Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice xx (2019) xxx-xxx

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration

Erin A. Kaufman, *University of Western Ontario*
Antoine Douaihy and Tina R. Goldstein, *University of Pittsburgh and Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center*

Dialectical behavior therapy (DBT) and motivational interviewing (MI) are two widely used and efficacious psychosocial interventions. An immense and growing number of studies examine DBT, MI, or adaptations of these approaches across diverse treatment contexts and across various clinical populations. Because DBT and MI are in high demand, it is probable that trainees and established practitioners will encounter one or both treatments over the course of their careers. Although MI and DBT initially evolved in distinct contexts for different populations, these approaches share a number of common fundamental principles. Each provides distinct and complementary strategies for enhancing clients' motivation and ability to change. For some, an integrative or sequenced application of MI and DBT may enhance client care. The present article highlights areas of divergence, convergence, and opportunities for integration, and offers practical tips for applying DBT and MI in conjunction.

Dialectical behavior therapy (DBT) and motivational interviewing (MI) are two popular and efficacious psychosocial interventions (Douaihy, Gold, & Kelly, 2015; Priebe et al., 2012). Both DBT and MI were initially designed to treat stigmatized and underserved groups previously assumed to be incapable of change—specifically, individuals with suicidality and borderline personality disorder, and substance use disorders, respectively (Linehan, 1993; Miller & Rollnick, 2013). Each has been rigorously evaluated in the target population with a considerable number of randomized clinical trials and meta-analyses (see DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Linehan Institute, 2018). Furthermore, an immense and rapidly growing number of studies are examining DBT, MI, or adaptations of these approaches across diverse treatment contexts (e.g., behavioral medicine, inpatient psychiatric units, outpatient therapy, primary care) and clinical populations (e.g., eating disorders, bipolar disorder, posttraumatic stress disorder, disordered gambling, and co-occurring psychiatric and substance use disorders; Behavioral Tech, 2016; DiClemente et al., 2017; Goldstein et al., 2015; Linehan, Dimeff, Koerner, & Miga, 2013). Both are efficacious with culturally diverse groups (e.g., Davidson, Cave, Reedman, Briffa, & Dark, 2012; Hettema, Steele, & Miller, 2005; McFarr et al., 2014). Impressively, MI has twice the effect size when delivered to U.S. minority populations as compared to White majority samples (Hettema et al., 2005).

DBT and MI have each been successfully disseminated and implemented in training, community, and Veteran Administration settings (Brodsky, Cabaniss, Arbuckle, Oquendo, & Stanley, 2017; Douaihy et al., 2015; Drapkin et al., 2016; Hawkins & Sinha, 1998; Herschell, Lindhiem, Kogan, Celedonia, & Stein, 2014; Landes et al., 2017). Furthermore, each appears to be cost-effective—reducing the financial burden of disorder-associated morbidity and mortality, as well as future service utilization (e.g., Feliu-Soler et al., 2018; Neighbors, Barnett, Rohsenow, Colby, & Monti, 2010; Priebe et al., 2012). Because DBT and MI have demonstrated efficacy for many populations, and have garnered support from systems, practitioners, and clients alike, these approaches are in high demand. As such, it is probable that trainees and established practitioners will encounter one or both treatments over the course of their careers.

MI has been successfully integrated into cognitive-behavioral approaches and appears to be incrementally beneficial for important outcomes (CBT; Westra, Constantino, & Antony, 2016). A recent randomized clinical trial for patients with generalized anxiety disorder found that integrating MI into CBT specifically in moments of patient resistance and ambivalence outperformed standard CBT across a 1-year follow-up period.

Keywords: Dialectical Behavior Therapy; Motivational Interviewing; Psychotherapy; Applied Practice

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

Specifically, those assigned to the combined CBT/MI condition experienced a steeper rate of worry decline, greater reduction in their general distress, and half the dropout rate as clients assigned to the CBT-only condition (Westra et al., 2016). The odds of GAD remission were approximately 5 times higher at 12 months for clients receiving a combined approach. Research has also shown that clinicians' use of MI-consistent strategies during periods of client/therapist disagreement yields more favorable outcomes as compared with more directive CBT methods (Aviram, Westra et al., 2016). Importantly, MI-like behavior during randomly selected therapy segments was not incrementally beneficial—highlighting the importance of identifying specific instances when incorporating MI may be most appropriate within an overarching therapy.

For the purposes of this article, we assume that readers will have some level of previous exposure to and familiarity with MI and DBT. We focus on highlighting areas of divergence, convergence, and opportunities for integration, and offer practical tips for using DBT and MI in conjunction to promote effective client care. Although we provide some orientation to the structure and function of DBT and MI, a substantive overview of either treatment is beyond the scope of this article (interested readers are referred to Douaihy et al., 2015; Linehan, 2015).

Historical Context

Although now widely practiced and well-generalized, understanding the original context in which DBT and MI were developed elucidates important theoretical underpinnings of each. MI emerged within the addictions field as a method for aiding clients to work through ambivalence about behavior change (Rollnick, Heather, & Bell, 1992). A fundamental assumption underlying the approach is that most clients do not enter an encounter with a practitioner in a state of readiness to change their patterns of health behaviors including drug use, drinking, smoking, diet, or exercise. Thus, commonly used fear-based strategies such as lecturing clients about associated risks, advice-giving, and shaming may be of limited utility. Miller and Rollnick argued such approaches often lead to unproductive dialogue. Advising clients about what actions(s) to take to reduce their problem behavior is misguided and premature when clients are not ready to change (Miller, 1983; Miller & Rollnick, 1991). In traditional client/practitioner exchanges, client ambivalence was ignored *and* attempts at direct persuasion often pushed the client into a position of defensiveness—arguing for why change is difficult. MI represented a radical departure from most common therapeutic exchanges of the day.

DBT similarly emerged in response to shortcomings of the current treatment climate for chronically suicidal individuals diagnosed with borderline personality disorder (BPD). In the late 1970s, Linehan attempted to apply standard change-based therapy (Cognitive Behavior Therapy; CBT) to women from this population, yet encountered a number of problems (Linehan, 1993). Clients found CBT's unrelenting focus on change to be invalidating of their suffering. Many withdrew from treatment, became frustrated with the practitioner, or shut down within their therapy sessions. Furthermore, the volume and severity of presenting problems made applying standard CBT exceptionally challenging. Practitioners were caught between addressing urgent problems (e.g., suicide attempts, self-harm urges, urges to quit treatment, noncompliance with homework assignments, untreated comorbid diagnoses, etc.) and building adaptive skills. CBT alone also did not decrease suicidal thoughts and behaviors. In response to these limitations, Linehan and her research team incorporated acceptance-based strategies to balance and enhance CBT's focus on change, and placed emphasis on holism and synthesis of opposing perspectives. They also developed a separate skills-focused group component to help clients learn and apply emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness strategies. As a result, clients stayed in therapy, felt greater therapeutic alliance, and made faster improvements (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

Although MI and DBT initially evolved in distinct contexts for different populations, each was designed to empower clients to make needed changes through incorporating accurate empathy, equanimity, and validation (discussed further below). DBT and MI share a number of common principles. Each provides distinct and complementary strategies for enhancing clients' motivation and ability to change. Traditional models cast the practitioner as the expert and maintained such an implacable focus on change that many practitioners overlooked the genuine barriers preventing clients from making use of the education/skills they were offered. We begin by focusing on domains where DBT and MI deviate in their overarching composition, theory, and purpose. Acknowledging fundamental areas of divergence highlights the unique topography and utility of each intervention and provides a fuller context for our subsequent discussion of common principles.

Areas of Divergence

Focus of Intervention

Vast differences in the structure of DBT and MI (discussed below) reflect underlying differences in the foci and intent behind these interventions. Each approach has distinct hypothesized mechanisms of behavior change.

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

MI

The purpose of MI is to identify and enhance intrinsic client motivation for enacting values-consistent changes in their lives. Motivation is conceptualized as fluid and intrapersonal in nature, yet highly influenced by interpersonal factors and contextual cues. For example, many individuals seek to make changes in their lives in order to maintain or foster social ties. A practitioner using MI seeks to use interpersonal skills and social contingencies to elicit and explore their client's *own* reasons for change through the following: complex reflective statements, evocative open-ended questions, summarizing the person's experience, and specific affirmations (Miller & Rollnick, 2013). The practitioner is focused on encouraging clients to talk about their desire, ability, reasons, need, and level of commitment to changing target behaviors, as well as explore what specific steps are needed to enact such changes. Adherent practitioners take care to identify and highlight client ambivalence about change without expressing judgment or disapproval.

MI ideally functions to bolster client autonomy and the client's sense of responsibility for decision-making. Practitioners do not provide unsolicited feedback; instead, they ask permission to provide information or suggestions. Successful intervention in MI hinges upon the practitioner's ability to: (a) believe in the client's capacity to change, (b) listen deeply with the intention of understanding the client's unique perspective, (c) communicate accurate empathy for the client, and (d) collaborate with the client using an egalitarian approach throughout therapeutic conversations. MI is meant to optimize clients' motivation for making changes to their lives in order to bring them closer to their values. It does not aim to teach specific therapeutic strategies or skills beyond self-reflection and broad problem-solving. Rather, MI is often the catalyst for subsequent treatment engagement.

DBT

DBT also uses motivation-enhancing techniques for treatment engagement and implementation. However, DBT practitioners use specific strategies like *foot in the door* (asking for a small demonstration of commitment followed by larger and larger expressions of commitment over time), *door in the face* (asking for an outrageously large demonstration of commitment and accepting a small action of commitment instead), and *devil's advocate* (e.g., arguing for why the client *doesn't* need DBT) in order to attain client commitment to treatment. Within this treatment model, client motivation is viewed as necessary yet insufficient for change. DBT does not directly focus on client ambivalence about changing problem behaviors beyond initial orientation sessions. Rather than experiencing difficulties committing to change, clients are conceptualized as having skills deficits and/or difficulty with enacting adaptive responses. Thus, skills acquisition for coping with distress, regulating emotional experiences, building interpersonal efficacy, and increasing mindfulness are the hypothesized mechanisms of action. Exploring motivation is not the basis of the intervention, but is rather treated as a spring-board for addressing emotion and behavior regulation problems. DBT is far more didactic than MI, yet the client is still seen as the expert on his/her/their own experience.

Length and Structure of Intervention

MI

DBT and MI differ significantly in terms of their length and structure. MI is a collaborative, goal-oriented style of communication designed to strengthen clients' personal motivation for and commitment to their specific goal(s). It is not a psychotherapy, but rather a deliberately brief and focused intervention, requiring as little as one session with a single practitioner. MI is typically offered in 1 to 4 sessions. It may be particularly useful when the primary obstacle to change is client ambivalence rather than a lack of resources or skills. Brief motivational counseling can be offered in an initial session with the intention of strengthening motivation, as well as retention and adherence in subsequent treatment contacts. Thus, there can be a synergistic effect when MI is joined to other evidence-based counseling. We argue below that MI can be effectively *embedded* within DBT treatment.

DBT

By contrast, DBT is a long-term structured psychotherapy (Linehan, 1993). DBT practitioners and clients typically agree to 12-month contracts, which can be renegotiated and renewed as needed. The standard DBT treatment model is multimodal, including weekly individual therapy, weekly group skills training, and telephone coaching components, as well as a peer consultation team for DBT practitioners. DBT is further organized into a hierarchy of treatment priorities and core strategies designed to address those priorities. Clients progress through stages of care based on the severity and type of presenting symptoms. For example, Stage 1 DBT is dedicated to addressing severe behavioral dyscontrol and life-threatening behavior. DBT is systematic both in its comprehensiveness and its sequence. The structure is intended to provide practitioners with an evidence-based roadmap for managing clinical decision making around treating life-threatening and therapy-interfering behaviors (Koerner, 2012; Linehan, 1993).

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

Individual sessions. Individual sessions are tailored to fit the client's stage of DBT treatment. Initial visits focus on orienting the client to DBT and building commitment to treatment engagement. Once a contract is signed, early sessions often focus on understanding patterns of behavior contributing to and sustaining target behaviors, as well as those that lead to more adaptive outcomes. Practitioners help clients identify instances when skills they are learning in group can be effectively and creatively applied in the context of their lives. As clients progress through therapy, practitioners incorporate other therapeutic techniques such as emotional exposures, mindfulness, and values identification.

Skills group. Group is co-led by two DBT practitioners and focuses on teaching a range of skills that fall within four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The group format allows the treatment team to convey information about core therapeutic strategies to many clients at once, freeing the individual practitioner to reference and draw upon DBT skills without having to use individual session time to teach them. Group allows for sharing and modeling of skillful behavior and allows multiple practitioners on the treatment team to observe and interact with clients.

Phone coaching. Standard DBT programs offer phone coaching, whereby clients can communicate with their individual practitioners between scheduled sessions. This is intended to help clients effectively translate their new behavioral repertoire to daily life through brief phone or text exchanges. Phone coaching is not phone-based therapy sessions, but rather a brief, focused conversation. The practitioner gathers information about the challenging context and offers suggestions on skills for the client to try (ideally, prior to his/her engagement in a problem behavior) before ending the interaction.

Consultation team. Practitioners are embedded within a consultation team where they discuss topics relevant to optimal treatment delivery. Paralleling the therapy itself, consultation meetings are guided by a target hierarchy. Each week, teams discuss practitioners' challenges in providing effective treatment to their DBT clients. Importantly, the team serves to enhance practitioners' skills and motivation for treatment delivery by strengthening therapeutic responses and reducing responses that interfere with effective care. For example, the consultation team explicitly targets practitioner burnout and gives recognition to effective behavior.

The Practitioner's Role

MI

The role of the practitioner is conceptualized differently across DBT and MI models. The skillful MI practitioner provides an appropriate context for clients to explore their own reasons for change and enhance their commitment to behavior that aligns with their own personal values. The practitioner rarely brings his or her own beliefs or reactions into the session, and only provides opinions or suggestions with explicit permission.

Even though little empirical work has evaluated its efficacy, MI provides a specific strategy for aiding the practitioner in collaboratively exchanging information with clients (without turning into the expert, and the client into a passive recipient). In this technique, termed *elicit-provide-elicit* or E-P-E, practitioners first "elicit" clients' current awareness and perspective on a topic (e.g., what do you know about the effects of drinking on your seizure disorder?). Practitioners then fill in the gaps or correct any client misconceptions—tailoring the information to clients' individual needs ("provide"). Finally, practitioners "elicit" client reactions to the information and discus how it fits in relation to their situation (e.g., "How does that fit with your experience?"; Douaihy et al., 2015; Hettema, Barbir, Viar, & Hund, 2017).

The MI practitioner is unlikely to disclose personal information. Although exceptionally present with the client, the MI practitioner does not interact with or talk to clients in the manner he or she would in the context of nontherapeutic relationships (e.g., as though speaking with a partner, friend, or family member).

DBT

By contrast, DBT practitioners are *trained to use or even leverage the therapeutic relationship* as a means of facilitating change, teaching skills application, and assisting with skills generalization. Building rapport does more than increase client engagement. Practitioner/client interactions serve to create a real and transactional relationship where practitioners are present as their genuine selves. Although the nature of the client/practitioner relationship is focused on benefiting the client, DBT practitioners are authentic in treatment. They deliberately and thoughtfully give feedback about how client behavior affects them personally. For example, a DBT practitioner may state, "I was disappointed you didn't reach out for skills coaching like we had discussed" or "When you raise your voice and curse, I find it difficult to focus. It will need to stop for us to continue our work together." The function of these communications is not to "vent" or be aversive, but rather to highlight natural interpersonal consequences of client behavior in the context of a safe environment. The contingencies affecting the therapeutic relationship likely mirror those in the client's life more broadly. A skillful

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

DBT practitioner will use interactions in the therapy room as a means of facilitating discussion about the client's other relationships. In the example above, the practitioner might share his or her observation about the client's cursing behavior and then follow up by asking, "How do others in your life react when you raise your voice and curse with them?" This discussion may then be followed with identification of a DBT skill that could help with the interpersonal problem behavior.

In DBT, self-involving self-disclosure is considered an important tool for modeling skillful behavior and enhancing client commitment to treatment. Practitioners are encouraged to discuss their own personal successes and failures with applying skills (e.g., "I have such a hard time with the observe skill. I often find myself slipping into describe."). DBT practitioners also routinely express approval for a client's skillful behavior (i.e, an interpersonal contingency; cheerleading) and explicitly endorse caring about their clients. Practitioners use the relationship as leverage for enhancing client safety. For example, a practitioner might state "It would devastate me if you killed yourself. I don't know if I could continue to do this work."

Both MI and DBT

Although the same practitioner may behave quite differently when practicing MI versus DBT, each intervention maintains a strong focus on providing accurate empathy, maintaining belief in clients' abilities to change, and helping clients develop values-consistent behavior. There are a number of other common themes across these interventions, which may differ in technical application and theoretical origin, yet serve similar functions for the client, practitioner, or both. These common principles facilitate practitioners who are well trained in one approach to learn and competently practice the other. Clients may also find it easy to transition fluidly between the two therapeutic styles.

Both DBT and MI focus on identifying the patterns leading to and reinforcing both problematic and adaptive client outcomes. In MI, these patterns are understood through strategies like evocative open-ended questions coupled with a therapeutic style of "[a] curious and itchy mind" (Rosengren, 2017). The MI practitioner digs deeply into the client's story in an attempt to understand the mechanisms contributing to and sustaining problem behavior. Without first establishing such an understanding, the MI practitioner is not able to accurately empathize or effectively mobilize client change talk. This highlights a crucial process underlying MI efficacy: the client-practitioner relationship, and, more specifically, the therapeutic skill of empathic understanding (Rogers, 1959). Rogers hypothesized that accurate empathy, congruence, and positive regard are essential conditions for creating an atmosphere of safety and acceptance in which clients are free to share, explore, and change. Thus, the relational and technical components of MI are each functioning to aid the client in making desired changes.

This same function is accomplished in DBT through chain analysis. Here, the practitioner and client review a recent incident of problem behavior, often in painstaking detail, to investigate client thoughts, sensations, emotions, urges, and actions leading up to and following the target response. This practice similarly aims to collaboratively develop a deep and thorough understanding of the behavior. The DBT practitioner looks for opportunities to validate emotions that precede problem behavior and works with the client to identify where skills could be inserted to yield a different outcome. Both MI and DBT highlight how thoughts, emotions, urges, and behaviors are connected and mutually influential. Each is also reliant on the client-practitioner relationship.

Common Principles

Increasing Flexibility and Reducing Rigidity

Adherent DBT and MI require creativity and adaptability on the part of the practitioner, who in turn, models a flexible style of thinking for the client. DBT and MI are empirical, principle-based approaches with relatively few fixed "rules" that practitioners must follow. There are no specific session-by-session checklists—rather, practitioners use core therapeutic strategies to aid clients in making desired changes (e.g., see Table 1; Koerner, 2012; O'Donohue & Fisher, 2009). Although these therapeutic tools are fairly ubiquitous, DBT and MI have characteristic styles. Practitioners apply familiar strategies in an imaginative fashion with tremendous precision. Koerner (2012, p. 77) described DBT as "ask[ing] the practitioner to approach therapy sessions as a jazz musician approaches his or her sessions. Mastery of [basic tools] allows improvisation that is both disciplined and free." This analogy also applies to MI, which is simultaneously energetic and deliberate. The "movement, speed, and flow" (Koerner, 2012, p. 77) of these interventions are tailored to individual clients and shift dynamically in accordance with their changing needs. This is not to say that practitioners respond haphazardly to client behavior. Rather, the principles of each approach are used as a North star, guiding the practitioner's decisions throughout treatment.

Dialectics

Adopting a dialectical worldview is an essential and fairly unique facet of DBT that serves to increase psychological flexibility. Dialectics emphasize holism and synthesizing seemingly opposing perspectives. In

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

Table 1
Core Psychotherapeutic Strategies Across DBT and MI Modalities

Core Strategy	DBT	MI
Teaching self-monitoring	• Chain analysis	• Behavior analysis
Emotional Exposure	• In-session emotional experiencing • Exposure Home Practice	• In-session emotional experiencing
Cognitive Restructuring	• Through chain analysis • Cognitively-oriented skills • Dialectical thinking • Non-judgmental stance	• Through exploring client ambivalence
Didactic and Orienting Strategies	• Woven into sessions • Handouts	• Woven into sessions
Skill Application	• Solution Analysis • Skills Group • Phone Coaching	• Planning for change (i.e. how will you make these changes, who will you ask for support, what might get in the way?)
Contingency Management	• Within the therapeutic relationship	

other words, two contrasting ideas are simultaneously true. This concept can be challenging to understand and is crucial to both the overarching model and implementing specific in-session strategies.

In DBT, there are multiple ways to think about a situation, feeling, behavior, or emotion. All perspectives have something unique and valuable to offer. A dialectical stance counters the tendency for practitioner and client to become mired in arguments, polarizing positions, black-and-white and extreme thinking. For example, a key dialectical assumption is that clients are doing the best they can, *and* they need to work harder, try harder, and be more motivated to change (Linehan, 1993). Although seemingly in competition, it is freeing to believe these ideas are simultaneously true. Doing so also helps the practitioner work more effectively without judgment of client progress. When confused, polarized, or stuck, the practitioner assesses what is being left out and seeks validity in each position. Endeavoring to synthesize information from more than one perspective ideally leads to more effective solutions.

Dialectics permeate DBT. In addition to adopting a dialectical worldview, specific dialectical strategies are used in session (e.g., the devil's advocate technique, metaphor), to help prevent practitioner and client from becoming stuck in the rigid thoughts, judgments, feelings, and behaviors that easily occur when emotions run high. An important dialectical communication strategy is *irreverence*. Here, the practitioner flexibly shifts from a *reciprocal interaction style* (warm, engaged, and actively validating the client's emotional responses) to an *irreverent communication style* characterized by a matter-of-fact, jocular, or confrontational tone. Practitioners use irreverence to surprise the client, increase engagement, and shake up established patterns. Irreverent communications *must* come from a position of compassion and are used as a means of pushing the therapy forward.

DBT practitioners may use irreverence to go "where angels fear to tread"—as a device for discussing taboo or painful topics that are often avoided. For example, when a client expresses a desire to die, a therapist might remind the client he or she had agreed not to drop out of treatment or say something ridiculous like "They may not have pizza in the afterlife. Is that a risk you're willing to take?" After the client is knocked off balance, the therapist resumes a reciprocal style and reengages in problem-solving or further assessment.

Although more explicit in DBT, dialectical thinking also appears within an MI framework via double-sided reflections. Here, the practitioner points out the tension inherent in the client's ambivalence. For example, "A part of you wants to keep smoking. You find it calming and you've smoked for a very long time. At the same time, another part of you wants to quit smoking very badly. You have talked about how it's expensive and you are frightened of the damage it is doing to your lungs."

A Focus on Client Values

The MI practitioner embraces a flexible and open stance by following client values rather than imposing his or her own. It takes thorough assessment and well-honed listening skills for the practitioner to (a) actively built a working model of the client's value system from which to work, and (b) creatively evoke client exploration of how his or her values and behaviors align or misalign. Entering the conversation rigidly tethered to one's own belief system could destroy the therapeutic relationship and

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

undermine the spirit of the intervention. Clients' needs change dynamically throughout the course of therapy or a single conversation, and practitioners must be able to adjust their approach to match client goals. Discussions are catalyzed through reflection and validation of client values, support of client autonomy and flexibility, and open questions (Pollak et al., 2015). MI's theoretical and practical flexibility makes it especially well suited to increase clients' intrinsic motivation to change (Csillik, 2015).

Balancing a Focus on Acceptance *and* Change

DBT and MI practitioners also help their clients progress toward their goals by deliberately balancing a focus on acceptance and change. In DBT, a dialectical worldview enables the practitioner to dynamically blend acceptance and change strategies within individual sessions and across the course of treatment. As discussed earlier, a relentless focus on change can be overwhelming for clients with multiple complex problems. The issues to address may seem insurmountable—particularly for those who have difficulty tolerating distress. DBT's roots in Zen philosophy highlight the inherent value of accepting reality as it is. Acceptance strategies also provide a counterpoint to the urgency so often experienced when pushing for change. DBT practitioners accept the client as he or she is, as well as his or her current state of progress, and the status of the therapeutic relationship. This practice serves to model for clients how to accept themselves and reality as it is in the moment. Without accepting reality, effective change is unlikely to take root. For example, many clients become stuck in bargaining/wishing away their troubles or denying their current emotions rather than turning the mind toward acknowledging the reality of their situation. To promote an attitude of acceptance, DBT practitioners teach and practice mindfulness. This aids the client in becoming aware of their current thoughts, urges, feelings, etc., and ultimately facilitates change when paired with change-focused strategies.

MI also builds a bridge between acceptance and change. As stated above, MI directly recognizes and explores client ambivalence as a reality barring progress. Client exploration of problem behavior is strongly influenced by the practitioner's style. Using an MI style provides a therapeutic atmosphere that minimizes resistance and facilitates change (Miller, Benefield, & Tonigan, 1993). Practitioners roll with "client resistance" to change instead of trying to persuade (Miller & Rollnick, 2002). On the change-oriented side of the scale, the MI practitioner is an "opportunist"—listening carefully for communications regarding the client's own desire, ability, reasons, need, and commitment to enacting new or different behaviors. By highlighting and evoking change talk, the practitioner encourages more thoughtful self-exploration on the part of the client and deeper commitment to engaging in the work needed for improvement. The MI practitioner meets the client where he or she is, while simultaneously eliciting motivation to change, and eventually, planning next possible steps to capitalize on their enhanced motivation.

Balancing Being Directive and Following the Client

Another area of deliberate tension within DBT and MI involves maintaining a balance between direct instruction and following the client's lead. Each model views the client as the expert on his or her life and the practitioner as an expert on the intervention. The practitioner serves the client by functioning as a tree, moving its branches flexibly in response to the wind, yet remaining firmly rooted. Thus, as the client experiences dysregulation and is pulled hither-and-thither, the practitioner is responsive, and remains predictably stable and reliable. The practitioner will advocate for new behavior by making compelling and benevolent observations about the client's need to change and even request for them to do so (e.g., "we will not be able to continue working together if you are unable to attend your sessions at least once per month"). This always occurs in the context of a warm and accepting relationship that supports the client's freedom to choose (Koerner, 2012).

DBT practitioners are typically most directive when engaging in acute suicide risk reduction (e.g., telling the client not to kill him- or herself, instructing him/her to throw away a method of self-harm, insisting he or she present to the hospital, or—in extreme cases, calling the police for a safety check), and when engaged in skills coaching. Here, the client contacts the therapist when experiencing distress in their everyday life and the practitioner will suggest skill(s) to try. Depending on the client, the practitioner may insist the client attempt to use the suggested skills before calling back for further coaching as needed.

Although unusual in other models, MI practitioners may offer advice to the client *with permission*. They can bring up their own experiences working with clients in similar circumstances and what worked well and what didn't work for them. They may also provide psychoeducation on what scientific studies have shown regarding a particular issue and make specific recommendations based on those findings. Another important aspect of offering advice in MI is to avoid unloading information on the clients, and instead elicit the clients' perspectives on the information you provided and help them reach their own conclusions about what you shared. This is described

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

as the elicit-provide-elicit strategy. For example, an MI practitioner who is working with a client focused on his recovery from alcohol use may say, "Would it be alright if I shared my thoughts about your smoking? You would benefit tremendously from reducing or giving up cigarettes as part of your plan to quit drinking. Research studies have shown that, for many people, smoking and drinking go together. Working on giving up cigarettes may actually make it more likely that you will be successful in your decision to give up alcohol. So what are your thoughts about what I shared with you?" Finally, an MI practitioner may make suggestions based on their own understanding of the client's issue. For example, a practitioner once told a client that although she wished to reconcile with her mother (with whom she had historically a tumultuous relationship), it was not the time to do so given the recency of her sobriety and how fragile her recovery was at the time of the conversation.

Embracing a Nonjudgmental Stance

One of the most important areas of overlap across DBT and MI involves embracing a nonjudgmental stance. Within these models, behavior is simply behavior without any inherent moral value. Behaviors (even those that are maladaptive) occur for valid reasons and are seen as solutions to managing emotions. With rare exception, the client's value systems are what guide the treatment. This is not to say that practitioners do not acknowledge that certain behaviors probabilistically lead to certain outcomes or that some behaviors are generally helpful while others are harmful for client goals. For example, illicit drug use does put a client at risk for arrest, losing child custody, poor health, feelings of shame, financial difficulties, etc. However, these outcomes are discussed in relation to the client's own values and goals, not the therapist's or society's. Dialectically, drug use also dulls emotional pain and creates an escape; in MI, these aspects of the behavior would be explored with pros/cons. A nonjudgmental atmosphere encourages self-disclosure and self-critique, and opens the client and practitioner to giving and receiving sensitive, direct feedback.

Emphasis on Psycholinguistics and Word Choice

One of the most obvious and important ways DBT and MI work toward a nonjudgmental stance is by emphasizing the power of psycholinguistics and word choice. Practitioner language is consciously and intentionally selected to reduce stigma and unhelpful or inaccurate appraisals. DBT argues against using words that carry an evaluative quality that is difficult to observe, prove, or is nonspecific. For example, the terms "good/bad" and "right/wrong" are rejected as shorthand in favor of more nuanced, specific, and behaviorally observable descriptions. A "bad" mood is not specific enough for the client to respond adaptively. The precise nature of the person's emotional experience is important for determining what skill to use and how to effectively implement a strategy. As another example, the word "should" implies there is an objectively and universally preferable process/outcome (when this is rarely the case) and places undue pressure on the individual. Using obviously judgmental words, like "horrible," "pathetic," "stupid," and "best," often affects the person thinking/saying them in such a way as to induce greater discomfort than if he or she described or observed the situation more objectively. Thus, the DBT practitioner avoids judgmental language him/herself and encourages clients to do the same. Nonjudgmental language is often practiced in the context of mindfulness strategies, yet is given special attention throughout treatment sessions.

MI practitioners are exceptionally thoughtful with their language, cadence, and phrasing. Excess words are viewed as distracting and idiosyncratic utterances (e.g., "wow," "I see," "uh-huh") are conceptualized as adding little to no value to the therapeutic conversation. Using terms that imply client failure such as "relapse," "clean," or "dirty" are pejorative (e.g., "addict," "alcoholic") is highly discouraged. Most questions are framed as open-ended so as to encourage the client to explore their feelings on a given topic. Practitioners must therefore be especially self-aware and careful with their communications.

Both DBT and MI practitioners seek to use language as a primary means of validating elements of their clients' experience that are true or understandable. Linehan proposed six levels of validation, which include the following: (1) paying attention and listening nonjudgmentally; (2) accurately reflecting a person's thoughts, feelings, or emotions; (3) articulating another's unspoken thoughts and feelings; (4) communicating an understanding of the historical background of a behavior; (5) confirming thoughts, behaviors, and feelings as normal based on current circumstances; and (6) radical genuineness, or speaking authentically (Linehan, 1997; Woodberry, Miller, Glinski, Indik, & Mitchell, 2002). Reflections and affirmations are also methods of validating clients within the MI model as they demonstrate that the practitioner understands and values the client's experience. Through reflection, a practitioner may repeat or substitute synonyms to express close to what the speaker has said, make a restatement in which the speaker's meaning is inferred, or emphasize emotional aspects of communication through feeling statements. At times a practitioner may choose to overstate or understate a reflection to encourage a client to reconsider their position or belief

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

or explore a deeper commitment to their position or belief. Affirmations are statements that recognize client strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. They build confidence in one's ability to change. As with level-6 validation in DBT, affirmations must be genuine and congruent in order to be effective.

Theoretical Synthesis and Practical Application

There are a number of factors practitioners must consider when employing multiple approaches to treating an individual. Although DBT and MI share many central tenets, they serve distinct functions. Each offers unique and complementary strategies for enhancing clients' motivation and ability to change. For some, an integrative or sequenced application of these interventions may enhance client care. Yet, combined treatment is not universally indicated and we do not encourage practitioners to cobble together techniques from these approaches without first engaging in thorough case formulation. We advocate for evidence-based practice, where the merits of incorporating elements of DBT with MI (or vice versa) are considered on a client-by-client basis, applied deliberately, and assessed for efficacy.

Research is needed to formally assess who may derive the most incremental benefit from combined MI and DBT (above and beyond either delivered in isolation), identify the circumstances under which these interventions can be most effectively applied together, and evaluate the relative cost-effectiveness of a combined approach. Both DBT and MI require careful training and supervision for successful and ethical execution. Neither model reflects a simple technique but rather a complex set of counseling skills that require significant time and effort to learn. For example, research examining the use of therapists' validating language in DBT has found the effect of validation strategies differ based on the type of validation offered and the context in which it is used (Carson-Wong, Hughes, & Rizvi, 2018). The authors found validation can lead to increases in client positive *and* negative affect—highlighting the importance of appropriately identifying when to use specific techniques. Research is also needed to assess the degree of training and expertise a practitioner must accrue in *both* approaches to effectively integrate these models. These are empirical questions that will require longitudinal studies.

At the same time, we believe there are significant benefits associated with learning both modalities. Evidence suggests that using MI skills and strategies can enhance client adherence and outcomes when combined with CBT approaches (Hsieh et al., 2012; Spoelstra, Schueller, Hilton, & Ridenour, 2015). Furthermore, using an MI-style characterized by empathy, collaboration, and client-centeredness *specifically in response to markers of client ambivalence and therapist/client disagreement* significantly enhances outcomes within an overarching CBT framework (Aviram, Westra, Constantino, & Antony, 2016; Westra et al., 2016). Extrapolating from these findings, we believe incorporating a person-centered MI approach into DBT may be best suited to addressing client or practitioner ambivalence, low motivation, alliance ruptures, or willfulness. These behaviors wax and wane throughout the course of treatment. Although MI is often presented as a preparatory or prelude intervention for a specialized treatment (e.g., for depression), preliminary evidence supports its repeated use throughout a broader therapy (Aviram et al., 2016; Westra et al., 2016).

Engaging and retaining clients in treatment is essential to the success of any modality, yet is particularly challenging among groups who have been stigmatized, marginalized, or have experienced previous treatment failure (Maura & Weisman de Mamani, 2017; Mckowen et al., 2017). MI is a gold-standard model for increasing client engagement transdiagnostically (Mistler, Sheidow, & Davis, 2016) and is particularly efficacious with groups that historically have lower retention rates (e.g., Bachiller et al., 2015; Hettema et al., 2005; Mistler et al., 2016). Thus, a combined approach may be particularly helpful for clients from traditionally underrepresented and marginalized groups, who may otherwise be at increased risk for treatment discontinuation. Furthermore, DBT is quite intensive, and often lengthy. Interweaving MI throughout DBT may result in increased client commitment to therapy, more engagement in treatment processes, and greater clarity about the reasons for skills use (resulting in greater skills generalization).

The MI practitioner who learns DBT will find that he or she has a number of effective skills to teach that further mobilize clients to take advantage of their enhanced motivation to change. The assumption of MI is that an individual has the skills to implement desired change if his or her motivation is activated. However, many individuals who could benefit from motivational enhancement also lack sufficient skills to cope effectively with internal and external stressors. In fact, repeatedly struggling with poor support and skills deficits may function to lower an individual's motivation to change (e.g., learned helplessness; Thornton et al., 2003). Incorporating DBT skills and chain analysis into MI conversations may be especially helpful in inpatient and other highly structured settings where clients engage in brief MI sessions and have significant remaining time on the unit to practice new skills that may benefit them upon discharge.

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

DBT and MI are two truly harmonious approaches—each functioning in such a way as to enhance the qualities of the other. Practitioners who are fluent in one modality may more deeply understand the second due to corresponding fundamental principles. In order to illustrate application of a combined approach, consider the following case vignettes.[1]

Case Vignettes

Sarah is a 46-year-old woman presenting to a comprehensive DBT treatment center for severe difficulties with emotion regulation and behavioral impulsivity. She has elected to discontinue a number of other treatments over the previous 5 years, as she felt they were unhelpful. Sarah describes desperately wanting to find "something that works" for her, and expresses considerable frustration with previous treatment experiences and hopelessness about recovery. Upon hearing this element of the client's history, the provider elects to engage in a brief MI conversation to assess Sarah's level of ambivalence about enrolling in an intensive program after multiple treatment discontinuations. The following conversation illustrates how the practitioner might use MI to enhance Sarah's commitment to engaging in DBT by using reflections, affirmations, open questions, and summarizing statements. She highlights Sarah's underlying motivations for treatment by tying in her unique values and increasing Sarah's sense of responsibility and capability to follow-through with DBT.

"You have tried a number of different treatments and feel exhausted from the effort."
"*Yes. I feel like nothing works. It's so tiring to keep jumping around.*"
"You are frustrated and disappointed. You have stopped attending therapy in the past. At the same time, you have come here to receive DBT."
"*Well, yeah. I need help.*"
"You are willing to try another approach because you are very distressed. Your life is unlivable as it currently is. You need support."
"*Right.*"
"How would your life be different if this treatment were successful?"
"*I would see a lot more of my kids. They won't talk to me unless I get therapy. I would be able to get a job again. I lost my last one because I yelled at customers. I just feel angry all the time. Something has got to change.*"
"You are fed-up. You want to think more clearly and get along with others. How did you make the decision to leave the other treatments you have started in the past?"
"*I didn't feel like those others were doing anything.*"
"Help me understand what the other approaches you tried looked like for you. What were you doing in and between sessions to work on your anger and your relationships?"
"*I don't know. I met with the therapists a few times, but it didn't change anything.*"
"You met with providers but did not do any practice between sessions. You talked with providers for a few weeks and then made the decision to leave when you still felt angry, distant from your children, and continued to experience difficulty at work. May I share with you some of the ways DBT looks different from what you have described?"
"*Yeah.*"
"You will meet with your provider weekly for individual therapy like the other approaches. However, there is a great deal more that will be expected of you. You will also attend a skills group every week and be given skills to use at home between sessions. For example, we will cover distress tolerance strategies designed to help you make it through a crisis without worsening the situation, emotion regulation skills to help you understand and decrease your anger over time, and interpersonal effectiveness skills that might help you improve your relationship with your kids. It's very important that you practice skills in your real life as often as you can. That's how you will really benefit from treatment. You will be able to call for coaching if you get stuck. It will be very important for you to attend our visits and the skills group every week. We sign a contract that I will go over with you if we decide DBT is a good fit. We both agree to work together for 6 months. That is a much longer length of time than you have participated in other treatments and DBT requires a tremendous amount of work. How does that fit with your expectations for therapy?"
"*6 months is a long time.*"
"It is. You are on the fence about whether or not you want to sign up for this. Part of you is feeling overwhelmed by the commitment required for this treatment. Another part of you is willing to do anything to connect with your children, be able to hold a steady job, and feel in control of your anger. These are huge motivators for you. You are the only one who can decide if DBT is right for you."

Here, a sequenced approach is used where the practitioner saw the potential benefit of using MI to strengthen client commitment to full-program DBT. This short excerpt demonstrates how MI might be used to explore Sarah's ambivalence about treatment prior to enrolling in an intensive program. A second vignette

[1] All information in presented case vignettes was generated for demonstration purposes. The clients described are not based on specific individuals.

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

illustrates how DBT skills may be incorporated into an MI session.

> Greg is a 21-year-old man who presented to an inpatient detox facility for heroin and alcohol use. His practitioner is engaging Greg in an MI session targeting his substance use. Greg identifies a number of reasons to reduce his substance use, engage in treatment, and discusses a high sense of urgency to do so now before he enters a community college setting (where he hopes to earn high grades in order to attain better employment). When exploring the factors contributing to his use, Greg identifies that he often uses heroin after fighting with his mother, with whom he lives. He states that moving out would aid with his recovery, yet expresses serious reservations about telling his mother. Greg states he's tried to speak with her on several occasions and it has ended in a fight each time. The MI practitioner sees an opportunity to capitalize on Greg's motivation to decrease his substance use by teaching him an interpersonal effectiveness skill from DBT. This skill is designed to help people effectively ask for what they need from others. After asking permission, the practitioner shares the skill with Greg, and elicits feedback about what it might be like to use such a skill with his mother.

Here, a DBT skill was woven into an MI session. This may be particularly helpful in cases where clients are seen in inpatient or primary care settings where the practitioner and client will have a limited number of interactions. Supplementing MI's focus on increased commitment to change behavior with appropriate practical skills may aid clients in achieving their goals. The practitioner remains adherent to MI throughout the interaction. See Table 2 for a list of practical tips when practicing these approaches.

Conclusion

DBT and MI are distinct interventions that share a number of common principles. Each focuses on holding the client's perspective and values as the guiding light for the intervention, while the practitioner also keeps the session goal-oriented and focused. Practitioners deliberately interact with clients in an authentic manner. Both DBT and MI are creative approaches that function to increase practitioner and client flexibility in how they conceptualize, and strategize to manage or modify, problem behavior. Moving toward client goals often involves a degree of acceptance in addition to identifying areas for change. The exploration of both acceptance and change is considered complementary and part of the same process toward health. Although DBT and MI differ considerably in their length, scope, and delivery, each highlights the great importance of a nonjudgmental stance and building effective rapport through purposeful and mindful listening to the client. This creates a deeper understanding of client needs, motivations, and strengths. Some areas of overlap between MI and DBT are also shared with other mindfulness-based behavioral therapies. For example, mindfulness-based cognitive behavioral therapy (MCBT) also highlights the balance between focusing on acceptance and change (Kahl, Winter, & Schweiger, 2012; Lau & McMain, 2005). MI may also be effectively combined with such therapies.

Practicing DBT and MI will likely influence how practitioners engage with the world around them in day-to-day life (Douaihy et al., 2015; Jergensen, 2017). Many report that learning these interventions profoundly changed their interactions with clients, enhanced their personal relationships, increased their effectiveness when managing personal difficulties, and increased their awareness of personal values. DBT encourages practitioners to incorporate skills practice into their daily repertoire. Thus, practitioners are able to authentically speak to the worth and difficulties associated

Table 2
Tips for Practitioners When Implementing DBT and MI

Practice	Avoid
Adopting a non-judgmental stance • Use non-pejorative, descriptive language • Keeping your client's values at the forefront of your work (while also recognizing where they deviate from your own)	Imposing your values on your client Evaluative language • Good/bad, right/wrong
Seeking to understand your client's unique value system; identifying what is most important to the client and finding the "why" underlying the treatment.	Making assumptions about what your client wants/needs/believes.
Thinking creatively, accepting client's perspectives as inherently valid	Rigidity, assuming you know what's best, assuming that what works for one client or situation will work for another
Dynamically moving between focusing on acceptance and focusing on change	Focusing solely on what needs to be different, strictly providing warmth and validation.
Reflection and open-ended questions	Close-ended questions

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

with applying intervention strategies, model effective skills usage, and benefit directly from skills usage themselves (Douaihy et al., 2015; Jergensen, 2017). In sum, learning principles of these approaches can be helpful in guiding practitioners seeking to improve their interactions with their clients.

References

Aviram, A., Westra, H. A., Constantino, M. J., & Antony, M. M. (2016). Responsive management of early resistance in cognitive–behavioral therapy for generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 84*(9), 783–794, https://doi.org/10.1037/ccp0000100.supp (Supplemental).

Bachiller, D., Grau-López, L., Barral, C., Daigre, C., Alberich, C., Rodríguez-Cintas, L., & Roncero, C. (2015). Motivational interviewing group at inpatient detoxification, its influence in maintaining abstinence and treatment retention after discharge. *Adicciones, 27*, 109–118 https://doi-org.ezproxy.lib.utah.edu/10.20882/adicciones.696.

Behavioral Tech (2016). Peer-Reviewed & Published Randomized Controlled/Comparative Trials. Retrieved from:. , https://behavioraltech.org/wp-content/uploads/2018/04/RCT4ModesResearchDatatoDate2016.06.28-new-logo.pdf.

Brodsky, B. S., Cabaniss, D. L., Arbuckle, M., Oquendo, M. A., & Stanley, B. (2017). Teaching Dialectical Behavior Therapy to psychiatry residents: The Columbia psychiatry residency DBT curriculum. *Academic Psychiatry, 41*, 10–15, https://doi.org/10.1007/s40596-016-0593-0.

Carson-Wong, A., Hughes, C. D., & Rizvi, S. L. (2018). The effect of therapist use of validation strategies on change in client emotion in individual dbt treatment sessions.*Personality Disorders, Theory, Research, and Treatment, 9*, 165–171 https://doi-org.ezproxy.lib.utah.edu/10.1037/per0000229.

Csillik, A. (2015). Positive motivational interviewing: Activating clients' strengths and intrinsic motivation to change. *Journal of Contemporary Psychotherapy, 45*, 119–128, https://doi.org/10.1007/s10879-014-9288-6.

Davidson, F., Cave, M., Reedman, R., Briffa, D., & Dark, F. (2012). Dialectical Behavioral Therapy informed treatment with deaf mental health consumers: An Australian pilot program. *Australasian Psychiatry, 20*, 425–428, https://doi.org/10.1177/1039856212458981.

DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational Interviewing, enhancement, and brief interventions over the last decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors, 31*, 862–887, https://doi.org/10.1037/adb0000318.

Douaihy, A., Gold, M. A., & Kelly, T. M. (2015). *Motivational interviewing: A guide for medical trainees*. New York: Oxford University Press.

Drapkin, M. L., Wilbourne, P., Manuel, J. K., Baer, J., Karlin, B., & Raffa, S. (2016). National dissemination of motivation enhancement therapy in the Veterans Health Administration: Training program design and initial outcomes. *Journal of Substance Abuse Treatment, 6*583–6587, https://doi.org/10.1016/j.jsat.2016.02.002.

Feliu-Soler, A., Cebolla, A., McCracken, L. M., D'Amico, F., Knapp, M., López-Montoyo, A., & Luciano, J. V. (2018). Economic impact of third-wave cognitive behavioral therapies: A systematic review and quality assessment of economic evaluations in randomized controlled trials. *Behavior Therapy, 49*, 124–147, https://doi.org/10.1016/j.beth.2017.07.001.

Goldstein, T. R., Fersch-Podrat, R. K., Rivera, M., Axelson, D. A., Merranko, J., Yu, H., & Birmaher, B. (2015). Dialectical behavior therapy for adolescents with bipolar disorder: Results from a pilot randomized trial. *Journal of Child and Adolescent Psychopharmacology, 25*, 140–149, https://doi.org/10.1089/cap.2013.0145.

Hawkins, K. A., & Sinha, R. (1998). Can line practitioners master the conceptual complexities of dialectical behavior therapy? An evaluation of a State Department of Mental Health training program. *Journal of Psychiatric Research, 32*, 379–384, https://doi.org/10.1016/S0022-3956(98)00030-2.

Herschell, A. D., Lindhiem, O. J., Kogan, J. N., Celedonia, K. L., & Stein, B. D. (2014). Evaluation of an implementation initiative for embedding Dialectical Behavior Therapy in community settings. *Evaluation and Program Planning, 4*355–4363, https://doi.org/10.1016/j.evalprogplan.2013.10.007.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91–111, https://doi.org/10.1146/annurev.clinpsy.1.102803.143833.

Hettema, J. E., Barbir, L. A., Viar, K. R., & Hund, L. (2017). Collaborative information exchange using elicit-provide-elicit to reduce risky drinking among college students. *Journal of Communication in Healthcare, 10*, 108–115, https://doi.org/10.1080/17538068.2017.1336359.

Hsieh, M. -Y., Ponsford, J., Wong, D., Schönberger, M., Taffe, J., & Mckay, A. (2012). Motivational interviewing and cognitive behaviour therapy for anxiety following traumatic brain injury: A pilot randomised controlled trial.*Neuropsychological Rehabilitation, 22*, 585–608 https://doi-org.ezproxy.lib.utah.edu/10.1080/09602011.2012.678860.

Jergensen, K. (2017). Practice what you preach: An exploration of DBT therapists personal skill utilization in burnout prevention.*Clinical Social Work Journal* https://doi-org.ezproxy.lib.utah.edu/10.1007/s10615-017-0633-6.

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: What is new and what is effective? *Current Opinion in Psychiatry, 25*, 522–528, https://doi.org/10.1097/YCO.0b013e328358e531.

Koerner, K. (2012). *Doing dialectical behavior therapy: A practical guide*. New York: Guilford Press.

Landes, S. J., Rodriguez, A. L., Smith, B. N., Matthieu, M. M., Trent, L. R., Kemp, J., & Thompson, C. (2017). Barriers, facilitators, and benefits of implementation of dialectical behavior therapy in routine care: Results from a national program evaluation survey in the Veterans Health Administration. *Translational Behavioral Medicine, 7*, 832–844, https://doi.org/10.1007/s13142-017-0465-5.

Lau, M. A., & McMain, S. F. (2005). Integrating mindfulness meditation with cognitive and behavioural therapies: The challenge of combining acceptance- and change-based strategies.*The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie, 50*, 863–869 Retrieved from , http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-11303-010&site=ehost-live.

Linehan, M. M. (1997). Validation and psychotherapy. In B. C. Greenberg (Ed.), *Empathy reconsidered: New Directions* Washington DC: APA.

Linehan Institute (2018). Evidence for DBT. Retrieved from. , https://linehaninstitute.or/evidence-for-dbt/.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Linehan, M. M. (2015). *DBT® skills training manual*, 2nd ed. New York: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064, https://doi.org/10.1001/archpsyc.1991.01810360024003.

Linehan, M. M., Dimeff, L., Koerner, K., & Miga, E. M. (2013). Research on Dialectical Behavior Therapy: Summary on non-RCT studies. Retrieved from. , https://behavioraltech.org/wp-content/uploads/2018/04/Non-RCTs-Research-Data-to-Date-2013.12-new-logo.pdf.

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review.*Journal of Clinical Psychology in Medical Settings, 24*, 187–210 https://doi-org.ezproxy.lib.utah.edu/10.1007/s10880-017-9510-2.

McFarr, L., Gaona, L., Barr, N., Ramirez, U., Henriquez, S., Farias, A., & Flores, D. (2014). Cultural considerations in dialectical behavior therapy. In A. Masuda, & A. Masuda (Eds.), *Mindfulness and*

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004

acceptance in multicultural competency: A contextual approach to sociocultural diversity in theory and practice (pp. 75–92). Oakland, CA: Context Press/New Harbinger Publications.

Mckowen, J., Carrellas, N., Zulauf, C., Ward, E. N., Fried, R., & Wilens, T. (2017). Factors associated with attrition in substance using patients enrolled in an intensive outpatient program.*American Journal on Addictions, 26*, 780–787 https://doi-org.ezproxy.lib.utah.edu/10.1111/ajad.12619.

Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psycho-therapy, 11*, 147–172.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*, 455–461.

Miller, W. R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour*. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*, 2nd ed. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping people change*, 1st ed. NY: Guilford Press.

Mistler, L. A., Sheidow, A. J., & Davis, M. (2016). Transdiagnostic motivational enhancement therapy to reduce treatment attrition: Use in emerging adults.*Cognitive and Behavioral Practice, 23*, 368–384 https://doi-org.ezproxy.lib.utah.edu/10.1016/j.cbpra.2015.09.007.

Neighbors, C. J., Barnett, N. P., Rohsenow, D. J., Colby, S. M., & Monti, P. M. (2010). Cost-effectiveness of a motivational intervention for alcohol-involved youth in a hospital emergency department. *Journal of Studies on Alcohol and Drugs, 71*, 384–394, https://doi.org/10.15288/jsad.2010.71 .384.

O'Donohue, W., & Fisher, J. E. (Eds.). (2009). *Cognitive behavior therapy: Applying empirically supported techniques in your practice*, 2nd ed. Hoboken, NJ: Wiley.

Pollak, K. I., Jones, J., Lum, H. D., De La Cruz, S., Felton, S., Gill, A., & Kutner, J. S. (2015). Patient and caregiver opinions of motivational interviewing techniques in role-played palliative care conversations: A pilot study. *Journal of Pain and Symptom Management, 50*, 91–98, https://doi.org/10.1016/j.jpainsymman.2015.02.003.

Priebe, S., Bhatti, N., Barnicot, K., Bremner, S., Gaglia, A., Katsakou, C., & Zinkler, M. (2012). Effectiveness and cost-effectiveness of dialectical behaviour therapy for self-harming patients with personality disorder: A pragmatic randomised controlled trial. *Psychotherapy and Psychosomatics, 81*, 356–365, https://doi.org/10.1159/000338897.

Rogers, C. R. (1959). The essence of psychotherapy: A client-centered view. *Annals of Psychotherapy*, 151–157.

Rollnick, S., Heather, N., & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health, 1*, 25–37, https://doi.org/10.3109/09638239209034509.

Rosengren, D. B. (2017). *Building Motivational Interviewing skills: A practitioner workbook*, 2nd ed. New York: Guilford Press.

Spoelstra, S. L., Schueller, M., Hilton, M., & Ridenour, K. (2015). Interventions combining motivational interviewing and cognitive behaviour to promote medication adherence: A literature review. *Journal of Clinical Nursing, 24*, 1163–1173 https://doi-org.ezproxy.lib.utah.edu/10.1111/jocn.12738.

Thornton, C. C., Patkar, A. A., Murray, H. W., Mannelli, P., Gottheil, E., Vergare, M. J., & Weinstein, S. P. (2003). High- and low-structure treatments for substance dependence: Role of learned helplessness.*American Journal of Drug and Alcohol Abuse, 29*, 567–584 https://doi-org.ezproxy.lib.utah.edu/10.1081/ADA-120023459.

Westra, H. A., Constantino, M. J., & Antony, M. M. (2016). Integrating motivational interviewing with cognitive-behavioral therapy for severe generalized anxiety disorder: An allegiance-controlled randomized clinical trial.*Journal of Consulting and Clinical Psychology, 84*, 768–782 https://doi-org.ezproxy.lib.utah.edu/10.1037/ccp0000098.

Woodberry, K. A., Miller, A. L., Glinski, J., Indik, J., & Mitchell, A. G. (2002). Family therapy and dialectical behavior therapy with adolescents: Part II: A theorical review.*American Journal of Psychotherapy, 56*(4), 585–602 Retrieved from. , http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2003-01021-011&site=ehost-live.

The authors would like to acknowledge Nina Hotkowski and Rachel Fersch for their valuable consultation.

Address correspondence to Erin A. Kaufman, Ph.D., University of Western Ontario, Westminster Hall, 361 Windermere Road, London, ON N6A 3K7.; e-mail: erin.anne.kaufman@gmail.com.

Received: January 21, 2019
Accepted: July 5, 2019

Please cite this article as: Kaufman et al., Dialectical Behavior Therapy and Motivational Interviewing: Conceptual Convergence, Compatibility, and Strategies for Integration..., (2019), https://doi.org/10.1016/j.cbpra.2019.07.004