. So there would always be something that functioned with the alcohol outside of his intoxication.

Upon hearing that his client wanted to gain employment to foster his autonomy, John decided to develop discrepancies between the client’s stated goal—to have a job—and his drinking:

> I would develop discrepancies constantly. He wanted a job. He wasn’t very capable of holding a job but I figured maybe I could get him something with a wage for 5 hours a week or something, but he would drink so much and . . . I’d point out constantly the discrepancy between his goal of getting a job and what he thought the alcohol was actually doing. . . . It was kind of more reflective
statements. We would see each other so frequently that I would revert back to a conversation maybe we had a few days ago where I would say, “Ok, kind of fill in the blanks for me here. You would say that you wanted to go up to this place and fill out an application. You know that they’re probably not going to like your drinking but you’re drinking more now this week than you were last week. Kind of fill in the gap for me. Which one becomes more of a priority for you?”

John was also intentional about using the client’s terminology and definition of sobriety. John described that the client considered “sobriety” to occur when he stopped drinking in the evening to the time that he began drinking the following day. John used the client’s meaning of sobriety and developed discrepancies to raise the client’s awareness of the alcohol use problem, and the client began to further contemplate changing his alcohol use. John also witnessed changes in the client’s alcohol use patterns in that the client stopped drinking earlier in the evening as their work continued.

Chris described raising awareness of the problem with his client, an adolescent male who was referred to counseling for cannabis use. Chris described the client’s initial perspective as: “He, of course, did not believe any of it was a problem. [He] really didn’t see any point to learning, talking about marijuana use or learning anything about it.” In response, Chris used MI to roll with resistance, express empathy, and elicit the client’s perspective:

[I used] just real open-ended questions, real broad reflections of, “There have been some issues going on. It seems like . . . [the problems] these external sources are talking about, . . . you usually don’t see those as a problem. What are
the problems for you or what are some things that you see marijuana causing a problem with?”

In response to Chris’s language, the client began to open up about problems in his relationship with his girlfriend. Chris reported he then used reflections to guide the client to make connections between his cannabis use and his relationship problems. Chris described the client’s response:

He started to really make the connection of, “Maybe it’s not me or me in general or her, maybe it is marijuana that’s maybe causing the problem” . . . and [he] kind of started to open up to get the insight of, “Maybe the fact that I smoke marijuana and that I’m different when I do, that’s what’s causing the problem.” And I think it was saving the relationship, or kind of getting that thought together was a big motivator for him where it was more internal motivation. . . . That was one of the big ones that he used to fuel the motivation, kind of continue moving forward and engaging.

In addition to enhancing the client’s motivation to change by exploring the client’s relationship problem, Chris also elicited the client’s acknowledgement that cannabis use had caused him to be suspended from school. Chris described his understanding of the client’s motivations to change and how he matched his language to enhance the client’s desires for and commitment to change:

Desire was pretty low. So I worked on trying to raise that desire up, to really explore. He says, “Well I guess I’d kind of like to be able to stay in school.” Explore what it’s like at school, what he liked about school. How does being
suspended because of marijuana affect, you know, life in general and his desire to be in school? And through that he started thinking, “You know what, I’d like to be able to, you know stay on track with my friends. I know that to graduate, if I get stuck . . . I won’t move on to the next grade with my friends, you know, I’ll get behind.” So wading through that, it raised his desire to do something to which . . . curbing or changing his marijuana use ended up being the thing to which he could do to kind of change that. Kind of eliciting and responding to his change talk. Kind of really strengthen his desire, eventually moving towards more commitment type language.

**Sub-theme 2.2. Resolving ambivalence.** The second sub-theme of Theme 2 included participants’ interpretations of and responses to client ambivalence about change. Debra described how she conceptualized ambivalence and how MI was useful in helping her client resolve ambivalence:

I always find ambivalence a great opportunity. Because whenever someone is ambivalent, it’s uncomfortable. And so they would really like to change, and they would really like to have a decision one way or another. . . . Any time I heard ambivalence with him, and there was quite a bit of ambivalence in the beginning part of therapy, any time he had ambivalence, using MI would really . . . empower him to make the decision to go one way or another.

George also described using MI to respond to his client’s ambivalence about whether or not to sacrifice time with her infant child in order to be in graduate school:
I was thinking in terms of ambivalence and, you know, mixed feelings and wanting to have time with her [child] and yet sacrificing that time. So I was thinking really in just standard motivational interviewing and ambivalence. . . . I tried to steer it more into . . . the examination of the ambivalence and the pros and cons of staying in graduate school.

George described his own language used to guide the client to explore both sides of ambivalence and the client’s response to this:

I also at the time was trying to question and reflect to get her to look at both sides. . . . All I did was say something like, “It sounds like, you know, you’re struggling with these sacrifices” and then she kind of gave me both sides of the coin. . . . So she started dialoguing on her own the mixed emotions and those mixed thoughts of being a terrible mother versus, you know, “It’s really not going to be that bad for [my child] considering [he or she is] so young.” And then she seemed to come to the conclusion that, “Well, you know, this is best for the long run.” That seemed to be tipping the scale for her, that seemed to be what helped her continue to be a graduate student and living with . . . these negative feelings of being a poor mom and all that, you know, “In the long run I will be able to support my [child], I’ll have my Ph.D. and I’ll be able to support my family even more.” That seemed to be tipping her scale in the direction of staying in the program.

George described his language used to guide the client to explore her ambivalence, and the client was able to examine both sides and reach a resolution—her decision to remain in graduate school. George and the client then explored the client’s time management
and her beliefs and self-talk, and George described using CBT methods to help the client feel content with her decision. This aspect of George’s experience is further described in Theme 3.

In another example of resolving ambivalence, Flor regarded her client with a diagnosis of alcohol dependence as ambivalent about returning to sobriety. This client had been sober for two years prior to being affected by a natural disaster which led to his relapse. Flor listened to the client’s language and conceptualized his ambivalence:

He even blamed the fact that he had relapsed on [the natural disaster] and he said that that was making him real angry too because . . . he wanted to get sober, but he felt like he couldn’t stop drinking. . . . He said, “I want to get sober. I want to get my family relationships to improve. I want to be able to save money again.” . . . I think in his head he really wanted it. You know, he wanted to get sober, but it’s just that every afternoon, he said when he’d go home it was easier, easier to start drinking because everything’s so horrible and the drinking would, you know, mask all the feelings and make the problem go away but he said, “I’d wake up the next morning and the problem is still there.” . . . I think he was very much aware that the alcohol was just causing, was fueling the anger . . . or that he was using the alcohol to not feel frustrated or whatever, to just escape. He was using it as an escape. And he really didn’t want to continue like that. He was tired of it. He said, you know, “It’s been eight months, something’s got to change.” . . . So I asked, “What [are you] doing to stop drinking?” And he said, “Well, I’ve tried to
go to meetings here, but they’re not like [the meetings in the client’s city of origin] and I haven’t met anybody really that I could be friends with.”

Flor learned that prior to the natural disaster, the client attended Alcoholics Anonymous (AA) meetings frequently to help him in his recovery. Flor elicited change talk from the client by exploring his past success in sobriety and his reasons for and desires to return to sobriety. She responded to his language with encouragement and offered information about local AA meetings:

When he told me it was difficult to get sober the first time, I asked him about that. I asked, “How were you able to quit?” You know, “What did you do?” and “What was it like for you?” and, you know, using a lot of open-ended questions to get him to talk about the situation. . . . And I encouraged him to start going to meetings and he thought that’d be a good idea. . . . He was willing to talk about and to try and follow some suggestions and I provided some resources about some local meetings

According to Flor’s account, by the end their 10 sessions, the client committed to going to 90 AA meetings in 90 days and he returned to sobriety.

**Sub-theme 2.3. Enhancing confidence in ability.** The third sub-theme of Theme 2 consists of participants’ interpretations of clients’ confidence in their abilities to make changes. These participants used language to enhance clients’ confidence in their abilities to change to assist clients’ movement toward change. In the following examples, the participants heard language that expressed client desires, reasons, and needs to change, but they noticed an absence of client language about their ability to change or
language that revealed a deficit in confidence. George described how he used MI in his interpretation of his client’s language:

> Being so knee-deep in motivational interviewing I’m still going for the [change talk] in my mind, and we definitely talked about she wants the Ph.D., she wants to get the degree. . . . That really helped her tip the scale; the scale was tipped to staying in graduate school. It seemed mostly to be a crisis of confidence in, you know, an identity and, “What do I think of myself as a student and what am I willing to do and accept in terms of performance and sacrifice in terms of a mother?” . . . And that’s kind of where I started because she really seemed like she was really questioning her ability.

This conceptualization led George to implement CBT to explore and to help the client modify her beliefs and ways of thinking that were potentially causing her lack of confidence. George and the client also developed a plan for the client to engage in new behaviors (e.g., listening to recorded material) in order for her to maximize the time spent during her long commute to and from the university to enhance her confidence in her ability to be successful as a student. As a result, George heard more confidence expressed through the client’s language:

> I think her confidence was, “I can be, I’m confident in getting through this. I’m confident being okay with not being perfect or not being, you know, completely an A student and all that stuff.” I think I was seeing, hearing confidence in her ability to get through this point of crisis and through this, these stressors or through these questions she was having about herself and her performance.
In Evelyn’s account, she interpreted her client, an adolescent female seeking counseling for weight management, to have sufficient reasons and need to maintain weight loss:

She was consistent in returning to the center for her appointments. So she, you know, perceived that there was a high level of value there and recognized that . . . it was more about her health rather than how she looked . . . and she had said . . . her language was such that “I know I need to lose weight . . . I have to get this weight off,” and “I really need to do this.” So her language indicated to me that high reason, high need.

By listening to the client’s language, however, Evelyn assessed the client’s confidence in her ability to maintain her weight loss to be low:

Not only was she discouraged but her confidence was low . . . I got the sense and she even said herself that it was discouraging and her confidence clearly had taken a bit of a shot.

Evelyn then decided to elicit the client’s strengths and emphasize her past successes in weight loss in order to help increase the client’s confidence in her ability:

[To build] her back up and [help] her to again acknowledge that she had all of these strengths and she had all of this positive experience that she could go back to. And so that was my intention to mirror or to reflect her ability to be successful. In an effort to increase confidence.

Through their conversations, the client realized that a reduction in physical activity may have been the reason for her weight gain, and together, the client and Evelyn
established a plan to increase the client’s amount of physical activity. Evelyn described the change she witnessed in the client’s confidence in her ability to make the changes as well as an increase in her sense of autonomy:

Her confidence that she could follow through on the plan was a nine. . . . She had come in [and] the energy was low, and like I said, just felt deflated and when she left there was a feeling, I could tell she felt hopeful, and she felt, you know like things had lightened up. And she felt in control. . . . Also, so [a family member] was waiting for her in the waiting room and I asked her . . . if she wanted me to pull [the family member] in so that we could talk with him about this specific plan. And she said, “No,” right away. She said, “I want to talk to [the family member] myself.”

**Summary of Theme 2.** Theme 1 described participants’ interpretations of client language in order to determine how to work with the client in the therapeutic relationship, and Theme 2 described how participants interpreted client language as readiness and motivation to change once the therapeutic relationship was established. Participants then used their own language to meet the client in their process of change and to assist them in their movement toward change. Specifically, participants used MI-consistent behaviors to raise problem awareness when clients were considered to be precontemplative about change (e.g., eliciting the client’s perception of the problem, developing discrepancies); to resolve ambivalence when clients were contemplating change (e.g., facilitating the exploration of ambivalence, eliciting what has worked in the past); and to enhance
clients’ confidence in their ability to change (e.g., developing a collaborative plan, supporting client autonomy).

**Theme 3**

Theme 3: Counselors interpret client language that suggests problematic thinking or a need for behavior change and then respond with the use of CBT when clients are determined to be ready to change.

All participants described using CBT to conceptualize and address problems related to client thinking or to modify client behaviors to help clients make their desired changes. Each participant became aware of his or her client’s problematic thinking or need for behavior changes by interpreting client language. Participants, however, only used CBT to address the client’s ways of thinking, beliefs, and behaviors after they determined the client to be ready to change. As Chris described, “When I use CBT, I am sure that, well, as best as I can assess, that this person is ready to move forward and actually put in the work to make change.” In her account, Evelyn mentioned that MI is a part of every counseling session she engages in, but pertaining to her use of CBT, she described:

I would say that’s different for me. . . . Sometimes people, the patients I see aren’t ready to make changes. So therefore, there’s no introduction of skills. . . . And then for the people who are ready and want skills, that’s where the CBT comes in.

Two sub-themes were identified within Theme 3: using CBT to address problematic thinking, and using CBT to modify behaviors.
Sub-theme 3.1. Using CBT to address problematic thinking. Several participants described using CBT to conceptualize clients’ cognitions and to address problems in the clients’ thoughts or beliefs when they perceived the client to be ready to change. As discussed in Theme 2, Debra heard her client express his discontent with having “vanilla” friends which she interpreted as the client moving toward change. Therefore, Debra responded by exploring and challenging the client’s ways of thinking about people who were different from him. Debra described the client’s positive response:

> When he was challenged on how he thought and challenged on where he developed the thoughts, that’s where he got it. And he had ah-ha moments. And would challenge himself at times and he’d give me that little sheepish grin like, “Well I figured out that one by myself.”

By the end of their two years of work together, Debra reported that the client had significantly changed his thoughts and beliefs to respect and appreciate diversity among persons.

Also mentioned in Theme 2, George and his client explored and resolved the client’s ambivalence about pursuing graduate school while being a new mother. George described his decision to move into CBT work following the resolution of the client’s ambivalence:

> Then my thought was, “Well let’s transition into some problem solving or some coping skills or coping thoughts, coping strategies for just being okay with that decision.” . . . She’s made a decision and yet she’s still having some consequences
of the decision . . . [The client may have been thinking] “Okay, I’m going to make this sacrifice, but that doesn’t mean it’s going to feel good.” So I was just thinking, “Okay, how can we address that and maybe come up with some different thoughts or some different strategies to lessen the sting of the decision she’s already made?”

George also described how the client’s language pertaining to her beliefs about being a mother and about the quality of her academic work triggered him to think in terms of CBT:

I was also seeing some good segues into the cognitive behavioral part in terms of her beliefs about “What kind of mother am I before? What kind of mother am I now?” You know, this belief about beating herself up for doing this. And not that I was so much looking for irrational beliefs, I was more looking for maybe quasi-irrational beliefs that were causing her undue stress or unneeded stress. . . . The self-talk or the self-beliefs is about performance and perfection . . . As soon as she said, you know, “I turn in an assignment, it’s just not what I want to turn in,” and then I think, “Okay, bring on the REBT here.”

George described the client’s response to him challenging her beliefs about her standard of academic work as follows:

She understood it, but it seemed like she was holding on to that standard. She would say something like, “I know what you’re saying,” and “Yeah, you might be right.” And so on and so forth and then of course, the classic, “But . . .” You know, she’s like, “But I really want to do well at this,” and so on and so forth.
George noted that they were continuing to work on modifying the client’s beliefs in their ongoing work together.

Flor used a structured CBT workbook with her client who was struggling with anger related to the aftermath of a natural disaster. The workbook guided clients to identify their thoughts and to understand how their thoughts affected their emotions and behaviors. Flor described how she interpreted the client’s language to indicate that he was using “problematic” or “negative” thinking and how she addressed this with the client who she believed was ready to change:

I felt like the reason he was having so much problem with it was that he kept phrasing it . . . as “should,” “I have to,” “I must.” He kept using those words. . . . He felt guilty because he . . . felt responsible for what was happening and, you know, wanted to kind of beat himself up a little about it. You know, he wanted, he felt like he was a good provider for his family and now he wasn’t able to provide and . . . his frustration was not being able to provide as he was doing before . . . [I said] “But when you make statements, you know, you’re beating yourself up with the musts, ‘I must do this. I should’ve done that.'” I said, “When you make all of those negative statements, that alone makes you feel bad. You start feeling guilty. You know, the anger comes in.”

Flor described the client as having some difficulty identifying his thoughts, but she believed that he benefited from heightening his awareness of how his thoughts were influencing the intensity of his emotions (e.g., anger). According to Flor, the client was
calmer and appeared to experience “relief” after completing the 10 session counseling program specific to survivors of a natural disaster.

In John’s account of his work with a client who experienced psychosis, John described how he used CBT to conceptualize and further understand the client’s delusions. John noted that when the client was taking his antipsychotic medication, he would attempt to create insights for the client into his own “faulty thinking”:

I found out [his] way of thinking. I found out the delusion. I tried to identify a lot of symptomatology. . . . I got into his world, his emotions and what was going on with him cognitively as he was going through these processes. So it was a whole lot of direct, concrete, “What is going on in your mind, [client’s name]?” . . . And then it’s finding out where I think there’s faulty thinking.

In the examples above, the participants described how they used CBT to heighten clients’ awareness of their problematic thinking and, in some cases, begin to modify it. Each participant used a similar approach, although clients’ cognitions varied. Debra identified and challenged the client’s beliefs about others; George did similar work but targeted the client’s beliefs about herself; Flor’s work was also similar but was directed towards the client’s thinking about his situation; and John attempted to raise awareness of faulty thinking with his client who experienced psychotic delusions.

In regard to outcomes, Debra’s client modified his beliefs and his racism diminished. At the time he was interviewed for the current study, George was continuing to work with his client on thought modification, although he mentioned that the client was struggling to alter her expectations of herself in her academic work. Flor believed
her client became more aware of thoughts that contributed to his anger, but he struggled to identify specific thoughts and therefore had difficulty modifying his thinking. John described some success in raising the client’s awareness of his faulty thinking when he was on his antipsychotic medications, but these gains were negated when he stopped taking the medication.

**Sub-theme 3.2. Using CBT to modify behaviors.** Participants described behavior modification or learning new behaviors or skills as one of the main purposes of implementing CBT in their work with clients. Participants described client behavioral changes in various ways. George and Evelyn described how they developed plans with their clients to engage in specific behaviors to help them reach their goals. The plan for George’s client entailed time management strategies whereas Evelyn’s client focused on how to increase her physical activity. John encouraged his client to substitute alcohol use with alternative behaviors with fewer negative consequences, such as drinking coffee, and to expand his coping and social skills. Flor described teaching her client relaxation techniques in order to help him manage the stress of his situation.

Debra described how she collaborated with her adolescent client and used CBT with the client and his parents to improve the quality of their family dynamics:

We [Debra and client] set the goal together and when the parents came in we would achieve those goals or compromise on those goals, but they would always do something they could walk out with, walk out of the session with together . . . Very cognitive behavioral process. We had him doing chores when he’d never
done chores before. Mother stopped nagging him so much . . . Father spent more time with him and doing things with him.

Using CBT with the family unit occurred only after Debra determined the client was ready to engage in this type of work. According to Debra, this was following months of using only MI and hearing client language that suggested he was ready to consider changing his interactions with his family members.

Chris described his conceptualization of how learning refusal and assertiveness skills in CBT group counseling sessions would assist his adolescent client meet his goal of abstaining from cannabis use while at school:

Through the dialogue most of it came down to the issues at school, the reason why he’s using at school is because it’s hard for him not to with all of his friends doing it. . . . [The client said] “I really wish that, you know, I wouldn’t have to or I wouldn’t be forced to do it at school,” meaning peer pressure and so forth. . . . I think that his specific peer group was on the higher end of peer pressure. So it made skills that much more necessary. . . . It was almost a fight not to use it. [It was] like [you were] looked down upon if you didn’t smoke marijuana. So it made it that much harder for him and for us. I believe it made it that much more important to really look at those skills, especially assertiveness skills.

Following two individual MI sessions, Chris described the client in the CBT group sessions as “Very engaged . . . He served as a positive role model for other people. . . . He was the kind of person to refute other people’s . . . lack of motivations or justifications. And he became kind of an insightful person for himself.” In addition, at his 90-day
follow-up assessment, the client reported sustained behavior changes including not having been suspended from school for using cannabis and maintained overall reductions in use.

Although each participant mentioned behavior changes to some degree, Chris and Debra were explicit in their descriptions of using CBT to modify clients’ behaviors. Debra encouraged her client and his parents to engage in behaviors familiar to them, but that they were not doing prior to participating in family counseling sessions. According to Debra, these behavior changes allowed the client and his parents to have closer, more satisfying relationships. Chris’s client, however, learned skills that were new to him, and he used CBT group sessions to practice the new skills so that he could be effective in being assertive and refusing cannabis at school to help him reach his goals.

**Summary of Theme 3.** Although each participant described using CBT to address client cognitions or behaviors, participants described their approaches to implementing CBT in various ways, including how they blended CBT with MI. For example, as mentioned in Theme 3.1, Debra began to transition into CBT work when she interpreted the client’s language as ready to begin making changes in how he thought about others. She described her approach to CBT as follows:

> With cognitive behavioral, with the cognitive restructuring, you’re not attacking anyone, you’re really questioning and [having] them look at things differently. And I like that! Because it’s honoring them and they can look at it if they want to and if they don’t, they can leave it. So it’s really giving them the chance to make their own changes and own decisions.
Debra also described how she maintained MI as her primary style of counseling even though she was doing CBT work with the client:

> I used MI for the full two years, but I really didn’t get into the cognitive aspects until about three to four months with him. . . . Even when I started to use CBT, I used the MI to introduce it, ask him if he was okay with it, if he was ready for that change in therapy, if he’s okay in how we work together . . . And I would always check with him throughout the process, “How are you doing with this? Is this okay? Is it okay if we try this out?” And so I was always asking permission throughout the treatment process.

George described his use of CBT which included the use of open-ended questions and reflective statements, suggesting he blended MI-consistent language into his CBT approach:

> I really wanted to challenge, and I guess I was stepping out of motivational interviewing and more into the . . . cognitive restructuring or I tend to go more from a rational-emotive standpoint, not where I’m disputing beliefs but maybe challenging them, and I use a lot of open-ended questions and reflections to challenge a belief. . . . I become more kind of directive and I’ll start, you know, poking on a particular thought or belief or a statement they said.

Flor and Chris described how they used structured CBT guides when implementing CBT. Flor used a CBT client workbook that was created specifically for survivors of a natural disaster and Chris used the Cannabis Youth Treatment (CYT;
Sampl & Kadden, 2001) guide. Flor described how she appreciated the workbook and how it fit with her approach to CBT as well as the specific needs of this population:

That person has to want to change if change is going to happen and I cannot tell them what they need to do. I feel like I have to show them. And you know, with having a client workbook . . . to give them and it was so simple that . . . not all clients could follow it, but . . . a lot of the clients [found it helpful]. It made sense to them. They could see it, I mean, it had [the natural disaster] throughout the workbook. So it was specifically geared, specifically written for [survivors of a natural disaster] . . . So this was real important, I think, to the clients who saw this . . . Something they could take home and practice . . . because it was really necessary to narrow it down and keep it real simple and stay focused on one issue and go through the steps.

As discussed in Theme 2.2, Flor used MI to help her client resolve his ambivalence about returning to sobriety. Flor also mentioned that she used MI to guide her communication with the client, including offering affirmations and expressing empathy by using reflective statements, and it seemed as though Flor alternated her use of MI and CBT depending on the client’s needs at that time. For example, she described how she would use CBT to help the client identify his thoughts that contributed to his anger, but then he would become upset at the unfairness of his situation and Flor would use MI-consistent behavior to express empathy and support the client. Her account provided several similar examples of how she used the two approaches in tandem based on her understanding of client needs.
Chris described the CYT protocol (Sampl & Kadden, 2001) to have both MI and CBT components. Chris described how he used two individual MI sessions to roll with resistance, raise awareness of the problem, and enhance motivation and commitment to change. Chris then used CBT to assist the client in learning specific skills to help him accomplish his goals. Chris expressed his belief that MI was a helpful precursor to CBT work:

I think had we started with the skill building upfront, he would have been completely disengaged and angry to be there. . . . I think he was a lot more open than he would’ve been had another approach [other than MI] been used.

Although a guide for both the MI and CBT components were provided in the CYT protocol, Chris noted that “the MI part we were less manualized and more open” and he diverted from the MI guide because he “found that sticking to . . . the way it was laid out was limiting.” Chris believed the CBT component, however, required no modifications in order to be effective. As Chris described:

The CBT is where we stayed a little bit more to the guidelines, or to the guide we had . . . It gave different exercises and different topic areas to talk about, different in group and home exercises . . . were the ones we used. We kind of found those to be useful as well as they kind of fell in line with the guide. We didn’t add anything or take . . . exercises away.

Chris also described how he maintained the spirit of MI throughout the CBT group sessions:
The spirit of motivational interviewing was still being upheld, where especially the idea of autonomy, support, and that’s where we allowed the consumers, each participant to kind of choose their goals and work on the goals that they had chosen.

Evelyn described how she integrated the two approaches when she said, “I don’t know that I would be able to . . . consciously identify, ‘Here is where MI stops and CBT started’ . . . but definitely an integration.” She described how she used MI to guide how she communicated with the client including focusing on elicitation and collaboration while she used CBT to conceptualize the client’s “negative thoughts” and need for behavior changes. Similarly, John described an integration of MI and CBT. He explained that he used MI to guide his interactions with the client and to establish a therapeutic relationship while he used CBT to conceptualize the client’s thoughts and mental illness and to encourage him to experiment with new behaviors.

All participants used CBT to facilitate client changes in cognitions or behaviors. Some participants described how they focused on helping their clients modify problematic thoughts about themselves, others, or their situations, and each participant described implementing behavioral interventions that were related to learning new skills or modifying behaviors (e.g., doing chores, refusal and assertiveness skills) or developing plans for behaving differently in specific situations (e.g., time management, increasing exercise). Although all participants implemented CBT in their work with the clients they discussed for the current study, they went about using it with MI in unique ways. Debra described how she retained the MI style even after she began implementing CBT.
methods. George described that he blended MI-consistent behaviors (e.g., open-ended questions and reflections) with CBT, and that he became more directive when challenging his client’s beliefs. Both Flor and Chris used CBT guides and, similar to Debra, Chris seemed to retain the MI style when implementing CBT whereas Flor seemed to alternate between the two approaches contingent on client needs. Evelyn and John described how they integrated the two approaches in that MI was used to guide their interactions with the clients while CBT was used to conceptualize client cognitions and behaviors.

**Theme 4**

Theme 4: Counselors are intentional about their use of language, including having an awareness of what they are *not* saying.

All participants described being intentional in their use of language with clients, meaning they were purposeful in choosing what language to use and to not use. For some participants, MI required more intentionality that CBT. As Chris described:

With motivational interviewing, especially with this young man, at the beginning . . . I assessed the readiness and I chose my words a lot more carefully with motivational interviewing than I do with CBT. . . . That is one of the biggest differences between the two in my mind is really thinking about with motivational interviewing, really being careful or cautious about where the conversation is and kind of guiding them at an appropriate pace to minimize evoking resistance from them based on pushing them too far or being too far behind them . . . and still trying to explore when they just want to move on . . . [Using] MI, I’m in there
with them . . . constantly thinking . . . matching our, you know, my readiness words with where they show me they are readiness-wise. . . . I have to be very careful too, when I even . . . allude to the idea of change that that is something that they’ve talked about or are open to, that they’re comfortable with. [Whereas using] CBT there’s an assumption, of course motivation’s going to go back and forth, well, in the back of my mind I’m thinking, “Are we going too fast? Is this person still, you know, are they still engaged?” But it’s not as cautious as it is with the MI.

Debra described a similar experience as Chris in her work with clients: “Where their readiness is, I’ve always tried to meet them there and it’s very MI adherent.” Debra also discussed her careful selection of her language when using MI at the beginning of her work with her adolescent male client. As she described, “Any questions I asked him I wanted to really know internally with me, ‘Why am I asking this question?’ . . . I really had to figure out, ‘Is there a purpose to this question before I ask this question?’”

Participants described various ways they were purposeful with their language. Sub-themes that emerged within Theme 4 were avoiding confrontation and judgment, and eliciting collaboration from the client.

**Sub-theme 4.1. Avoiding confrontation and judgment.** Consistent with MI’s nonconfrontational and accepting approach, participants described being intentional about *not* using specific language to avoid being confrontational or being perceived as judging by the client. For example, Debra noted her intentions as she responded to her client who talked about White supremacy:
With him, any time there was a biased statement, I would make sure I did not use that word, that I used something that was very analogous . . . I always respected everything. So he could follow that. And what happened was I would not confront him on them, on the statements he used, but sooner or later because I modeled that behavior, he changed the behavior.

Not only was Debra intentionally not using bigoted language, but she was also aware that she was not confronting the client or using language that would express judgment. She was aware of the possible effects of her language on the therapeutic relationship which guided her to avoid certain language: “Without showing him that it offended me, without showing there was judgment . . . associated with it . . . I knew that if I did anything that was in any way confrontative or me leading the conversation, he would’ve run away.”

Other accounts described similar participant awareness of avoiding confrontation and statements of judgment. Flor described her style:

I seldom get confrontative, argumentative with my clients. I don’t feel like that’s the . . . way to go. I’m sure family members and people have hounded them enough about, “This is what you need to do,” “This is what you should do,” or “You better do this.”

Flor also reported using the statement “I’m not going to judge you,” when describing her interactions with her client. John expressed that he was also aware of what he was not saying when he was addressing his client’s alcohol use: “No more reprimands. No assessment of his character, nothing like that.”
Sub-theme 4.2. Eliciting collaboration from the client. Eliciting perspectives, ideas, and goals from clients as opposed to providing or imposing them was another intentional use of language described by participants in the current study. Similar to Theme 4.1, this theme is also MI-consistent as evocation is a main component of the MI spirit.

George described being intentional in refraining from acting on his own agenda in session when he stated, “And not press any kind of agenda at all.” Instead, George elicited from the client her agenda for counseling and then followed her lead. George was also intentional in eliciting both sides of the client's ambivalence to fully explore her experience of the internal conflict. This resulted in the client resolving her ambivalence by deciding to remain in graduate school. George then further elicited from the client their agenda during a counseling session by asking, “Well how do you reconcile, you know, being with your [child] as much as you can with the quality of your assignments?” Her response guided them into a collaborative discussion and plan development pertaining to how she could maximize her time spent during her long commute.

Similarly, during a session with a female adolescent client who was struggling with weight management, Evelyn described how she intentionally elicited information from her client. Evelyn elicited the client’s beliefs about her own strengths and about what she was doing well to manage her weight, and then elicited from the client what additional changes the client believed she needed to make in order to be successful in managing her weight. Upon the client’s determination that she needed to increase her amount of physical activity, Evelyn then elicited a plan from the client in regard to how
she believed she would be able to put the change into action. According to Evelyn’s account, this session ended with the client verbalizing increased confidence in herself that she would make the changes she identified.

In John’s account, when the client began to contemplate change, John described how he refrained from using language that overtly pushed the client towards change and “jumping through the ceiling and going, ‘Yeah let’s talk about that!’” Instead, John was intentional in eliciting the client’s ideas about why he was contemplating change, such as “Okay, so what brings you to that?” John also described his difficulty in not imposing his agenda on the client when he saw the unsafe housing conditions in which the client was living: “[This was] where I found myself really struggling not to force my will, that we’ve got to get out of here now. I don’t care exactly what you think of this place or that place or how urbanized it was. You need to go.”

John noted that he used supervision specific to the integration of MI and CBT to help him monitor his urges to be directive and to help to maintain use of MI-consistent behaviors. John noted that he wanted to remain MI-consistent based on his belief that by using MI and enhancing the intrinsic motivation of the client, the changes made tend to be longer lasting compared to using CBT only. As he described:

The changes [clients] make because they retain their autonomy tend to be longer lasting. . . . Because the literal answers for what they want come from their mouth. If you take action on what your thinking is, it’s your decision. If they’re the ones . . . [to] say what their real solution is, and they themselves state that, they tend to retain the changes they make.
Debra and Chris both used MI to elicit client perspectives and goals and to diminish resistance and build a therapeutic relationship. As Debra stated, “I did straight MI with him—finding out what he wanted to work on, finding out what was going on in his life.” In Chris’s account, he described how he focused on eliciting the client’s goals for treatment, although referral sources may have preferred the client abstain from cannabis:

Instead of kind of telling him what the risks were, what issues he was having, using again the skills of asking him what he thought were some of the things. . . . Honing in on the goals [the clients] had in mind as opposed to imposing the more abstinence-based goal on them. . . . Abstinence is not our ultimate goal, although that may be the goal that [referral sources] may have or that the school may have. . . . So abstinence by no means was the goal. It was, “What is this person, where are they at, what are they willing to change, how will they get the skills to do it?”

Eliciting the client’s goals and intrinsic motivations for achieving his goals consumed the majority of Chris’s two MI sessions with the client. According to Chris’s account, the outcome was that the initial resistance diminished, the client identified his own goals for counseling, and he was motivated to learn skills to help him to reach his goals.

**Summary of Theme 4.** Theme 4 described participants’ intentional use of their language when working with the client they discussed for this study. In their accounts, participants described their intentionality in various ways. Some discussed using language that was consistent with client’s readiness to change; others emphasized
avoiding language that could be perceived as confrontational or judgmental; and some focused on using language to elicit the client’s thoughts, perspectives, and goals.

**Theme 5**

Theme 5: Counselors’ responses are guided by their interpretations of client factors (e.g., psychopathology, sociodemographic information, personal resources).

Participants described how they interpreted client factors and then responded to these interpretations. For example, from the client’s description, Chris understood the culture of his client’s peers in an inner-city school environment that promoted cannabis use and that led Chris to believe that refusal and assertiveness skills would be very useful for the client to be able to achieve his goal of not using while at school. As he described:

I think that his specific peer group was on the higher end of peer pressure. So it made skills that much more necessary. I think that drug use was a lot more common and that made it a lot more acceptable. . . . In his case, it seemed that it was the norm. That it was almost a fight not to use it. [It was] like [you were] looked down upon if you didn’t smoke marijuana.

Some participants of the current study described how they elicited and utilized clients’ personal resources from past successes to help them with their current struggles with change. Other participants described how they attended to their own internal reactions to client factors. These different experiences constituted two sub-themes of Theme 5: building on past successes and attending to counselors’ responses to client factors.
Sub-theme 5.1. Building on past successes. Both Flor and Evelyn described working with clients who had experienced success in changing their problem behaviors in the past, but were struggling with relapse. In Evelyn’s account, the client had regained a significant amount of weight after being successful in weight loss. Evelyn conceptualized the client as follows:

I also know this individual as someone who does want to help herself. She had been successful in the past with the physical activity in particular. . . . She had all of these strengths and she had all of this positive experience that she could go back to. . . . And she makes efforts. She makes efforts.

Evelyn’s understanding of the client’s past success gave her confidence in the client:

I knew that she would eventually be able to figure out . . . [as in] “Okay, what are the pieces that I have that were helping me be successful in the past that I don’t have right now?” I knew she would be able to figure that out.

Consistent with MI, Evelyn then elicited from the client what she believed she was already doing well, and the client was able to identify what changes she needed to make in order to be successful once again in losing weight. With Evelyn’s guidance, the client developed a plan and committed to implementing the changes.

Flor interpreted her client’s two years of sobriety prior to his relapse as a resource. She described her understanding of this client resource:

Apparently he had some good sobriety in those first two years and he knew that he was . . . living pretty peacefully even though he didn’t have everything
material that he wanted but he was . . . doing well for himself. . . . He had been sober before so he knew what it was like to enjoy the piece of mind of sobriety.

Flor then elicited from her client how he was able to achieve and maintain two years of sobriety prior to the natural disaster. Based on his response, Flor provided the client with information about local AA meetings and encouraged him to begin attending.

**Sub-theme 5.2. Attending to counselors’ responses to client factors.** In several accounts, participants described how specific client factors expressed through client language affected them on a personal level and how they managed their internal responses. For example, George described how he could relate to his client’s situation of being a new parent while in graduate school. When listening to the client’s language describing the sacrifice of being away from her child, George described his experience: “I was really feeling . . . the sacrifice you’re making and knowing how I feel about my kids now, it was hard. The strong emotion I was having, it was my own and kind of counter-transference.” George described how he managed his internal response: “I really kind of stuck that away . . . I was really trying to let that go and I guess attempt to be neutral.” As described in Theme 1.1, George used his personal experiences to help normalize the client’s responses and to express empathy to the client, and George interpreted the client to “resonate” with his self-disclosure.

Both Debra and John were working with high-risk clients as Debra was concerned about her client’s propensity for violence, and John was working with a client who experienced active delusions when he was not taking his antipsychotic medication. Debra, who disclosed she is Jewish, described her internal responses to the adolescent
client’s language referring to White supremacy and violence and how she addressed her personal responses through consultation. Debra explained that she considered referring him to another therapist, but through consistent consultation (not specific to MI or CBT) she was able to address her own internal responses to the client’s language and work with him. She noted that approximately six months into their work together, Debra began to be fond of the client and to appreciate him as a person.

Debra described how she also used consultation to discuss her internal response to the client’s violent language which she interpreted as the client’s propensity to harm others. In response to her concerns, Debra described how she addressed the issues with the client’s parents:

I really felt he could be a “Columbine kid” 100%. I even warned the parents at one point that the anger in him was very representative of what the Columbine boys were like. And so I made them very aware . . . They were really very cognizant of that as well and they were concerned about him too.

Debra credited the consultation she received to be a key component that allowed her to address her personal responses to the client to ensure that she interacted with the client in a helpful way, as well as ensuring the client’s and others’ safety. At the close of their work together after two years, Debra no longer determined the client to be at risk to harm himself or others.

John also sought consultation (specific to using MI and CBT together) to assist him in attending to his internal reactions to his client’s situation. As John described, “I was actually, emotively, I was frightened by the fact that I had a client in such disarray.”
John also noted that he struggled to remain MI-consistent in his language and he often slipped back into using a directive CBT approach, his primary counseling method prior to learning MI. John described this experience as “I felt like I was sitting on my hands. I knew damn well what was best for him, and that was my way of looking at it, but the more that I did it my way, the further the client resisted me.” John’s consultation was specific to using MI and CBT together, which he reported was helpful for him in maintaining MI-consistency and in fostering client change.

John also described attending to his own responses in terms of how he was affected by being in the presence of the client’s manic behavior and delusional thoughts for a period of time:

I will let you know there were points where I wanted to drop him off hours before I did. You have to hang in there. This is where motivational interviewing becomes awful tough because if you’re really truly going to be an empathic listener and get into their world, you’re going to have to go to the nitty gritty to the end. And there would be times where I’d need lucidity and you know, he was who he was so it’d be real easy to pan him and say, “Oh, alright, I’ll take you home,” but [at] that point I realized that then he would see the difference between what I was attempting to do and who I really was.

**Summary of Theme 5.** Participants of the current study described varying factors of their clients including cultural considerations, personal resources, and presenting or mental health concerns, and they described how they responded to client factors in order to facilitate client change. Chris considered his client’s peer culture when
assisting him change his cannabis use behaviors. Flor and Evelyn emphasized their clients’ previous successes in order to help their clients overcome current barriers to change. George attended to his ability to relate to his client’s presenting concern. Finally, Debra and John sought professional consultation to ensure they were providing quality care and addressing their own responses to their clients’ language and presentations.

**Summary of Themes**

In the current study, each of the above five themes constituted an essential component of participants’ experiences of client and counselor language while using MI and CBT to facilitate client change. Theme 1 described how participants listened to client language to determine the needs of the therapeutic relationship and then primarily used MI-consistent responses to meet those needs. Theme 2 was consistent with MI and described how participants interpreted client language to assess readiness and motivation to change and then matched their own language to meet clients in their current place in the change process and to assist clients’ movement toward change. Theme 3 described how participants implemented CBT to address problems in cognitions and to modify behaviors when clients were perceived to be ready to change. Theme 4 was consistent with MI and described participants’ intentional use of language including having an awareness of what they are not saying to avoid being perceived as confrontational or judgmental and to focus on eliciting collaboration from clients as opposed to imposing goals, perspectives, and values. Finally, Theme 5 described how participants responded to client factors using MI and CBT to facilitate client change.
Together, the five themes comprise the essence of participants’ experiences of client and counselor language while using MI and CBT to facilitate client change. As the themes portray the essence of participants’ experiences, they reflect a phenomenological description. The themes also described participants’ engagement in the therapeutic process of using MI and CBT.

**Therapeutic Process of Using MI and CBT**

Each participant in the current study seemed to engage in a sequential process while using MI and CBT to facilitate client change. This finding was identified by the researcher during data analysis, and in the final stages of data analysis, the researcher consulted with the peer reviewer about how to incorporate this process into the findings. The peer reviewer and researcher agreed that it did not lend itself to being a theme, yet it appeared to be an essential component of each participant’s experience of the phenomenon. Therefore, the process was retained as a finding separate from the themes. Although the identification of a process in addition to themes is not typical in phenomenological research, the therapeutic process of using MI and CBT emerged from the data and during member checking, each participant verified that the therapeutic process of using MI and CBT was indeed a part of his or her experience. Therefore, the therapeutic process is included in the findings of the current study.

The therapeutic process of using MI and CBT incorporated each of the five main themes described above. Whereas the themes describe the content of participants’ experiences, the therapeutic process appeared to provide a structure, or the process, of participants’ experiences of client and counselor language while using these two
approaches. Figure 3 provides an outline of the therapeutic process of using MI and CBT to facilitate client change.

Within the therapeutic process, participants interpreted client language, presentations, or factors and then made decisions about how to respond to clients based on these interpretations. Participant responses included the use of MI and/or CBT contingent on what the participant anticipated the client to benefit from. The therapeutic process then repeated with the client’s response to the participant’s language spoken in session. According to participants’ accounts, this process seemed to occur continuously within and across counseling sessions.

Figure 3. The therapeutic process of using MI and CBT.
Phases of the Therapeutic Process

The first phase of the therapeutic process continued throughout counseling after initially occurring when clients first presented for counseling. Content of this phase included client language, nonverbal presentations (e.g., facial expressions, eye contact, gestures, posture, etc.), and specific factors (e.g., psychopathology, sociodemographic information, personal resources).

In the second phase of the therapeutic process, each participant described how he or she interpreted client language and characteristics so as to understand the needs for counseling. Examples of participants’ interpretations included identifying needs of the therapeutic relationship (as in Theme 1), needs to enhance readiness to change (as in Theme 2), and needs for changes in cognitions and behaviors (as in Theme 3). These interpretations guided participants’ interactions with clients, including the language they used, which constituted the third phase of the therapeutic process.

Examples of the third phase included participants describing their use of MI-consistent language to diminish resistance in the therapeutic relationship and to enhance client readiness to change, and describing their use of CBT methods to help clients modify their thoughts and behaviors. Client responses to participants’ language led to the therapeutic process repeating itself in that the client’s response was then interpreted by participants to help them evaluate the effectiveness of their own language and to determine what the client might benefit from in their process of change. Subsequently, participants then determined their next response to continue to guide the client toward his or her change goal.
Complexity of the Process

Participants from the current study engaged in the therapeutic process of using MI and CBT to conceptualize and address multiple client issues simultaneously. For example, when Debra described her first meeting with her client and she interpreted resistance to be present, Debra made the decision to respond with MI to diminish resistance and establish a therapeutic relationship. While she was doing this, the client continued to use violent language to describe his hatred for others. Debra interpreted the client’s language as conveying a propensity for violence, and she reacted by seeking consultation and discussing safety issues with the client’s parents. In the meantime, Debra continued to use MI to interact with her client to foster client engagement and build a therapeutic relationship. In this example, Debra listened to client language in Phase 1 of the therapeutic process, and in Phase 2, she interpreted (a) what was needed in order to develop a therapeutic relationship and (b) safety as a potential issue. In Phase 3 of the therapeutic process, Debra used MI to address the needs of the therapeutic relationship (as described in Theme 1.3), and she used more directive communication to address her concerns of safety with the client’s parents.

Whereas Debra’s account provides an example of engagement in the therapeutic process for two issues simultaneously, an example from John’s account illustrates the fluidity and progression of using MI and CBT. In his account, John listened to client language and understood that trust was essential to the therapeutic relationship with his client who experienced psychosis and alcohol dependence. John used MI-consistent language to develop trust with the client and he listened to the client’s responses in order
to determine if trust was indeed being developed. In addition to evaluating the progression of the therapeutic relationship from client language, John reported he heard the client inform him that he would like to gain employment. Therefore, in Phase 2, John not only believed the client was developing trust because he was disclosing more information to John, but John also began assessing the client’s readiness to change his alcohol use. John’s interpretations guided him to develop discrepancies to heighten the client’s awareness of the conflicts between his drinking and employment. In this way, John was addressing the needs of the therapeutic relationship and working to enhance the client’s motivation to change his drinking behaviors. When, based on client language, John determined the client was ready to begin making small changes in his alcohol use, he implemented CBT to introduce new behaviors to the client to replace alcohol use. The client responded by reducing his alcohol use.

This example from John’s account illustrates the fluid and dynamic therapeutic process of MI and CBT and the progression of client needs as they move toward change. John began by determining the needs of the therapeutic relationship and using MI to meet these needs. Client language then led John to develop discrepancies between the client’s alcohol use and his desire for employment. The client’s response guided John to implement CBT to introduce alternative behaviors.

These descriptions of Debra’s and John’s accounts exemplify the potential complexity of the therapeutic process of using MI and CBT. Participants in the current study engaged in the process to address multiple client issues simultaneously and they adapted their own language to meet clients’ changing needs as they progressed towards
change. The therapeutic process also illustrates how MI and CBT can be used together to facilitate client change when the counselor is interpreting the client’s language and responding with behaviors consistent with MI or CBT. Each participant described how they engaged in the therapeutic process of using MI and CBT to meet client needs as they understood them by interpreting client language.

**Participants’ Engagement in the Therapeutic Process**

The process of using MI and CBT to facilitate client change is illustrated in each of the following descriptions of participant accounts. The number of examples described by participants appeared to be contingent on the complexity of client issues. Participant descriptions also seemed to vary depending on how long the clients and participants had worked together. For example, some participants had only seen their clients a handful of times and were mid-treatment with their clients at the time of the current study whereas others had had extensive contact with their clients over months or years and were able to describe clear outcomes in their work with clients due to the work being complete.

**Debra.** Debra described her engagement in the therapeutic process to address and facilitate client change pertaining to several client issues. In the example portrayed in Figure 4, pertaining to Phase 1 of the process, the client’s language conveyed his anger and frustration as well as negative experiences with past counseling. The client’s language and presentation led Debra to interpret the client as “guarded” in the second phase of the therapeutic process. Debra’s interpretation led her to use MI in Phase 3 to diminish resistance in the relationship and to enhance the client’s engagement in the counseling process. Debra reported that based on the client’s responses (e.g., disclosing
<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client expressed his feelings about counseling and described his previous counseling experiences.</td>
<td>Debra interpreted the client to be angry and guarded.</td>
<td>Debra used MI to diminish resistance in the relationship and enhance client engagement.</td>
</tr>
<tr>
<td>Client engagement increased. Client began to express his desire for more diversity among his friends.</td>
<td>Debra interpreted client to be ready to modify his thinking about others.</td>
<td>Debra used MI and CBT to challenge client’s thinking and continued to move at the client’s pace for change.</td>
</tr>
</tbody>
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*Figure 4.* Debra’s engagement in the therapeutic process using MI and CBT to facilitate client change.

more about himself each session; Phase 1), she believed resistance was diminishing and trust was being established. When the client began discussing his discontent with his “vanilla” friends in phase one of the therapeutic process, Debra interpreted the client’s language to suggest he might be ready to begin modifying his beliefs about people different from him (Phase 2). In Phase 3, she responded to the client by combining components of MI and CBT to challenge the client’s beliefs while continuing to match
his readiness to change. The client responded with continued engagement and, over time, successfully changed his belief about others.

**George.** Figure 5 provides an example of George’s engagement in the therapeutic process of using MI and CBT. In this example, upon hearing the client’s description of her dilemma (Phase 1), George interpreted his client to be ambivalent about remaining in the graduate program (Phase 2), and he responded by using MI to guide the client to explore and resolve her ambivalence (Phase 3). As the client dialoged

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**Figure 5.** George’s engagement in the therapeutic process using MI and CBT to facilitate client change.
both sides of her ambivalence, George heard the client use self-talk (Phase 1) which suggested to George that she was using “irrational or quasi-irrational beliefs” (Phase 2). Upon the resolution of her ambivalence, George then used CBT to guide the client to explore her cognitions (Phase 3) which he believed were contributing to her distress.

**Flor.** Flor described how she used the therapeutic process to address her client’s presenting problems of anger and alcohol use. Pertaining to anger, Flor heard the client use the words “should” and “must” (Phase 1) which indicated to Flor that the client was using “negative thinking” and this was contributing to the intensity of his anger (Phase 2). Flor addressed these issues by using a client workbook that incorporated CBT methods (Phase 3) to help the client identify his negative thinking and heighten his awareness of how his thoughts were affecting his emotions and behaviors. Although the client experienced some difficulty identifying his thoughts initially, through the course of their 10 counseling sessions together, Flor reported the client eventually became aware of his thoughts and their affect, and his anger subsided.

Figure 6 depicts how Flor engaged in the therapeutic process to facilitate change in the client’s alcohol use. Flor reported the client verbalized reasons and desires to stop drinking, but he also mentioned that he was unable to stop drinking and that it was difficult for him to become sober the first time he entered recovery. Flor interpreted the client’s language and his two years of sobriety in the past to indicate that he was capable of regaining sobriety. She elicited from the client how he was able to become sober and maintain sobriety in the past and the client informed her that attending AA meetings were essential to his success. Flor guided the client to apply what he knew had helped him in
The client, who had been sober for two years in the past, expressed his desire to stop drinking, but described the difficulty he was having in doing so.

Flor interpreted the client to have personal resources based on his success in the past.

Flor elicited how the client became sober in the past.

Client described AA meeting attendance to be an integral part of his success in sobriety in the past.

Based on client’s description of his past success, Flor believed AA meetings would be helpful to the client.

Flor provided the client with information about local AA meetings and encouraged him to begin attending.

*Figure 6.* Flor’s engagement in the therapeutic process using MI and CBT to facilitate client change.

the past to his present struggle and provided him with information about local AA meetings. The client agreed to begin attending meetings and eventually agreed to attend 90 meetings in 90 days and stopped drinking.

**Evelyn.** Evelyn described how she interpreted client language and nonverbal presentations to suggest that the client felt overwhelmed and disappointed by her weight gain and that she was lacking confidence in her ability to be successful in reaching her goal of weight loss. Evelyn’s interpretation led her to use MI to elicit from the client what she believed she was doing well and what additional changes she needed to make in
The client, who had been successful in weight loss in the past, expressed her surprise and disappointment in her weight gain. Evelyn interpreted the client to be overwhelmed, yet capable of identifying what she needed to change in order to be successful again. Evelyn elicited from the client what the client was doing well and what additional changes she needed to make in order to reach her goal.

Client identified that she needed to increase the amount of physical activity she was doing. Evelyn believed the client would benefit from a plan for how to increase her physical activity. Evelyn elicited from the client a plan for exercise that the client could commit to.

**Figure 7.** Evelyn’s engagement in the therapeutic process of using MI and CBT to facilitate client change.

**John.** John was working with a client who was experiencing several complex issues including alcoholism, homelessness, and psychotic delusions. This client also immigrated to the United States and he mistrusted American culture and systems (e.g.,
housing and mental health agencies, social security). John described how he used the therapeutic process of using MI and CBT to facilitate client change on a number of these issues.

An example of John’s engagement in the therapeutic process is illustrated in Figure 8. Based on the client’s presentation and language that expressed his mistrust, John interpreted the client’s psychotic features and his beliefs about the housing and mental health systems and Americans in general to suggest that developing trust with the client was imperative in order to help this client make positive changes. From John’s understanding that trust was a cornerstone issue for the client, he used MI to express

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**Figure 8.** John’s engagement in the therapeutic process using MI and CBT to facilitate client change.

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empathy and to elicit the client’s perspectives, values, and goals to develop a sound therapeutic relationship. The client responded to John by gradually developing trust in him and disclosing more to him. When the client disclosed to John that he would like to gain employment as a way to become more independent, John interpreted the client’s alcohol use behaviors to impede his chances for employment. John then decided to develop discrepancies between the client’s alcohol use and his desire for employment. The client defined “sobriety” as the time in which he stopped drinking at night to the time he resumed drinking the next day. John used the client’s definition and referred to sobriety in the same terms as the client. The client contemplated changing his alcohol use and after John introduced alternative behaviors for the client to engage in instead of alcohol use, the client made slight changes in that he was “sober” for a longer period of time each day.

Chris. Chris described how he engaged in the therapeutic process to diminish resistance in the therapeutic relationship, enhance the client’s motivation to change, and introduce skills to help the client reach his goals for change. Based on the client’s initial presentation and language that included closed posture and offensive language to describe his referral sources, Chris interpreted the client to be “precontemplative” and resistant to being told that he had a problem with cannabis. Chris used MI to diminish the resistance in their relationship in that he expressed empathy and elicited the client’s ideas about his cannabis use. The client responded by verbalizing his own thoughts about how cannabis use might be causing him problems and he identified his own goals for engaging in CBT group sessions.
When discussing his cannabis use, Chris heard the client describe peer pressure to use at school and he believed that refusal and assertiveness skills would be helpful for the client to achieve his goal of no longer using cannabis at school. The client completed three CBT group sessions during which, per Chris’s account, he served as a positive model for other group members. At a 90-day follow-up, Chris reported the client had made and maintained changes in his cannabis use to meet his goals. Figure 9 represents Chris’s therapeutic process of using MI and CBT to facilitate client change.

**Figure 9.** Chris’s engagement in the therapeutic process of using MI and CBT to facilitate client change.
Therapeutic process summary. As discussed, all participants seemed to follow three sequential phases of the therapeutic process of using MI and CBT. In Phase 1, client language and presentations varied greatly between participant accounts, and therefore, participants’ interpretations and responses differed in Phases 2 and 3 of the therapeutic process. Each participant response, however, represented counselor language that was grounded in the implementation of MI or CBT. The complexity of the therapeutic process, or the number of client issues to be attended to simultaneously or the progression from one issue to the next, also varied between participant accounts. The complexity of the therapeutic process in which participants engaged appeared to be contingent on the complexity of the client and his or her presenting concerns.

Each of the five main themes identified in the current study were present within the therapeutic process of using MI and CBT. The themes constitute the content of the phenomenon, or what the experience was for participants, whereas the therapeutic process offers an overarching structure describing how participants engaged in that experience. The therapeutic process also provides an understanding of how participants made decisions about their behaviors in session. The themes and the therapeutic process identified in the current study offer a phenomenological description that serves the purpose of hermeneutic phenomenological investigations in that it offers insight into the meaning of these participants’ interpretations of client and counselor language when using MI and CBT to facilitate client change. By gaining an understanding of how participants interpreted client and counselor language, the decision making processes that
occurred as a part of this phenomenon for these six counselors have been somewhat illuminated.

**Chapter III Summary**

The findings of the current study included the identification of five main themes and the therapeutic process that incorporates each of the five themes. These findings constitute a phenomenological description of these six counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change. Through member checking, each of the participants verified that the five main themes and the therapeutic process were a part of their experience of client and counselor language while using MI and CBT to facilitate client change. In Chapter 4, a discussion is presented on how the findings of the current study relate to professional literature and pertain to the counseling profession. Suggestions for future research are also described.
CHAPTER IV

DISCUSSION

The purpose of the current study was to enhance understanding of counselors’ experiences of client and counselor language while using motivational interviewing (MI) and cognitive behavior therapy (CBT) to facilitate client change. The narrative accounts of six licensed professional counselors were subjected to hermeneutic phenomenological analysis. This resulted in the identification of five main themes and a therapeutic process of using MI and CBT. These findings comprise a description of the phenomenon under investigation—the six counselors’ experiences of client and their own language while using MI and CBT.

Findings of the current study revealed that participants primarily used MI-consistent behaviors to establish a working therapeutic relationship and to enhance client readiness and motivation to change. When participants perceived clients to be ready to change, they incorporated CBT strategies to help clients implement changes. Findings also showed that participants paid careful attention to their language spoken in session, including having an awareness of what they were not saying, especially when using MI. Finally, participants interpreted client factors, including client resources and challenges, and then responded with components of MI or CBT contingent on what participants believed would be most helpful.

In this fourth and final chapter, findings of the current study are compared and contrasted to relevant professional literature and research. First, the findings of the current study are consistent with Miller and Rose’s (2009) idea of an emerging theory of
MI as participants’ descriptions of their use of MI included both relational and technical components. Participants were also intentional about meeting clients in their current readiness to change. However, as a group they made very few references to Prochaska and DiClemente’s (1984) stages of change dimension of the TransTheoretical Model.

Findings of the current study enhance understanding of how counselors might use MI and CBT together in terms of psychotherapy integration (Norcross, 2005) and how counselors might implement MI in combination with other approaches (Miller & Rollnick, 2004). Results support the speculation that MI and CBT have complementary foci which may lead to a possible synergistic effect in that participants described using MI to help their clients prepare for change and CBT to assist clients implement change. Two participants employed manual-guided approaches and their experiences are discussed as they relate to the literature. The importance of diminishing MI-inconsistent counselor behaviors is discussed, along with the possible benefits of receiving supervision while learning MI and integrating MI and CBT. The chapter concludes with a discussion of implications for professional counselors and counselor educators, suggestions for future research, and considerations for the current study.

**The Emerging Theory of MI**

Miller and Rose (2009) conceptualized MI as an emerging theory consisting of relational and technical components. The relational component encompasses the interpersonal style of MI including the MI spirit of evocation, collaboration, and promoting client autonomy. The technical component is the directiveness of MI including the focus on eliciting and strengthening client change talk. In their narrative
accounts, participants of the current study described their use of the relational and technical components of MI.

**Relational Component of MI**

As illustrated in Theme 1—counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs—participants used MI to express empathy, enhance client engagement, and satisfy the needs of the therapeutic relationship. For example, with their adolescent male clients, Debra and Chris described their use of MI to diminish resistance within the therapeutic relationship and to enhance client engagement in the counseling process. They both described using reflective statements to express empathy and roll with resistance and then eliciting the clients’ perspectives about their situations. Although their clients presented with different issues and participated in different treatment, resistance was diminished in both relationships and the clients became engaged in the counseling process. In addition, according to the narrative accounts of Debra and Chris, both clients made significant progress on their presenting issues and completed treatment.

Similar to Debra and Chris, John described his use of MI to roll with resistance and to develop trust with his client. John also reported promoting his client’s autonomy. John indicated that he was able to establish trust and develop a therapeutic relationship with his client, and he was also successful in assisting the client into stable housing at a group home. George and Flor described how they used MI’s relational component to express empathy and normalize client responses to stressors. Evelyn served as a guide
for her client and she supported her client’s self-efficacy and autonomy by eliciting her strengths and collaboratively developing a plan for change.

Each participant described using language and behaviors consistent with MI when attempting to meet the needs of the therapeutic relationship. These participant responses illustrate the relational component of Miller and Rose’s (2009) emerging theory of MI and are consistent with research findings that MI significantly increases client engagement in treatment and client intention to change (Lundahl et al., 2010).

**Technical Component of MI**

Theme 2 of the current study—counselors interpret client language specific to readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change—illustrates the technical component of the emerging theory of MI. This theme describes how participants interpreted client language in order to determine their readiness to change and then used their own language to enhance client motivation and commitment to change. For clients who were precontemplative about change, as was the case for the clients of Chris and John, participants raised their client’s awareness of the problem by eliciting the client’s perception of the problem and what the client would like to change about the situation. John recounted how he developed discrepancies with his client to further raise the client’s awareness about the problems caused by his alcohol use.

Participants also described their use of MI-consistent language to assist clients who were contemplating change. For example, Flor’s client was ambivalent about pursuing sobriety following a relapse after two years in recovery from alcohol
dependence. Flor responded to her client by eliciting his reasons, desires, and ability to change based on his previous success in sobriety. The client then committed to engaging in behaviors he found to be helpful in the past (e.g., attending Alcoholics Anonymous meetings) and returned to sobriety. Evelyn’s client was also struggling with relapse of a problem behavior—weight gain. Evelyn interpreted her client to be experiencing low confidence in her ability to be successful in weight loss. Evelyn decided to elicit from the client her perceptions of her own strengths and how she had been successful in the past with weight loss. This resulted in the client identifying the changes she needed to make in order to reach her goal and then committing to make the changes.

Participants of the current study illustrated the technical component of MI when they described listening for client change talk and then intentionally using their own language to elicit and strengthen client language that spoke to their motivations and commitment to change. In this way, and in combination with participants’ descriptions of their use of the relational component of MI, the findings of the current study are consistent with Miller and Rose’s (2009) proposed emerging theory of MI.

**MI and the Stages of Change**

As Miller and Rollnick (2002, 2004, 2009) have discussed, MI and the stages of change can be used together, but are completely separate notions. Participants of the current study often spoke of meeting clients where they were in their change process, and three participants, Flor, Chris and John, sparsely used terminology from Prochaska and DiClemente’s (1984) stages of change dimension of the TransTheoretical Model (TTM).
Flor described her client as “eager” to change and not “precontemplative.” Although she referenced the client’s readiness to change using other language, this was her only use of language from the TTM. Chris described his client as “precontemplative” upon their first meeting. Consistent with DiClemente and Velasquez’s (2002) definition of precontemplation—being unaware or underaware that a problem exists or lacking readiness to address and change problem behavior—Chris explained that his client did not see his cannabis use as a problem and he had no intentions of changing his behavior. Chris described how he used MI to explore the client’s perceptions of the problem and to validate his experiences and beliefs. Consistent with DiClemente’s (2003) tasks to move to the next stage of change, contemplation, Chris’s client began to consider change and became aware of potential problems with his cannabis use. Chris interpreted the client’s language as the client moving toward change when he identified problems he had experienced (with his girlfriend and at school) that he believed were related to his cannabis use. Chris did not use Prochaska and DiClemente’s terminology (1984) beyond precontemplation, but he used terms common in MI to describe the client’s readiness to change, including “ambivalence,” “change talk,” and “commitment language.”

John explained that the supervision he received when working with the client he discussed in the current study was specific to using MI and CBT together and included a process of “staging clients.” This meant that he and his supervisor discussed the client’s current stage of change for each of the client’s presenting issues (e.g., alcohol use, medication compliance, various social skills). John and his supervisor would then discuss MI-consistent responses to help guide the client toward change. Consistent with
the literature that describes client movement through the stages of change as “recursive and cyclical” (DiClemente, 2003, p. 26) and resembling a spiral (Prochaska, DiClemente, & Norcross, 1992), John described how his client fluctuated between the early stages of change. For example, John stated that after the client agreed to begin cutting back on this alcohol use (moving into preparation), he seemed to revert back to the contemplation stage overnight, causing John to continually assess the client’s readiness to change and to refrain from making assumptions.

Chris and John appeared to incorporate the TTM somewhat in their work with the clients they discussed for this study, and Flor used the word “precontemplative” on one occasion. The remaining three participants (Debra, George, and Evelyn), however, did not mention using the stages of change or use terminology from the TTM. Debra explained her intentions to match her language with client readiness to change, but she stated that she did not use Prochaska and DiClemente’s model (1984) to do so and that she had done so prior to learning MI:

[The] stages of change have been a guiding light for me. I have always met my client in their stage of change except I did not know it was the stages of change until Prochaska and DiClemente came up with it. I’ve always, you know, where their readiness is, I’ve always tried to meet them there and it’s very MI-adherent. So it just fit in. It wasn’t that I learned that behavior through MI; it’s what I’ve always done and it’s just a part of me.

Similar to Debra, George and Evelyn described their interpretations of client readiness to change and their intentions of using language consistent with client readiness, but they
did not reference or use terminology that suggested their use of Prochaska and 
DiClemente’s model. For these participants, it seemed their practice of MI guided them 
to use language and interventions appropriate for their client’s stage of change rather than 
applying the TTM.

Participants’ minimal use of the TTM was a surprise to the researcher, likely due 
to my own customary use of the stages of change in my own work with clients (as 
demonstrated in Table 1 in Chapter 2). My bias interfered during data collection in the 
main interview with the first participant, Debra. Debra’s statement quoted above was 
evoked after I reflected back to her that she was “moving through the stages of change” 
with her client. After Debra’s correction of me in this first interview, I refrained from 
inserting language that directly applied to this model unless participants offered this 
language as their own to avoid leading participants’ accounts.

**Using MI and CBT Together**

Participants of the current study used MI and CBT together to facilitate client 
change. The finding of a therapeutic process of MI and CBT used in concert provides a 
structure for participant decision-making about which approach to use—MI, CBT, or a 
blending of the two. Participants described experiences consistent with Arkowitz and 
Westra’s (2004) notion that an integration of MI and CBT begins with MI to address 
client ambivalence and readiness to change, and then incorporates CBT, often retaining 
the spirit of MI to guide clients in implementing change.

Although participants described using both approaches with the clients they 
discussed, in general, MI appeared to be more prominent in participants’ experiences than
CBT. Themes 1 and 2 consisted mostly of MI-consistent responses, and overall, participants explicitly stated that they were using MI to meet the needs of the therapeutic relationship and to assess and respond to their clients’ readiness to change.

Theme 1—counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs—contained components specific to MI such as “guiding” clients towards change (Miller & Rollnick, 2009) and diminishing resistance (Miller & Rollnick, 2002), as well as components that are not unique to MI but are essential to MI, including expressing empathy and offering affirmations (Miller & Rollnick, 2002). Theme 2—counselors interpret client language specific to readiness and motivation to change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change—was also comprised of MI-consistent behaviors. These behaviors included meeting clients in their current readiness to change (Miller & Rollnick, 2002), raising problem awareness (Miller, 1999), exploring and resolving ambivalence (Miller & Rollnick, 2002), and focusing on the client’s ability to change (an example of preparatory change talk; Miller & Rollnick, 2004).

In addition to Themes 1 and 2, Theme 4—counselors are intentional about their use of language, including having an awareness of what they are not saying—also applied more to MI than to CBT. Participants reported they attended to their use of language more carefully when using MI compared to when using CBT, including using language consistent with the spirit and principles of MI, such as focusing on evocation and expressing acceptance (as opposed to using confrontational language or expressing
Theme 5—counselors are guided by their interpretations of client factors—included MI- and CBT-consistent participant responses. Participants seemed to determine which approach to use depending on what they believed the client would benefit from. For example, Chris interpreted that, for his client, peer pressure to use cannabis at school was a barrier to change. Chris then determined that it would be helpful for the client to engage in CBT to develop assertiveness and refusal skills to help him reach his goal of no longer using at school. In another example, based on her client’s previous success in weight loss, Evelyn decided to use MI to elicit the client’s strengths and ideas about what changes she needed to make in order to reach her goals.

Theme 3 was specific to CBT: Counselors interpret client language that suggests problematic thinking or a need for behavior change and then respond with the use of CBT when clients are determined to be ready to change. This theme described participants’ use of CBT methods to help clients identify and modify their cognitions or behaviors that may have contributed to their distress. Participants noted, however, that they only used CBT when they believed the client was ready to change. In contrast, several participants described their use of MI as a general style that was often integrated with CBT. Participants’ seemingly pervasive use of MI may be attributed to MI being a style of counseling or a method of communication that can be used alone or with other counseling approaches, such as CBT. It should also be taken into consideration that four of the six participants were members of the Motivational Interviewing Network of Trainers which might suggest that they have specific dedication to MI.
In order to gain understanding about how participants integrated MI and CBT in their work with the clients they discussed, participants’ descriptions are compared and contrasted with Norcross’s (2005) descriptions of psychotherapy integration. Participants’ accounts are also related to Miller and Rollnick’s (2004) suggestions about how MI may be used in combination with other treatment approaches.

Psychotherapy Integration

Norcross (2005) described two types of psychotherapy integration that apply to the current study. Norcross described theoretical integration as occurring when counselors essentially create a new counseling approach by synthesizing or blending two or more counseling theories and techniques, whereas assimilative integration occurs when counselors are firmly grounded in one counseling approach but selectively incorporate practices from another approach based on client needs. In the current study, participants described their use of MI and CBT in terms of both theoretical and assimilative integration, but as a group, participant accounts did not match completely with one or the other.

Theoretical integration. Of the six participant accounts included in the current study, Evelyn’s work with a female adolescent client appeared to be most consistent with theoretical integration. Evelyn described using a synthesis of MI and CBT components when working with this client. She stated, “I don’t know that I would be able to . . . consciously identify, ‘Here is where MI stops and CBT started’ . . . but definitely an integration.” This suggests she was melding the two approaches to essentially create a new type of therapy.
Contradicting theoretical integration, however, Evelyn described her general use of MI and CBT (not specific to the client discussed for this study) as using MI in every counseling session but only using CBT when the client is assessed as ready to change. Evelyn may therefore be grounded in MI, and she assimilates CBT when she believes the client will benefit from it. Several other participants seemed to verge on theoretical integration when using both approaches, but similar to Evelyn, these participants discussed using MI alone (with their clients discussed for this study) for specific reasons (e.g., diminishing resistance, resolving ambivalence) before implementing CBT, which might suggest assimilative integration.

**Assimilative integration.** In their work with the clients discussed in the current study, several participants described how they used MI as their “default” style and then selectively incorporated CBT according to client needs. Debra described her style to be grounded in MI when she stated, “I can’t do therapy anymore without using MI. I cannot use just a pristine type of therapy.” In working with her client, Debra described using MI alone for the first three to four months before she began incorporating CBT. Debra noted that she retained the MI style in that she continued to ask for the client’s permission when introducing a CBT intervention and she continued to move at the client’s pace.

George stated, “I try to set [MI] as a default mode of interaction,” and he described introducing CBT components with his client following the resolution of client ambivalence. George described his use of CBT to include the use of open-ended questions and reflective statements, suggesting he blended MI-consistent language into his CBT approach. He described, however, “stepping out of motivational interviewing
and more into the cognitive restructuring,” suggesting he shifted his focus from MI to CBT as opposed to remaining grounded in MI while assimilating CBT components.

Contrary to the other participants, Flor appeared to be grounded in CBT in that she described how she used a structured CBT manual to guide her work with a client. Flor appeared to assimilate MI into CBT when she anticipated the client benefitting from expressed empathy, affirmations, and resolving ambivalence about change. However, in addition to implementing MI for these purposes, Flor discussed how she generally avoids confrontation with clients to diminish the chance of argumentation. Given her MI-consistent style, an argument could be made that Flor may have been synthesizing the two approaches in a manner consistent with theoretical integration as opposed to assimilating MI into her foundational use of CBT.

**Summary of psychotherapy integration.** Although several participant accounts could be related to Norcross’s (2005) theories about psychotherapy integration, as a group, participant accounts did not fit neatly into one classification. Reminiscent of trying to fit square pegs into round holes, this suggests that MI and CBT are used together in a way that does not necessarily fit with Norcross’s taxonomy. For example, although Evelyn appeared to use theoretical integration with the client she discussed, she described using assimilative integration with other clients. In another example, George first described using assimilative integration, but he then conveyed that he discontinued using MI and implemented CBT as opposed to retaining MI as his foundational approach and assimilating CBT.
As previously mentioned, MI is defined as a method of communication and is not a theory-based psychotherapy (Miller & Rollnick, 2002, 2009), and therefore its integration with other approaches may differ from the integration of two theory-based counseling approaches. As such, a strength of MI may be its versatility to be used with other approaches in various ways. Constantino, DeGeorge, Dadlani, and Overtree (2009) recently proposed that MI may be “a bellwether for context-responsive psychotherapy integration” (p. 1246). Constantino et al. described context-responsive psychotherapy integration as counselors shifting between MI and other therapies as they see fit based on client needs and the limitations of other therapies. Participants’ descriptions of their integration of MI and CBT appear to be consistent with this type of psychotherapy integration, and the therapeutic process of using MI and CBT provides information about how counselors make decisions about shifting between approaches.

**Using MI With Other Treatment Methods**

Miller and Rollnick (2009) emphasized that MI is not a panacea and other treatments may be needed following or in combination with MI in order to fully address client concerns. As such, MI literature offers several discussions about the usefulness of MI as a precursor to treatment and when used in conjunction with other approaches, such as CBT (e.g., Arkowitz & Westra, 2004; Kertes et al., 2011; Miller & Rollnick, 2002, 2004; Westra, 2004; Westra et al., 2009), and the findings of the current study appear to be consistent with this literature. As described in Themes 1 and 2 in the current study, participants primarily used MI to establish a working therapeutic relationship with clients, resolve client ambivalence, and enhance client motivation and readiness to
change. Upon participants’ interpretations that clients were ready to change, they implemented CBT strategies as described in Theme 3.

Miller and Rollnick (2004) presented several ways to use MI with other treatment approaches: MI as preparation for treatment, MI used as the first approach and then other treatment approaches are implemented if necessary, MI as an overall counseling style, and MI as a fall back when motivation falters while implementing another treatment. Participants described each of these treatment approaches when practicing MI and CBT with a specific client.

**MI as preparation for treatment.** Miller and Rollnick (2004) first conceptualized MI as a prelude to standard treatment. In this way, MI is used prior to treatment to enhance client engagement in the counseling process, elicit intrinsic motivations to change, and solidify client commitment to engage in treatment. Research has found that MI used prior to treatment has improved treatment outcomes (Aubrey, 1998; Hettema et al., 2005; Lundahl et al., 2010).

Chris’s account illustrates the use of MI as a prelude to CBT group counseling. Chris described his work with a male adolescent referred to counseling after being suspended from school for cannabis use and possession on school property. Chris referred to the client as resistant to counseling and to accepting what others told him—that he had a problem with cannabis use. Chris then described how he used the Cannabis Youth Treatment (CYT; Sampl & Kadden, 2001) five-session protocol with this client. The protocol began with two individual MI sessions during which Chris rolled with resistance, elicited from the client his perception of his cannabis use, and
enhanced the client’s motivations and commitment to change. By the end of two MI sessions, the client had identified problems he was experiencing due to cannabis use and he committed to three CBT group sessions to develop skills to help him reduce his use. Three CBT group sessions were then used to help the client develop refusal and assertiveness skills, and subsequently he modified his cannabis use to reach his goals.

During his main interview, Chris stated that if MI had not been used to manage resistance and to enhance the client’s motivation to participate in CBT treatment and to change, the client likely would not have been as engaged in the treatment process or as successful in modifying his problem behaviors. Chris’s experience is consistent with previous research findings that MI used as a prelude to treatment has had a positive effect on treatment outcomes.

**MI as the first approach.** A second use of MI suggested by Miller and Rollnick (2004) is to implement MI as the first approach and then determine if additional treatment approaches are needed. For some clients, an MI intervention may be sufficient for behavior change. If this is the case, it would not be necessary for the counselor to introduce a second approach. Recent research has supported the use of MI as a stand alone intervention (e.g., Burke et al., 2003; Cleary et al., 2009; Lundahl et al., 2010; Monti et al., 2007). If additional treatment is necessary, however, the counselor can then introduce the next step in treatment. In the current study, George provided an example of using of MI as a first approach.

George described how he used MI as his “default style” with clients. When working with a client who was ambivalent about sacrificing time with her child to pursue
graduate school, George used MI-consistent behaviors such as expressing empathy and facilitating the exploration of her ambivalence. During their discussions, however, George heard the client use “self-talk” that he believed was contributing to her distress. Therefore, upon the client’s resolution of her ambivalence and decision to remain in graduate school, George discontinued using MI and implemented CBT with the client. George used CBT to help the client identify and challenge her beliefs that he thought were causing her undue distress. In this way, George described his use of MI as the first approach to help the client resolve her ambivalence, and then CBT as the second approach to help the client identify and then modify her self-talk and beliefs.

**MI as a counseling style.** MI is a communication style and can be combined with other approaches, and therefore Miller and Rollnick (2002, 2004) suggested MI may be used as a general counseling style to which other interventions may be added. In the current study, Debra’s and Evelyn’s accounts demonstrated how MI can be used as a general counseling style. Debra described using MI to begin her work with a male adolescent client, and then implementing CBT methods to help the client modify his beliefs and to experiment with new behaviors when she believed the client was ready to change. Debra stated that she retained MI as her counseling style even when using CBT techniques and interventions. Similar to Debra, Evelyn also described using MI as her primary style with clients and then implementing CBT when she believes clients are ready to change, and retaining the MI style when she does so.

John seemed to strive to use MI as his general style as well. However, John described some difficulty in remaining MI-consistent in his work with the client he
described. John attributed his difficulty to being new to MI at that time, to having practiced with a directive form of CBT prior to learning MI, and to working with a client who presented with more severe issues than John was accustomed to, causing John to revert back to an approach that felt natural to him. John described engaging in supervision that was specific to the integration of MI and CBT which he reported was helpful for him in learning to remain MI-consistent and retain MI as his general style, even when incorporating CBT interventions.

**MI as a fall back.** Counselors may also use MI as a fall back approach when another treatment is being used and clients experience ambivalence or struggle with motivation (Miller & Rollnick, 2004). This implementation of MI requires counselor flexibility as they shift between MI and the other treatment. Flor described using MI as a fall back approach when working with her client affected by a natural disaster and who was struggling with anger and alcohol dependence.

Flor described using a 10-session CBT treatment program with her client to help him identify how his thoughts were negatively affecting his emotions and behaviors and to develop healthy coping skills. While engaged in CBT treatment, Flor and the client explored the client’s thoughts about his situation that may have contributed to his anger and, as she described, “[It was] like I hit the button” and the client would begin to express his frustration and anger at his situation. When the client’s emotions appeared to take over his ability to attend to his thoughts, Flor described changing her approach to the client in that she would no longer challenge or question him about his thoughts, but she would listen to the client tell his story, express empathy, and provide affirmations. Flor
reported that she resumed CBT treatment when she perceived the client to be ready (e.g., the client’s anger diminished in intensity) until the next time she “hit the button.” In this way, Flor appeared to be using MI as her fall back approach for when she perceived the client to be unable to identify and challenge his thoughts and for when she anticipated that he would benefit from expressing himself in a safe environment, feeling understood and accepted, and receiving affirmations.

Flor also described using MI as a fall back approach when she believed the client was ambivalent about changing his alcohol use. Flor heard the client use change talk and sustain talk pertaining to changing his alcohol use. She then guided the client to draw on his past successes in sobriety to elicit further change talk and to solidify the client’s commitment to change. Once the client had resolved his ambivalence and committed to change his drinking behaviors, Flor described that she resumed the CBT manual-guided approach.

**Summary of using MI with other treatment methods.** MI is a counseling style that has a variety of applications with other counseling methods. In the current study, participants described how they used MI and CBT with a selected client. With his client, Chris followed an established protocol in which MI was used as a prelude to CBT group treatment. Chris described first using two sessions of MI to diminish resistance and enhance the client’s readiness and commitment to change, and then the client participated in CBT group treatment to learn behavioral skills. George described using MI as his default counseling style, and he appeared to implement MI as the first approach with his client. Once George’s client resolved her ambivalence, he then ceased using MI and
implemented CBT as a second step based on his conceptualization that the client had beliefs and ways of thinking that were contributing to her distress. Debra and Evelyn described using MI as their general style in that they blended MI with CBT when they believed the client would benefit from CBT interventions, but retained the MI-style throughout their work with their clients. Flor was primarily practicing CBT with her client and she seemed to use MI as a fall back approach when she believed her client would benefit from expressed empathy and affirmations and when he was experiencing ambivalence about changing his drinking behaviors.

**Complementary Approaches**

Previous literature has speculated that MI and CBT offer complementary foci, which may lead to a synergistic effect when used together (e.g., Arkowitz & Westra, 2004; Burke et al., 2004; Westra & Arkowitz, 2011). Several participants of the current study expressed their beliefs about the value of using MI and CBT together to facilitate client change. For example, George described his approach using MI and CBT as follows: “I tend to operate kind of from that standard mode of doing some MI and blending it with CBT. It just makes real good sense to me as a clinician . . . [being] knee deep into motivational interviewing and being practically oriented in CBT.” Debra also stated her appreciation of using both approaches with her client:

Talking about the work I did with him . . . and thinking about the case before our call, it really reaffirmed that I like both therapeutic modalities. And I felt I did not do any disservice to this client. I really felt like I helped this client . . . So looking
at it and talking about it really made me think, these two are really the two therapies that I embrace and that work with the clientele that I work with.

Kertes et al. (2011) investigated client experiences of MI and CBT and found that four of the five clients who experienced MI and CBT described the two approaches as complementary and to have worked well together to facilitate change. Participants in Kertes et al.’s study described how MI helped them prepare for change and CBT provided assistance in implementing change. This finding is consistent with the current study in that participants described using MI to diminish resistance, establish a therapeutic relationship, and enhance client readiness and motivation to change and then using CBT to help clients implement change. The findings of the current study and that of Kertes et al. offer preliminary process research consistent with the theoretical notion of a synergistic effect when practicing with MI and CBT.

**Facilitating Change**

Participants in the current study portrayed several examples of Burke et al.’s (2004) explanation that MI and CBT may be used together to help facilitate change in that MI can help clients answer the question, “Why might I change?” whereas CBT targets clients' question, “How do I change?” For example, Chris explained that he believed in MI’s usefulness to enhance client motivation to change, but in many cases another treatment is needed in order for clients to understand how to change. He noted his belief that his client would have been “left hanging” if treatment had been terminated after the two MI sessions without giving the client an opportunity to learn and practice refusal and assertiveness skills through the course of three CBT group sessions. Chris
also noted his belief that his client would not have been engaged in the CBT sessions had MI not been used first to diminish resistance, foster client engagement in counseling, and enhance the client’s intrinsic motivation and commitment to change. Chris’s account illustrates how both approaches were useful with this one client, and had one approach or the other not been present, client outcome may have suffered.

Professional literature has discussed the benefits of using MI and CBT together to optimize client outcomes. For example, Cleary et al.’s (2009) systematic review of 54 studies (one meta-analysis, 30 randomized control trials, and 23 non-experimental studies) examined efficacy of treatments for individuals with co-occurring disorders. They found that studies that paired MI with CBT demonstrated improvements in mental health symptoms. Cleary et al.’s findings relate to John’s account in the current study. John was using MI and CBT in his work with a man who was diagnosed with bipolar disorder with psychotic features, posttraumatic stress disorder, and alcohol dependence. In his account, John described using MI to establish a working therapeutic relationship with his client and to enhance the client’s motivation to make positive changes including reducing his drinking and taking his prescribed medications. John recounted using CBT to encourage the client to experiment with new behaviors to replace drinking and to enhance his positive coping skills. Again in John’s account, MI and CBT addressed complementary foci in that MI focused on enhancing the client’s intrinsic motivation to change whereas CBT offered ideas and skills to help the client implement change.
MI to Prepare for Change

Participant responses in the current study were consistent with Rollnick and Miller’s (1995) description that, “Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction” (p. 326). Participants described attending to client statements pertaining to their motivation and readiness to change (change talk) and then intentionally responding to their clients in ways to evoke additional change talk and to strengthen client motivation to change. Participants also described moving at the client’s pace toward change, a counselor behavior consistent with MI. This is consistent with Geller and Dunn’s (2011) statement, “A skillful CBT therapist may intuitively manage their pacing and interventions to patient readiness, but MI makes these goals explicit and provides a language and set of techniques to assist in the process” (p. 13). As described in Theme 1.3—diminishing resistance— and Theme 2, participants of the current study reported meeting clients where they were in the change process and then using MI to manage resistance in the therapeutic relationship, resolve client ambivalence, and enhance client’s motivations and readiness to change.

**MI to manage resistance and enhance client engagement.** Consistent with Theme 1.3, literature has recommended the use of MI to manage resistance (e.g., Arkowitz, 2002; Moyers & Rollnick, 2002; Westra, 2004) and to enhance client engagement in the counseling process (e.g., Moyers et al., 2005). In the current study, Debra expressed that “MI is so incredible for engagement and honoring the client.” She also described the client’s response to her use of MI for the purpose of diminishing resistance and enhancing client engagement:
He would always give me a little bit more every session. A little bit more about
the full story. And so it was a little like unwrapping an onion with him, in that he
gave me the rough terrible outside, that prickly paper that was really caustic, and I
unwrapped it with him and he gave me little pieces here and there.

Chris also described using MI to diminish resistance and enhance client
engagement with his adolescent client who was referred for cannabis use. Chris
recounted using reflective statements and open-ended questions to express empathy, roll
with resistance, and elicit the client’s perspectives. By the end of two counseling
sessions using only MI, the client had identified his own goals for counseling and had
committed to participate in three CBT group sessions.

Although Arkowitz (2002) described resistance as client ambivalence about
change, Miller et al. (2006) provided a distinction between client language that suggests
resistance and client sustain talk. Miller et al. suggested sustain talk includes client
counter-change talk statements or statements of desire, ability, reasons, need, and
commitment to the status quo rather than change. Resistance is reserved to describe
client behaviors such as interrupting the counselor, discounting the counselor, and
changing the subject (Miller et al., 2006). Participants’ descriptions in the current study
supported Miller et al.’s distinction between sustain talk and resistance. Debra and Chris,
who both described their work with adolescent males referred to counseling by their
schools for substance-related infractions, described resistance communicated verbally
and nonverbally. Closed posture, guardedness, and using profanity to describe their
referral sources and previous therapists were interpreted as resistance by Debra and
Chris. Client anger aimed at having to attend counseling was also part of both participants’ descriptions of resistance. Sustain talk was described by participants as client language that was the opposite of change talk (e.g., speaking against change or promoting the status quo) and was spoken when the client experienced ambivalence. For example, Chris’s client demonstrated sustain talk when he discussed the benefits he experienced from cannabis use and when he described the reasons he used which were related to the drug-promoting culture of his peers. Participants interpreted the presence of sustain talk along with change talk as evidence of the client’s internal conflict of feeling two ways about change. Overall, participants interpreted resistance as clients saying, “I don’t want to be here,” whereas sustain talk was interpreted as natural client language that represented their ambivalence about change.

**MI to enhance client motivation and readiness.** Theme 2 of the current study described participants’ interpretations of client language pertaining to readiness and motivation to change and then responding intentionally to assist clients in their movement toward change. Specifically, participants described how they used MI-consistent behaviors to elicit, reinforce, and strengthen client change talk and, consistent with Miller and Rollnick’s suggestions (2002), they described responding to client change talk by asking the client to elaborate on his or her statements, affirming the client, using reflective statements, and summarizing. These findings of the current study are consistent with literature that has emphasized the importance of change talk, as it has been found to lead to subsequent behavior change (Amrhein et al., 2003; Moyers et al., 2009).
As part of Theme 2, Debra described hearing her client express his desire to have friends who were different from him. Given that the client’s issues were related to anger and racism, Debra interpreted the client’s language as change talk (desire), and she responded by eliciting the client’s beliefs about the benefits he might experience by engaging with individuals who were different from him. Debra reported the client responded by stating, “If [my friends] were more exciting I probably wouldn’t be so depressed.” Debra continued to encourage the client to elaborate on his beliefs about other people which eventually led her to use CBT to help the client modify those beliefs to be more respectful and appreciative of diverse persons.

As described in Theme 2.1—raising problem awareness—Chris elicited change talk from his client when he first acknowledged that the client did not agree with the problems identified by his referral sources, and then inquired about what the client saw as potential problems with his cannabis use. According to Chris, the client described two significant intrinsic motivations to change: (a) conflicts with his girlfriend related to his cannabis use, and (b) the client’s belief that he needed to change his use behaviors to prevent additional suspensions from school. Chris described using open-ended questions and reflective statements to help the client strengthen his change talk (especially pertaining to his desire to change) and commit to participating in skill-building CBT sessions as well as commit to reducing his cannabis use, including abstaining from using while at school.

Theme 2.2—resolving ambivalence—described how participants helped their clients resolve their ambivalence about change. Flor’s description of her client’s
ambivalence about changing his drinking behaviors is consistent with Moyers et al.’s (2009) findings that change talk is often surrounded by sustain talk. Flor reported her client used language that described his desire to change (e.g., “I want to get sober. I want to get my family relationships to improve. I want to be able to save money again”) and need to change (e.g., “Something’s got to change”). However, she also heard sustain talk from the client which she summarized as: “Every afternoon he said when he’d go home it was easier, easier to start drinking because everything’s so horrible and the drinking would, you know, mask all the feelings and make the problem go away.” Flor responded to her client by summarizing and affirming the client’s change talk and eliciting from him how he was able to become sober in the past. Flor’s responses were consistent with Moyers et al.’s recommendation that sustain talk be viewed as normal and should not be challenged, and that clinicians should focus on eliciting and strengthening client change talk. According to Flor, following her MI-consistent behaviors the client changed his drinking behaviors and became sober.

Theme 2.3 described how participants used MI-consistent responses to enhance clients’ confidence in their abilities to change. From the client’s language (e.g., “I know I need to lose weight”) and behaviors (e.g., being consistent in attending her appointments), Evelyn believed her client had a desire to maintain a healthy weight and that she understood the reasons and the need for her to lose weight. However, Evelyn believed the client was experiencing low confidence in her ability to reach her change goals. Evelyn therefore, elicited from the client what she believed she was doing well and responded by affirming the client’s strengths. Evelyn also inquired how the client
had been successful in weight loss in the past, and the client identified that her amount of physical activity had changed. The client determined she needed to increase her physical activity which led Evelyn to guide the client to develop a plan for how to so. Upon developing the plan for change, the client reported her confidence in her ability to follow through with the change was a 9 on a 10-point scale.

Change talk plays an important role in facilitating client change. Consistent with the recommendations in the literature (Amrhein et al., 2003; Feldstein et al., 2011; Moyers et al., 2009), participants of the current study reported they attended to the change talk of their clients and responded to change talk in ways to strengthen and reinforce the client’s movement toward change.

**CBT to Implement Change**

Whereas participants of the current study used MI to help their clients resolve their ambivalence about change and to enhance their motivation to change, each participant of the current study described how he or she used CBT methods to help clients implement change. As illustrated in Theme 3, participants described using a range of CBT methods to facilitate changes in client thinking and behaviors. Participants used a variety of language to describe client cognitions that may have contributed to or caused client distress, and in general, participants saw CBT as the active or tangible ingredient of counseling that included problem solving with clients, learning skills to promote healthy behaviors, or suggesting homework for clients to engage in in-between sessions. Also in the current study, specific CBT methods were used to address specific client problems.
**Addressing cognitions.** Participants in the current study used a variety of terms to refer to client cognitions that may have contributed to or caused distress, but participants appeared to use similar methods to help clients modify their thoughts and beliefs. Debra stated that she did not use CBT terminology with her client; rather, she encouraged him to challenge his distorted thinking about people different than him in terms of race and ethnicity. Debra described using questions to challenge the client’s thoughts in “cognitive restructuring.”

George stated that his use of CBT aligned with Albert Ellis’s rational emotive behavioral therapy (REBT). George referred to his client’s cognitions as “irrational or quasi-irrational beliefs,” “self-talk,” and “self-beliefs.” Similar to Debra, George described how he aimed to assist his client by using “cognitive restructuring,” and he challenged her beliefs about herself as a mother and a student by using open-ended questions and reflective statements. George described that his goal in doing so was to help the client adopt different beliefs about herself that would reduce her distress.

Flor used a CBT workbook and used terms such as “problematic thinking” and “negative thinking” when addressing her client’s cognitions. Flor described using open-ended questions to challenge the client’s beliefs that Flor believed were contributing to the intensity of his anger. Similar to Flor, Evelyn used general terms, such as “negative thoughts,” and she described “reframing” the client’s setback into a learning experience with her client who was experiencing frustration with weight gain. With his client who experienced psychosis, John conceptualized the client’s cognitions as “confusion in his thoughts” and “faulty thinking.” John described using reflections and
questions to help his client gain insight into his disorder when the client was taking his antipsychotic medication.

Overall, participants in the current study used a range of terminology to conceptualize and address their clients’ thoughts and beliefs; however, they seemed to use similar methods (e.g., using open-ended questions and reflections) to assist clients in modifying or “restructuring” their cognitions. George and John mentioned that they used a form of CBT derived from Ellis’s REBT, and the remaining participants seemed to use a more general CBT approach. The current study is consistent with literature that suggests CBT has diverse applications for a variety of presenting issues.

**Action oriented.** In addition to focusing on changes in thinking and beliefs, participants in the current study also used CBT to help their clients understand how to go about making changes in their behaviors. Participants described how CBT lent itself to tangible or action-oriented therapeutic work. For example, Chris and John used CBT methods to encourage their clients to engage in new behaviors and emphasized *doing* things differently (e.g., drinking coffee instead of alcohol, refusing cannabis).

Flor referred to the action-orientation of CBT when she stated, “I cannot tell them what they need to do. I feel like I have to show them,” and she used a CBT workbook to help her client understand how to change. Flor explained the usefulness of the workbook in providing the client with something tangible when she stated, “We could give them a workbook, something they could take home and practice.” Similarly, Debra described the CBT work she was doing with her client and his parents as, “[We] would always do something they could walk out with,” suggesting that whatever was initiated during the
therapy sessions would be continued at home in-between sessions. These findings of the current study are consistent with the findings of Kertes et al. (2011) who investigated the experiences of clients who engaged in MI and then CBT treatment for generalized anxiety disorder. Participants of Kertes et al.’s study generally “perceived MI as more reflective and CBT as involving a more active pursuit of change” (p. 63).

**Problem-specific CBT.** CBT is a well-researched counseling practice that has demonstrated efficacy with a number of problem issues including eating disorders, posttraumatic stress disorder, and substance use disorders (Nathan & Gorman, 2007). In the current study, several participants were using CBT approaches specific to the treatment of particular presenting issues.

For example, Flor explained that she was trained in a CBT program specific to post-disaster relief for survivors of a natural disaster. Flor described her use of this program and her use of MI with the client she discussed for the current study. Flor’s training in post-disaster relief provided her with a CBT workbook that offered education and interventions to be used in counseling sessions and for clients to take home in-between sessions. Flor reported the program included 10 sessions that focused on self-care and healthy coping skills (e.g., guided relaxation), understanding how thoughts affected emotions and behaviors, and identifying and modifying problematic thinking.

Chris reported using a specific protocol, the Cannabis Youth Treatment (CYT; Sampl & Kadden, 2001), to address his client’s cannabis use. The CYT protocol included MI and CBT components specific for the treatment of youth cannabis abuse. The MI components focused on enhancing client motivations and readiness to change
whereas the CBT components provided education and exercises pertaining to developing refusal and assertiveness skills.

CBT is a popular treatment that has many evidence-based applications. Although participants did not verbalize their decisions to use problem-specific approaches because they had been deemed efficacious or evidence-based, it may be assumed that their intentions were so. As participant accounts suggested, program guides or manuals are frequently used to disseminate CBT programs developed and used to treat specific presenting problems (Morgenstern et al., 2001).

**Manual-Guided Approaches**

As demonstrated in Flor’s and Chris’s accounts, CBT can be very helpful when disseminated in a manual-guided treatment regimen. Research has shown, however, that effect sizes of MI were significantly higher when MI was not manualized compared to when MI was used in manual-guided approaches (Hettema et al., 2005; Lundahl et al., 2010). Chris’s account is consistent with this notion as he reported he strayed from the MI guide included in the CYT protocol because he believed it was “limiting.” Instead, Chris described how he gauged his language in session based on what he perceived the client would benefit from and he sought to “personalize” the content of the MI sessions, as opposed to strictly following the MI treatment guide.

Chris’s actions and decisions to respond to the client instead of following the guide are consistent with W. R. Miller’s (personal communication, April 15, 2010) notion that,
In its pure form MI is really a flexible clinical style in which what the therapist does is highly responsive to the client’s immediate responses. Within this perspective, it would be contraindicated to have a manual that prescribes what is to be done in sessions 1, 2, 3 etc.

Chris’s descriptions of his actions are also consistent with Hettema et al.’s (2005) speculation that poorer outcomes in MI research may have been a result of the clinicians listening to the MI manual as opposed to their clients when attempting to facilitate client change.

Contrary to the MI guide, Chris reported he felt it was not necessary to modify or alter the CBT guide included in the CYT protocol. He found the exercises to be helpful and effective in assisting the client reach his goals. Chris’s account illustrated the differences between MI and CBT related to manualizing the two different approaches.

In Flor’s account, she described utilizing the CBT client workbook as a guide to treatment including providing the client with exercises to do at home such as guided relaxation and attaining awareness of his thoughts. MI was not a part of the CBT workbook, and instead, Flor used MI as a part of her counseling style (i.e., expressing empathy, avoiding argumentation) and when she believed the client was struggling with his motivation to change (i.e., to resolve ambivalence). Given the magnitude of those affected by the natural disaster, Flor expressed her appreciation for the structured CBT program and client workbook.

Flor and Chris relayed positive experiences using a structured CBT program. Both participants expressed that the guide was helpful in providing them with tools to
pass along to their clients. The CBT guides used by Flor and Chris contained educational components as well as skill building exercises. Both Flor and Chris described little need for variations or straying from the CBT guides as they were written and they also described using MI flexibly when they blended MI with the CBT programs.

**Diminishing MI-Inconsistent Responses**

Theme 4 in the current study described participants’ intentionality in their language including being aware of what they were *not* saying. Consistent with MI’s non-confrontational approach and emphasis on accepting clients where they are in the process of change, Theme 4.1 described how participants intentionally avoided confrontational language or language that inferred judgment. This finding is consistent with MI literature (Miller & Mount, 2001; Miller et al., 2004; Moyers & Martin, 2006) that suggests it is not only essential to use MI-consistent language when practicing MI, but it is also important to diminish previous practice behaviors that are MI-inconsistent (e.g., confrontation).

In the current study, John reported an experience consistent with Westra’s (2004) account of using MI and CBT together. As described in Theme 4.2—eliciting collaboration from the client—John explained that when first learning MI he was tempted to be directive and overtly push the client toward change, but with practice and supervision he learned to sequester these urges and instead elicit from clients their own reasons to change. Similarly, Westra recounted her own experiences of applauding her client’s change to which the client responded that she was uncertain if she would
continue the change. Westra described that she then adjusted her language to elicit the client’s experience of change and refrained from overtly promoting change.

Kertes et al. (2011) investigated the experiences of five clients who engaged in four individual MI sessions as a pretreatment to eight CBT group sessions for generalized anxiety disorder and five clients who engaged in the CBT sessions without the MI pretreatment. Clients who engaged in MI and CBT saw the therapist as an “evocative guide” whereas clients who experienced CBT only described the therapist as “directive” (p. 61). Furthermore, the therapist’s approach appeared to affect the client’s perception of their role in treatment. Kertes et al. reported that all five participants who engaged in MI plus CBT believed that they had an active role in their treatment compared to four of the five participants who experienced CBT only and described their role in treatment as “passive, even noncompliant” (p. 62). Kertes et al.’s findings reinforce the importance of using MI-consistent behaviors to enhance client engagement in treatment, and are consistent with the current study’s findings in that participants sought to guide clients toward change by using collaboration and client evocation as integral components of the counseling process.

Diminishing previous practice behaviors that are MI-inconsistent has been discussed in MI literature, and participants of the current study described their intentions to avoid using MI-inconsistent language. Participant accounts are consistent with previous recommendations (Miller & Mount, 2001; Miller et al., 2004; Moyers & Martin, 2006) that encourage MI trainings to emphasize the reduction of MI-inconsistent behaviors in addition to increasing the number of MI-consistent responses. Consistent
with John’s account, previous studies have also suggested that practice feedback or supervision following MI training has been determined to be helpful in enhancing MI proficiency (Miller et al., 2004).

**Supervision and Coaching**

Based on their study of MI training effectiveness, Miller et al. (2004) recommended that those learning MI receive practice feedback or coaching following MI training workshops in order to attain MI-proficiency. In the current study, each participant described his or her engagement in CBT and/or MI practice supervision, feedback, or coaching on the demographic questionnaire. In their narrative accounts, however, only one participant, John, described the significance of receiving supervision specific to MI and CBT when working with his client who was experiencing many challenging issues including homelessness, bipolar disorder with psychotic features, posttraumatic stress disorder and alcohol dependence.

John recounted that when working with this client, he had only been recently trained in MI and he was attempting to remain MI-adherent and temper his previous style of using a directive ("Ellis-like") form of CBT. John described his experience of reconciling the conflicts between the styles of MI and CBT when working with a challenging client:

> Lots of supervision. . . . So, it was just drummed into us that it’s okay to really not do it the way that you used to. “What’s the method to the madness?” “I feel like I’m sitting on my hands.” “I feel like I’m going to lose my license.” I feel, I mean these are questions that I literally made or statements that I would
sometimes think. . . . It’s the part that makes consultation mandatory. You need the feedback of others to do this.

John credited the supervision he received that was specific to using MI and CBT together to help him refrain from reverting back to his old directive ways and learning to remain MI-consistent even when faced with challenging situations. John’s experience supports Miller et al.’s (2004) recommendation for follow-up practice feedback or coaching specific to MI in order to attain proficiency.

In her account, Debra reported that she sought professional consultation, not specific to MI or CBT, to assist her in addressing her own personal responses to her client and to ensure she was taking appropriate steps to minimize the client’s risk of acting violently towards others (described in Theme 5.2). Although not specific to her use of MI and CBT, Debra acknowledged the helpfulness of this consultation in allowing her to retain the role of a helper with this client.

**Implications**

The current study offers implications for counseling practice and counselor education. Findings may be helpful to individuals who hope to learn from counselors’ experiences of using MI and CBT to facilitate client change. MI and CBT are evidence-based practices and using both approaches would be consistent with the ACA *Code of Ethics* (2005) and may help counselors facilitate client change with a broad range of clientele. Offering education and training in both approaches would also be consistent with the Council for Accreditation of Counseling and Related Educational Programs’
(CACREP) standards for accredited counselor education programs in that students would be exposed to two evidence-based practices.

**Implications for Counseling Practice**

Findings from the current study offer what is proposed as the essence of six counselors’ experiences of client and counselor language while using MI and CBT to facilitate client change. Professional counselors may decide whether this information is transferable to their own learning and practice of MI and CBT together. For example, in the current study, participants described their use of MI-consistent language to meet the needs of clients within the therapeutic relationship. A counselor who is interested in practicing MI and CBT might take this into consideration and implement MI when beginning a counseling relationship with a new client. Similarly, Theme 3 may encourage counselors to implement CBT methods with clients who are ready to make changes and who might benefit from gaining an understanding of how to go about making cognitive or behavioral changes.

In addition to the themes identified in the current study, counselors who wish to practice these two approaches together may benefit from engaging in the therapeutic *process* of using MI and CBT. For example, a counselor may pay attention to client language to assess what is needed within the therapeutic relationship as the participants of the current study did when in Phase 1 of the therapeutic process. They may then consider how to interpret client language in Phase 2 of the process in order to determine how to respond to the client in Phase 3—with MI, CBT, or a synthesis of the two. The
therapeutic process may provide counselors with a decision-making framework for how to interact with clients when practicing both MI and CBT.

In regard to supervision or practice feedback, John’s account in the current study is consistent with the findings of Miller et al. (2004) that some type of practice supervision specific to MI is helpful for clinicians to remain MI-consistent and to avoid reverting back to previous counseling styles. Many counselors who learn MI have a pre-existing counseling style, and diminishing MI-inconsistent responses may be considered at least as important as increasing MI-consistent responses when learning MI (Miller & Mount, 2001; Miller et al., 2004). Therefore, as suggested by John’s account, it may be helpful for counselors who are pursuing an integration of MI and CBT to engage in supervision specific to using MI and CBT.

In the *ACA Code of Ethics* (2005), code C.2.f specifies that counselors must be receptive to and learn about counseling approaches that have demonstrated effectiveness with diverse populations. As defined by the American Psychological Association (2006), “Evidence-based practice . . . is the integration [emphasis added] of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273). By practicing MI and CBT, counselors are integrating two evidence-based practices that have demonstrated applicability for diverse populations and presenting concerns. Participant accounts from the current study suggest that using these two approaches together may help counselors facilitate client change, and previous research suggests client outcomes may be improved (e.g., Burke et al., 2004; Cleary et al., 2009; Kertes et al., 2011; Westra, 2004; Westra et al., 2009).
Participant accounts in the current study also suggest that MI and CBT can result in a positive experience for the counselor. Participants reported having positive experiences, including feeling competent and helpful, when using MI and CBT together with clients. For example, Debra stated, “I really felt like I helped this client . . . These two [MI and CBT] are really the two therapies that I embrace and that work,” and George stated, “I tend to operate kind of from that standard mode of doing some MI and blending it with CBT. It just makes real good sense to me as a clinician.” In addition, Chris explicitly described his appreciation for being able to use MI to engage clients and enhance their motivation to change and then using CBT to provide them with necessary tools for change. Each participant described having a positive experience of using MI and CBT in that it seemed to offer a sense of professional satisfaction and competence.

**Implications for Counselor Education**

Counselor education programs accredited by CACREP are required to meet certain standards to ensure quality counselor training. CACREP standards require counselor education programs to expose their students to counseling approaches informed by current research and that students should demonstrate knowledge about evidence-based treatments (CACREP, 2009). Therefore, offering counseling students an opportunity to learn about and practice two evidence-based counseling approaches—MI and CBT—is consistent with CACREP standards for counselor education programs.

Findings of the current study provide counselor educators with information about six counselors’ experiences of using two evidence-based practices, MI and CBT, to facilitate client change and, in turn, this information can be shared with students. By
relaying counselors’ experiences of using these two approaches, students may decide whether this information is transferable to their own learning of how to integrate MI and CBT. The therapeutic process of using MI and CBT may provide a breakdown of counselors’ decision-making in regard to how to determine if MI, CBT, or a combination of the two approaches may be used. This may be helpful for students to understand how to make decisions about using these two approaches together.

Counselor educators may wish to consider how students will best learn to use MI and CBT together. This integration may occur by learning and becoming proficient in one approach and then adding the other approach or by learning both approaches simultaneously. Further, if one approach is learned before the other, it is worth considering which approach should be taught first, MI or CBT, and which approach is integrated thereafter. Counselor educators may also consider the type of integration to teach their students—assimilative, theoretical, both, or otherwise. To whom to teach this integration should also be a topic of consideration. Due to the time and practice required to become proficient in one counseling approach, let alone two approaches and their integration, it may be unreasonable to expect counselor trainees in a master’s degree program to be able to learn and master both approaches as well as learn to integrate them. Such learning may be a better fit for more mature counselors or students in doctoral programs; however introductory and intermediate learning may be appropriate for master’s level students. Further investigations are needed to inform these queries.

As previously suggested (e.g., Burke et al., 2004) and supported by accounts of participants in the current study, counselors who use MI and CBT together are equipped
to work with clients who are in varying degrees of readiness to change and have diverse presenting concerns. MI provides counselors with an approach that emphasizes therapeutic relationship and attending to client readiness for and commitment to change whereas CBT affords them the ability to help clients understand how to change (Burke et al., 2004). By learning MI and CBT, it is proposed that students in counselor education programs will be equipped to work with a broad range of clientele.

As previously mentioned, the importance of supervision has been emphasized in MI literature (Miller et al., 2004) and supported by one participant’s account in the current study. Therefore, counselor educators may choose to include practice supervision and feedback when offering training in MI and the practice of MI and CBT together.

**Future Directions in Research**

Findings of the current study provide a phenomenological description of six counselors’ experiences of using MI and CBT together to facilitate client change. Pertaining to psychotherapy integration (Norcross, 2005), participant accounts from the current study demonstrated that MI and CBT can be used together in ways consistent with assimilative and theoretical integration. For example, in an assimilative fashion Debra was grounded in MI and selectively incorporated CBT and Flor was grounded in CBT and assimilated MI whereas Evelyn described theoretical integration when she stated that she used MI and CBT together in a manner in which she was unable to determine which counselor behaviors were MI and which were CBT. As a group, however, participants did not combine MI and CBT in ways that matched exactly one type of integration. It is speculated that due to MI being a style of communication as
opposed to a type of theory-based psychotherapy, it may offer greater versatility in the manner in which it can be integrated with other counseling approaches. Constantino et al. (2009) suggested that the practice of MI with other therapies illustrates context-responsive psychotherapy integration in that the counselor responds to the needs of the client and the circumstances of therapy; however, additional investigations are needed to further illuminate how counselors integrate these two approaches and how they make decisions about doing so.

Throughout data collection, participants described their experiences of using MI and CBT and I made a conscious effort to allow the data (i.e., the participants’ descriptions) to create the distinctions between “What is consistent with MI?” and “What is consistent with CBT?” When analyzing the data, I reviewed several participant statements that arguably could have represented MI or CBT and that the participants did not clearly identify as one or the other. For example, when reflecting on John’s statement, “I got into his world, his emotions and what was going on with him cognitively,” I could not determine if John was attempting to convey empathy (i.e., gaining an understanding of the client’s word), conceptualize the client from a cognitive standpoint, or both. Code-switching, therefore, might be a reasonable place to direct future research of counselors’ language while practicing MI and CBT. Code-switching can be defined as “the use of two or more linguistic varieties in the same conversation or interaction” (Scotton & Ury, 1977, p. 5). Literature pertaining to code-switching has primarily surrounded bilingual persons, and some studies have investigated the language and cultures of African Americans (e.g., Koch, Gross, & Kolts, 2001). Although
counselors using MI and CBT are not using different languages per se, the purpose of code-switching may apply to this area in order to identify counselor language that represents MI, CBT, or an integration of the two. For example, counseling sessions may be audio-recorded, transcribed, and then coded for counselor language that represents MI, CBT, or both approaches. This information would further enhance understanding of how counselors use these two approaches together, including when and how counselors transition from MI to CBT and vice versa and how they meld MI and CBT together.

Future research may also be directed toward gaining understanding about how to teach and learn an integration of MI and CBT. Possibilities may include first learning CBT and then incorporating MI or vice versa, or learning both approaches at the same time. Further, counselor educators may wish to consider the type of integration to teach their students (e.g., assimilative integration, theoretical integration) and to whom to teach this integration (e.g., master’s students, doctoral students). Research is needed in order to identify effective methods to teach and learn an integration of MI and CBT. An example of such research might be to ask practicum students in master’s or doctoral programs who have learned MI and CBT to demonstrate their practice of MI and CBT with a client. This work can then be reviewed by a third-party rater who would determine the type of therapies and the type of integration being use by the student. The student’s practice might also be rated by a supervisor and the student may self-evaluate their integrative practice.

Another area for future research would be to explore counselors’ experiences of incorporating MI into their pre-existing counseling practice. Due to MI being a newer
counseling approach and CBT being an established and one of the most popular theoretical approaches, it may be that counselors with a history of using CBT as their customary approach may be learning and integrating MI into their practice, as was the case with John. John reported that he practiced a directive CBT approach prior to leaning MI, and he offered a description of his difficulty remaining MI-adherent while new to MI and working with a challenging client:

The tendency to go back to what you were doing, everyday at first, everyday. . . . It was just because that was what you were used to doing. [You would be] constantly looking at yourself and reflecting, “Are you . . . approaching this from . . . a directive standpoint or are you looking at it more empathetically and attending?” . . . You really just have to self-monitor quite a bit.

John reported that especially when faced with difficult situations while working with his client, he would “go back to what [was] natural.” John credited consistent supervision specific to MI and CBT in helping him use both approaches effectively as he navigated through complex issues with his client. Gaining a greater understanding of counselors’ experiences of integrating MI with a pre-existing CBT practice and the role of supervision specific to an integration of MI and CBT would provide additional key information for educators and learners of the MI and CBT integration.

Counselors’ experiences of, specifically, client change talk is another area worthy of further investigation. This study explored counselors’ experiences of client and counselor language in general, and change talk appeared to be a significant element in participants’ experiences of enhancing clients’ readiness to change. This finding is
consistent with previous literature suggesting that client change talk is linked to subsequent behavior change (Amrhein et al., 2003; Moyers et al., 2009). Further exploration is needed to understand how counselors interpret specific client change talk and how these interpretations guide counselors’ decision-making and in-session behaviors. For example, counseling sessions may be audio-recorded and coded for client change talk and counselor responses to change talk. The audio-recording may then be replayed in the presence of the counselor. During the replay of the audio-recording, the counselor may be asked to talk aloud about his or her interpretations of client change talk and how the counselor made decisions about how to respond to the client.

Branching from additional research surrounding change talk, future research may also focus on how counselors interpret clients to be ready to change. The current study found that participants implemented CBT when they believed their clients were ready to change, but it failed to illuminate how they determined whether clients were ready to make progress and implement change. Further investigations are needed to understand how counselors determine whether clients are ready to change and how this affects their decision-making in counseling sessions.

**Considerations of the Current Study**

As with any research investigation, there are issues to consider regarding the current study’s implementation. These include participants’ selection of an experience with a single client to discuss for the current study, the length of time that had elapsed since the participants had the experience they chose to describe, and the amount of contact and duration of treatment participants had with clients they chose to discuss.
Although prior to data collection the researcher asked that participants discuss a recent experience with a client with whom they used MI and CBT, four of the six participants chose to discuss their work with clients that occurred between approximately one and three years prior to their main interview. It should be noted that the researcher did not operationally define “recent”; however, given that four of the six participants chose to discuss experiences that occurred over one year prior to the main interview might suggest that participants discussed work that was meaningful to them or that they believed illustrated their best work using MI and CBT. As Chris stated about his narrative account, “[It is] one of my best examples of my experience with it [using MI and CBT].” Debra also described why she chose to discuss this particular example of her work, “This [is an] extreme case that really illustrates . . . both of them [MI and CBT] for me. And I think it was because it was a case where I had to be more present, more aware, and less routine.” Debra also discussed how she learned a great deal from working with her client who she grew to appreciate as their work together progressed. She emphasized how meaningful this client was to her growth as a person and as a counselor.

John chose to discuss his work with a client who presented with many challenges and John, who was fairly new to MI when working with this client, recalled his struggle to remain MI adherent with a client with such complex issues. This experience appeared to be meaningful to John for a number of reasons including his struggle to remain MI adherent and his personal responses to having a client in “such disarray” (further described in Theme 5.2).
The remaining two participants (George and Evelyn) chose to discuss recent experiences with clients with whom their work was anticipated to be ongoing. Therefore, there was a large discrepancy between participant accounts in regard to the length of time working with clients and the amount of client contact that participants spoke about. Some participants were describing years of work with clients whereas others were describing a single session.

**Reflections of the Researcher**

One of the most important pieces of learning I encountered during this research process was the importance of reflexivity. I am grateful for the suggestions of previous researchers as well as my committee members and my peer reviewer for helping me incorporate reflexivity throughout my research process. As described in Chapter 2, in preparation for this study I documented my reflections of my experiences with the phenomenon under investigation and I continued to be reflective throughout the research process. For example, following the main interview with the first participant, I documented how easily I could relate to the participant’s description of using MI as a general style in her work with clients. I attended to and documented my experience in an effort to minimize my bias in the research. As I was interviewing participants, I intentionally maintained openness to their experiences as they were told to me as opposed to attempting to fit their experiences into my pre-existing ideas about the phenomenon. This required persistent reflexivity. I learned that reflexivity carried out by the use of memos to track my thinking, experiences, and decision-making and by employing a peer reviewer was essential in minimizing my bias in the current study.
As an MI practitioner myself, I have been trained to use reflective statements when working with clients as opposed to asking an abundance of questions. This affected my style as an interviewer in that while conducting interviews I would often make reflective statements to the participants instead of posing follow-up questions. Upon this realization, I worked to refine my role as a researcher and alter my style to ask questions in place of making reflective statements during the interviews.

During data collection and analysis, I learned that being open to and becoming well acquainted with the data was essential. I found that immersing myself in the data by transcribing all interviews myself and conducting thorough analyses by hand was helpful for me to learn the data and make connections between specific components of each participant’s account. I found the use of memos to be essential in furthering my thinking in the identification and refinement of the current study’s findings. Free imaginative variation was helpful for me to determine the essential themes of the phenomenon by questioning whether the phenomenon would losing its fundamental meaning if a theme was changed or deleted.

When I was identifying the themes and findings of the current study, I was hesitant to include the therapeutic process of using MI and CBT in my findings because a “process”—in addition to themes—is not typical in phenomenological research. Through reflection and dialogue with a peer reviewer, it became evident that the process was an essential component of each participant’s experience, yet it did not fit as a theme. Therefore, the process was included as a supplemental finding of this study. In hindsight,
I am satisfied to know that I listened to the data and included this finding and I did not attempt to force it into a “theme.”

One component I would have done differently for the current study would be to have operationally defined participants’ work with a recent client. For example, I might have stated that I preferred that participants discuss a single counseling session conducted within the past six months, or perhaps up to 10 sessions with a single client with whom their work ended no more than one year ago. This change would have reduced the variation between participants’ accounts in terms of the length of time participants had worked with their clients and the length of time in between the work completed with clients and data collection.

**Chapter IV Summary**

In this final chapter, the findings of the current study were discussed in light of previous research and literature pertaining to the practice of MI and CBT. Findings supported the emerging theory of MI as proposed by Miller and Rose (2009) and could be applied to assimilative and theoretical integration in Norcross’s (2005) taxonomy of psychotherapy integration. Participants of the current study also used MI and CBT in a ways consistent with Miller and Rollnick’s (2004) suggestions of how to use MI with other treatment methods. Participant accounts were consistent with literature suggesting that MI and CBT have complementary foci in that MI may help clients prepare for change and CBT may help clients implement change. Participant accounts were also consistent with literature emphasizing the importance of the role of change talk in facilitating client change, and one participant’s account supported literature that
recommends engaging in supervision when practicing MI. Participant accounts also reflected suggestions in the literature to use MI flexibly rather than following manual-guided MI and supported the use of CBT manuals.

Implications of the current study apply to counseling practice and to counselor education, including supporting the use of two evidence-based practices, which is consistent with the *ACA Code of Ethics* and CACREP standards. Suggestions for future research include further investigations of how counselors integrate MI and CBT, using code-switching to investigate counselors’ language specific to MI and to CBT, using talk aloud methods to illuminate counselor’s interpretations of client change talk and the effect it has on their decision-making in counseling sessions, and further investigations of counselors’ experiences of learning MI and incorporating MI into their pre-existing counseling practice. Finally, this study generated issues for consideration and the researcher’s reflections were presented.

**Conclusion**

MI is a style of counseling used to help clients enhance their intrinsic motivation to change. CBT is theory-based practice that focuses on modifying cognitions and behaviors. Due to their complementary foci, literature has suggested that when used together, MI and CBT may improve client outcomes (Westra, 2004; Westra & Arkowitz, 2011; Westra et al., 2009). However, investigations are needed to understand how counselors use MI and CBT together. The current study used hermeneutic phenomenological method to investigate six licensed professional counselors’
experiences of client and counselor language while using MI and CBT to facilitate client change.

Data collection included a main and follow-up interview with each of the six participants. Following the recommendations of van Manen (1990) for hermeneutic phenomenological analysis, the researcher used wholistic, selective, and detailed analysis to identify essential themes from the transcribed data. The researcher then read and reread participants’ accounts and wrote and rewrote the emerging themes using memo writing to reflect on her interpretations of the data and to further her thinking about the writing up of themes. A peer reviewer was employed on two occasions to question the researcher on her analysis process, examine the relevance of the findings to the research question, and discuss the wording of themes.

Findings of the current study included five main themes, each with at least two sub-themes, and the identification of the therapeutic process of using MI and CBT. The findings were verified through the member checking process.

The main themes were identified as follows:

1. Counselors interpret client language to identify what is needed in the therapeutic relationship and then respond to meet those needs.

2. Counselors interpret client language specific to readiness and motivation for change, and then match their own language to meet clients where they are in the process of change and to assist clients in their movement toward change.
3. Counselors interpret client language that suggests problematic thinking or a need for behavior change and then respond with the use of CBT when clients are determined to be ready for change.

4. Counselors are intentional about their use of language, including having an awareness of what they are not saying.

5. Counselors’ responses are guided by their interpretations of client factors (e.g., psychopathology, sociodemographic information, personal resources).

The therapeutic process of MI and CBT consisted of three phases and described the process participants engaged in as they experienced the five themes of the phenomenon. In Phase 1, counselors heard client language and witnessed client presentations. In Phase 2, counselors interpreted meaning from the client language and presentations from Phase 1 in order to determine how to respond to the client in Phase 3. Phase 3 consisted of counselor behaviors that were MI- or CBT-consistent.

Findings of the current study are consistent with literature that suggests MI and CBT have complementary foci and may produce a synergetic effect. Participant accounts were consistent with Miller and Rose’s (2009) proposed emerging theory of MI and Miller and Rollnick’s (2004) suggestions of how MI may be used with other treatments. Participants integrated MI and CBT in ways consistent with assimilative and theoretical integration (Norcross, 2005) and further research is needed to better understand how counselors integrate these two approaches. Future inquiries may also be directed at gaining an understanding about how counselor educators might teach an integrated practice of MI and CBT.
Further research is needed to better understand counselor language that is grounded in MI, CBT, or a blending of both. Findings of the current study supported literature that emphasizes the importance of change talk in facilitating client change (Amrhein et al., 2003; Feldstein et al., 2011; Moyers et al., 2009), yet further research is needed to understand more about how counselors interpret client change talk and how they perceive clients as ready to change. One participant’s account in the current study was consistent with literature that emphasized the importance of practice feedback when practicing MI (Miller et al., 2004), and further research is needed to better understand how counselors learn MI and integrate MI with a pre-existing CBT practice.
APPENDICES
APPENDIX A

APPROVAL FROM KENT STATE UNIVERSITY’S INSTITUTIONAL REVIEW BOARD
Appendix A

Approval From Kent State University’s Institutional Review Board

September 7, 2010

Melanie Marie Scherer Iarussi
School of Lifespan Development

Re: #10-273: “Counsellors’ Experiences of Client and Counselor Language While Using Motivational Interviewing and Cognitive-Behavior Therapy to Facilitate Client Change”

I am pleased to inform you that the Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I/Exempt research. This application was approved on September 7, 2010. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:

☐ Exemption 1: Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2: Research involving the use of educational tests, surveys, interviews, or observation of public behavior.

☐ Exemption 3: Research involving the use of educational tests, surveys, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4: Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5: Research and demonstration projects conducted by or subject to approval of department or agency heads, and which are designated to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6: Taste and food quality evaluation and consumer acceptance studies.

Submission of annual review reports is not required for exempt projects. If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation. Please contact the IRB administrator to discuss the changes and whether a new application must be submitted.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001833.

If you have any questions or concerns, please contact me by phone at 330-672-2704 or by email at Pwasko@kent.edu.

Sincerely,

[Signature]

Paulette Wasko
Manager, Research Compliance, Communications and Initiatives

cc: Dr. Cynthia Cotburn
    Dr. John West

Division of Research and Sponsored Programs
Office of Research Safety and Compliance
(330) 672-2704 Fax: (330) 672-2658
P.O. Box 5190, Kent, Ohio 44242-0190

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APPENDIX B

PARTICIPANT RECRUITMENT EMAILS
Appendix B

Participant Recruitment Emails

Email to the MINT Listserv

Subject line: Research Request

Hello members of the MINT! I am a MINTie (2008, Albuquerque) and a Ph.D. Candidate in the Counseling and Human Development Services program at Kent State University in Kent, Ohio. I am in the data collection phase of my dissertation research and I would like to extend an invitation to interested and qualified MINTies to participate in this study. I am conducting a phenomenological investigation of professional counselors’ experiences of client and counselor language in counseling sessions in which the counselor is using MI and cognitive-behavior therapy (CBT) to facilitate client change. It is my hope that this study will enhance understanding of how counselors use the essential directive component of MI - the focus on client and counselor language to facilitate client change - when making decisions about how to use both MI and CBT in counseling sessions.

I am currently seeking participants who are professional counselors licensed in their state of practice in the United States, who have been trained in both MI and CBT including completion of at least 20 hours of training in each approach (e.g., seminars, supervised practice), who used CBT as their primary counseling method prior to learning MI, and who (by self-report) now incorporate both of these approaches in their customary practice.

I understand your time is valuable, and I greatly appreciate your consideration to participate in this study. This study will require completion of a primary individual interview with me (approximately 60-90 minutes in duration) and one follow-up interview (approximately 30 minutes in duration). If you are interested in participating, or if you know of a licensed professional counselor who might qualify and be interested, please contact me directly at mschere1@kent.edu or (757) 749-9223.

Thank you and have a great day!

Sincerely,
Melanie Scherer Iarussi
Subject line: Research Request

Hello, __________. I am a doctoral candidate in the Counseling and Human Development Services Ph.D. degree program at Kent State University in Kent, Ohio and a member of the Motivational Interviewing Network of Trainers (MINT). I am in the data collection phase of my dissertation research and (___________ mentioned that you might be willing to participate in this study) OR (I thought you might be willing to participate in this study).

I am conducting a phenomenological investigation of professional counselors’ experiences of client and counselor language in counseling sessions in which the counselor is using MI and cognitive-behavior therapy (CBT) to facilitate client change. It is my hope that this study will enhance understanding of how counselors use the essential directive component of MI - the focus on client and counselor language to facilitate client change - when making decisions about how to use both MI and CBT in counseling sessions.

I am currently seeking participants who are professional counselors licensed in their state of practice in the United States, who have been trained in both MI and CBT including completion of at least 20 hours of training in each approach (e.g., seminars, supervised practice), who used CBT as their primary counseling method prior to learning MI, and who (by self-report) now incorporate both of these approaches in their customary practice.

I understand your time is valuable, and I greatly appreciate your consideration to participate in this study. This study will require completion of a primary individual interview with me (approximately 60-90 minutes in duration) and one follow-up interview (approximately 30 minutes in duration). If you are interested in participating, or if you know of a licensed professional counselor who might qualify and be interested, please contact me directly at mschere1@kent.edu or (757) 749-9223.

Thank you and have a great day!

Sincerely,
Melanie Scherer Iarussi
APPENDIX C
SCREENING QUESTIONS
Appendix C

Screening Questions

1. Are you a licensed professional counselor?

2. Have you been practicing CBT for at least one year?

3. Have you participated in at least 20 hours of training in CBT?

4. Did you practice CBT for at least six months before incorporating MI into your practice?

5. Have you been practicing MI for at least six months?

6. Have you participated in at least 20 hours of training in MI?

7. How long have you been practicing MI and CBT together?

8. Do you conduct at least five face-to-face individual counseling sessions per week in which you use MI and CBT? Have you maintained at least this frequency for the past six months?

9. Have you attended to client language and your own language while using MI and CBT to facilitate client change?

10. Are you interested in understanding more about the significance of client and counselor language when using MI and CBT together?

11. Are you willing to engage in an in-depth interview (60–90 minutes) and a follow-up interview (approximately 30 minutes)?

12. Will you give consent for the interviews to be audio recorded?
APPENDIX D

CONSENT FORM
Appendix D

Consent Form

Institutional Review Board

Informed Consent to Participate in a Research Study

Study Title: Counselors' Experiences of Client and Counselor Language While Using Motivational Interviewing and Cognitive-Behavior Therapy to Facilitate Client Change.

Principal Investigator: Melanie Scherer Jarussi

You have been invited to participate in the above named research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document.

Purpose:
The purpose of this study is to enhance understanding of how professional counselors in the United States experience language used in counseling sessions in which motivational interviewing (MI) and cognitive-behavior therapy (CBT) are used to facilitate client change. This study seeks to explore counselors' perceptions and interpretations of client language and the significance they attribute to their own language in counseling sessions in which MI and CBT are used to gain a greater understanding of the decisions counselors make about how to use MI and CBT together.

Procedures
In the current study, participants will complete a screening interview conducted by telephone with the researcher to ensure that participants meet all inclusion criteria established for this study. Following the screening interview, participants will be asked to sign this informed consent form and complete a demographic questionnaire and to return them to the researcher. Participants will be asked to complete a primary data collection interview which will last approximately 60 to 90 minutes, and one follow-up interview which will be approximately 30 minutes in duration. Primary interviews will be conducted face-to-face when distance between the researcher and participant permits, and over the telephone when distances are too extensive to travel. Follow-up interviews will be conducted over the telephone. The primary data collection interview will require participants to be thoughtful about and discuss their experiences of client and counselor language while using MI and CBT in counseling sessions and the significance of client and counselor language. Participants will receive the primary interview question prior to the interview. It may be helpful for participants to be mindful of the language used between client and counselor within their individual counseling sessions and be prepared to discuss a specific experience with a single client during the data collection interview. In the follow-up interview, the participant will be asked to respond to any follow-up questions developed by the researcher from the first interview. Member

School of Lifespan Development and Educational Sciences
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Human Development and Family Studies • Instructional Technology
Rehabilitation Counseling • School Psychology • Special Education
P.O. Box 5190 • Kent, Ohio 44242-0001
330-672-2294 • Fax: 330-672-2512 • www.chhs.kent.edu/lifes/
checking will be conducted following data analysis wherein participants will be asked to evaluate and provide feedback regarding the consistency of the preliminary themes identified by the researcher in representing the participant’s experiences.

**Audio and Video Recording and Photography**
Data collection interviews will be audio recorded. All recordings will be permanently erased at the completion of the investigation.

**Benefits**
It is anticipated that participants may benefit from the current study by exploring their experiences of client language and their own language in counseling sessions in which they are using MI and CBT. Specifically, it is intended that counselors will heighten their awareness and deepen their understanding of the meaning and interpretations of these experiences which may further their commitment to providing quality client care.

**Risks and Discomforts**
It is not anticipated that participants will experience any risks or discomforts in the current study beyond those encountered in everyday clinical experiences. The benefits of participating are anticipated to far outweigh any risks or discomforts.

**Privacy and Confidentiality**
Participants’ study-related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location. Pseudonyms will be used and research participants will not be identified by name in any publication or presentation of research results. All interview sessions will be audio recorded. Upon completion of the study, all audio recordings will be permanently erased.

**Voluntary Participation**
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty.

**Contact Information**
If you have any questions or concerns about this research, you may contact Melanie Scherer Larussi at (757) 749-9223 or John D. West or Cynthia J. Osborn, dissertation advisors, at (330) 672-2662. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672-2704.

**Consent Statement and Signature**
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

__________________________
Participant Signature

__________________________
Date

Counselors’ Experiences/M. S. Larussi
APPENDIX E

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE
Appendix E

Participant Demographic Questionnaire

Please complete this questionnaire and return it to the researcher along with your signed consent form. Thank you!

<table>
<thead>
<tr>
<th>Age:</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity:</td>
<td>State in which you are licensed:</td>
</tr>
<tr>
<td>White</td>
<td>Chinese</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>Filipino</td>
</tr>
<tr>
<td>Black or African-American</td>
<td>Japanese</td>
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<tr>
<td>American Indian or Alaska Native</td>
<td>Korean</td>
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<td></td>
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<td>Guamanian</td>
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<td></td>
<td>Samoan</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Academic degrees: 

Professional license and other credentials (please spell out):

Number of years licensed as a professional counselor:

Number of years/months practicing MI:

Number of years/months practicing CBT:

Do you currently or have you ever engaged in any type of CBT supervision or MI practice feedback (i.e., samples of your work are reviewed by an MI expert and feedback provided) or coaching (i.e., discussion with an MI expert about your work that is not directly reviewed)? If yes, what was the nature of this supervision or coaching? How often and for how long did you engage in it?

Please describe the general population with whom you work (e.g., presenting problem, age, race/ethnicity, sex):

Please describe the environment in which you work (e.g., outpatient community agency, private practice clinic, inpatient unit, residential program):
APPENDIX F

INTERVIEW QUESTIONS
Appendix F

Interview Questions

The following primary interview question was posed in the main data collection interview:

- Focus on a specific time when you used MI and CBT to facilitate client change in a counseling session. Please describe the client’s language that was significant to you as well as your own language that you thought was significant in assisting the client’s movement toward change.

The following secondary questions were posed as needed to facilitate depth:

1. Focus on a client utterance that was significant to you. What meaning did this utterance have for you? *If needed:* What was your perception of the client’s movement toward change prior to, during, and following this utterance?

2. How did a client utterance influence you in regard to your own thoughts and language when assisting him or her towards change?

3. Focus on language you used in session that seemed significant to you. What was meaningful about this utterance? *If needed:* What was your perception of the client prior to and following your utterances?

4. What was your experience in regard to your language influencing the client’s movement toward change?

5. What therapeutic constructs from either MI or CBT seemed significant in this session and how did you experience client language and your own language related to these constructs?
REFERENCES
REFERENCES


