Published in final edited form as:
Cogn Behav Pract. 2011 February 1; 18: 28–37. doi:10.1016/j.cbpra.2009.06.009.

Using Motivational Interviewing to Enhance Treatment Outcome in People With Obsessive-Compulsive Disorder

Helen Blair Simpson and
Columbia University/New York State Psychiatric Institute

Allan Zuckoff
Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine

Abstract

Obsessive-compulsive disorder (OCD) is a leading cause of health-related disability. There are two evidence-based treatments for OCD, pharmacotherapy and cognitive-behavioral therapy consisting of exposure and response prevention (EX/RP). Although effective, outcome from both treatments is often limited by patient lack of adherence to the treatment procedures. In this article, we present the rationale for using motivational interviewing (MI) to increase EX/RP adherence. We then review two published studies that used MI in different ways to foster EX/RP participation. Finally, we describe 6 cases in which we explored whether MI could help ready OCD patients who had refused or failed prior evidence-based treatment of any kind. Together, these data illustrate the promise and obstacles of employing MI to promote treatment adherence in OCD. We conclude by discussing future directions for researchers and for clinicians when using MI in this population.

Obsessive-compulsive disorder (OCD) is a leading cause of health-related disability (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2008; Murray & Lopez, 1996). The two evidence-based treatments for OCD are pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT) consisting of exposure and response prevention (EX/RP; American Psychiatric Association, 2007). Unfortunately, outcome from both treatments can be limited by patients' lack of adherence to the treatment procedures. For example, in a large randomized controlled trial that delivered EX/RP in an intensive format (Foa et al., 2005), the remission rate of those who completed the trial was 71% but was only 52% for all participants, including those who dropped out (Simpson, Huppert, Petkova, Foa, & Liebowitz, 2006). Therefore, one way to improve the outcome of people with OCD is to increase adherence to these evidence-based treatments.

One reason why patients may not adhere to treatment is that they are "ambivalent" about change (i.e., experience a conflict between mutually exclusive courses of action). Motivational interviewing (MI) is a client-centered, goal-oriented therapeutic method for enhancing a person's motivation to change by exploring and resolving this type of ambivalence (Miller, 2006; Miller & Rollnick, 2002). First developed to help motivate problem drinkers to change their use of alcohol (Miller, 1983), MI has since been shown to be effective at enhancing treatment entry and adherence when used as a prelude or an adjunct to other treatments (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller,

Address correspondence to: Helen Blair Simpson, M.D., Ph.D., Anxiety Disorders Clinic, New York Psychiatric Institute, Unit 69, 1051 Riverside Drive, New York, NY 10032; simpson@nyspi.cpmc.columbia.edu.

2005; Zweben & Zuckoff, 2002). We and others have begun to study whether MI can help people with OCD enter and adhere to evidence-based treatments for OCD.

In this article, we first review the rationale for using MI with OCD patients to enhance EX/RP participation. Then, we describe two published studies that used MI in different ways to foster EX/RP participation. Finally, we describe six cases in which we explored whether MI could help ready OCD patients who had refused or failed prior evidence-based treatment of any kind. Together, these data illustrate the promise and obstacles of employing MI for these purposes. We conclude by discussing future directions for researchers and for clinicians when using MI in this population.

Rationale for Using MI to Foster EX/RP Participation

Conceptualizing Treatment Resistance as Ambivalence

EX/RP teaches people new strategies to cope with obsessions and compulsions (Kozak & Foa, 1997). Specifically, patients are taught to confront what they fear ("exposure") and to refrain from performing compulsions when doing so ("response prevention"). Exposures involve live confrontations with feared situations (e.g., touching objects in public bathrooms for a patient with contamination fears) and imaginal confrontations with feared consequences (e.g., imagining killing someone for someone with aggressive concerns). The goal is to weaken the associations between feared stimuli and distress and between ritualizing and relief from distress and to confront and correct mistaken OCD beliefs. To achieve this goal, patients must be willing to face their fears for a prolonged period without ritualizing, allowing disconfirmation of their feared consequences and eventual reduction of the anxiety and discomfort.

As mentioned above, EX/RP is an efficacious treatment for some with OCD, but its effectiveness is limited in others by patient refusal, patient dropout, and partial adherence to the EX/RP procedures (Foa et al., 2005; Simpson et al., 2006). One way to conceptualize OCD patients who begin but then do not participate fully in EX/RP treatment is that they are "ambivalent." Specifically, as described by Miller and Rollnick (2002), they are caught between mutually exclusive courses of action: they want to reduce the time spent obsessing and compulsing and the impact of these symptomatic behaviors on their lives, but they are unwilling or unable to carry out fully and consistently the treatment procedures that would enable them to achieve that goal (e.g., because they perceive benefits as well as costs of their symptomatic behaviors, because of the aversiveness of the procedures, or both). Importantly, patients who refuse treatment altogether may or may not be ambivalent as conceptualized above.

Using MI to Resolve Ambivalence and Increase Motivation for Change

Based on this conceptualization, there are theoretical and empirical reasons to think that MI might help OCD patients participate more fully in EX/RP treatment. In EX/RP, OCD patients are asked to change what they do in response to obsessions (i.e., to expose themselves to feared stimuli without ritualizing or avoiding). To make such a change requires the willingness to tolerate the considerable anxiety and discomfort such exposures evoke and to commit substantial time and energy to a highly structured and demanding treatment. If ambivalence about making these changes were explored and resolved such that patients were more committed to engaging in the treatment procedures, patients might participate more fully in EX/RP.

MI has been proven effective at promoting treatment adherence in other populations. For example, MI has motivated alcohol abusers to adhere to alcohol treatment (Connors, Walitzer, & Dermen, 2002), pain patients to attend a pain reduction workshop (Habib,

Morrissey, & Helmes, 2005), obese women with diabetes to adhere to behavioral weight control treatment (West, DiLillo, Bursac, Gore, & Greene, 2007), and depressed Hispanic patients to take antidepressants (Lewis-Fernandez et al., in submission). In all cases, MI can be conceived of as increasing motivation to do something difficult or unpleasant in the short-term (i.e., follow treatment directives to resist urges to drink, engage in difficult physical rehabilitation activities, self-monitor dietary intake and blood-sugar levels, or take medications) for long-term gain. Analogously, MI might also be able to help motivate OCD patients to ignore urges to ritualize (even if rituals relieve short-term distress) and to confront fears (even if exposures produce short-term distress) for the long-term gain of reduced OCD symptoms. More specifically, there are promising data that MI can help motivate behavioral change related to fear or anxiety. For example, in a randomized controlled trial involving 55 patients, Westra and Dozois (2006) found three MI sessions prior to group CBT for patients with panic disorder, generalized anxiety disorder, or social phobia led to significantly greater homework compliance and a significantly higher rate of CBT responders (75% versus 50%) than group CBT alone.

There are additional reasons that make MI attractive as an adjunctive treatment to EX/RP. First, individual OCD patients give many different reasons for EX/RP refusal, attrition, and partial adherence in OCD. The structure of MI (e.g., open-ended questioning, reflective listening) permits the exploration and identification of individual patients' reasons, enabling the therapist to target treatment barriers specific to individual patients. Second, many aspects of MI are complementary with EX/RP's goals. For example, standard EX/RP relies upon a strong therapeutic alliance (since the patient is going to be asked to risk, in the therapist's presence, a frightening exposure), a sense of collaboration (since the treatment is tailored to the patient's OCD and adjusted according to the patient's experience), and on a patient's sense of self-efficacy (since the ultimate goal of treatment is for patients to do exposures on their own in everyday life; Huppert & Franklin, 2005). MI was designed to promote all of these. Third, MI does not include techniques that could undermine EX/RP, such as "neutralizing" (i.e., canceling out unwanted thoughts with positive alternatives).

Advantages of formally adapting the MI model include the following:

1. MI enables the packaging, integration, and specification of MI-congruent techniques sometimes used by expert therapists (e.g., evaluating the pros and cons of behavior change) but not systematically applied or explicated in EX/RP manuals.
2. MI provides additional MI-specific strategies developed to enhance motivation for change (e.g., eliciting change talk, rolling with rather than confronting resistance).
3. MI provides a clear theoretical and practical model for how and when to use these motivational techniques (e.g., focusing the therapist on assessing at all moments the patient's motivation and not "getting ahead" of where the patient is in terms of readiness to change, as might happen if a therapist strictly followed a standard EX/RP manual).
4. MI permits the delivery of these techniques in a focused and time-limited fashion.

In sum, MI is a novel strategy for enhancing EX/RP participation that is worth exploring.

Clinical Application

Published Studies Using MI With OCD Patients to Foster EX/RP Participation

To date, there are two small published studies that used MI in different ways to foster EX/RP participation. In the first study, Maltby and Tolin (2005) developed a brief, 4-session

readiness intervention that was intended to decrease EX/RP refusal among patients with OCD. The readiness intervention consisted of 4 individual visits with a therapist over 1 month and was comprised of several different components: (a) psychoeducation focused on OCD and the empirical data supporting the efficacy of EX/RP; (b) explicit use of MI procedures in 2 of the 4 sessions; (c) presentation of a videotape about EX/RP; (d) construction of a sample exposure hierarchy; (e) speaking with a patient who had completed EX/RP.

Twelve patients who had previously refused EX/RP (for other than logistical reasons) were randomly assigned to receive this readiness intervention (n =7) or to remain on a wait list (n=5) for 1 month. After 1 month, they were offered 15 EX/RP sessions. Of the participants who received the readiness intervention, 86% agreed to begin EX/RP treatment as compared to 20% of those who received the wait-list condition. When EX/RP treatment followed the readiness intervention (but not when it followed the wait-list condition), patients experienced a decrease in OCD symptoms comparable to that observed in OCD patients who did not refuse EX/RP. However, the dropout rate for EX/RP following the readiness intervention was 50%, a rate higher than the typical EX/RP dropout rate.

These data provide preliminary support for the hypothesis that a multimodal intervention that includes some MI elements can increase the rates of acceptance of EX/RP, but suggest that this intervention is insufficient to prevent later dropout. However, the small sample size precludes strong conclusions. Moreover, the fact that the readiness intervention was multimodal makes it impossible to ascertain the importance of the addition of the MI procedures per se.

Simpson and colleagues (Simpson, Zuckoff, Page, Franklin, & Foa, 2008) developed an alternative way of using MI to enhance EX/RP participation. Specifically, MI was combined with standard EX/RP treatment to target patients who enter EX/RP and then drop out or only partially adhere to the EX/RP procedures. The goal was to determine whether integrating MI into standard EX/RP can enhance EX/RP retention and adherence and thereby improve outcome.

This integration is described in detail elsewhere (Simpson, Zuckoff, et al., 2008). In brief, the 2 standard introductory sessions of EX/RP were expanded into 3. The goals of these introductory sessions were to accomplish the assessment, psychoeducation, and treatment planning tasks that normally occur during the 2 introductory sessions of standard EX/RP and to add MI strategies to evoke commitment to change as well as commitment to treatment. In addition, a short (15–30 minute) MI module was developed for use if resistance to EX/RP procedures arose during the 15 exposure sessions. The therapist was to shift into this module if standard methods for handling resistance (e.g., psychoeducation, encouragement) were insufficient to achieve adherence with the key procedures of EX/RP.

Six patients received this EX/RP-MI intervention in an open prospective pilot trial (Simpson, Zuckoff, et al., 2008), and all but 1 completed EX/RP treatment. Five showed a decrease in the severity of their OCD symptoms and an increase in their quality of life and 3 achieved an excellent response, with no to minimal symptoms at the end of treatment. The outcome in these 6 patients was at least as good as seen with standard EX/RP (Foa et al., 2005; Simpson, Foa, et al., 2008).

These preliminary data suggest that MI can be combined with EX/RP without diluting the effectiveness of EX/RP. Whether the addition of MI leads to superior adherence and outcome than can be achieved with standard EX/RP is now being examined in a controlled trial comparing EX/RP+MI to standard EX/RP alone. The fact that one patient in this open

trial refused to engage in EX/RP procedures despite the addition of MI serves as a useful reminder that MI is not a panacea; MI is only likely to be helpful if the main barrier to EX/RP engagement is patient ambivalence, the therapist can access this ambivalence in session, and the patient values something more than sustaining the status quo (Miller & Rollnick, 2002).

Can MI Be Used to Foster Participation in Any Evidence-Based Treatment for OCD?

Given this work to date, we wondered whether MI could be used more generally to facilitate the use of any evidence-based treatment in OCD. To explore this idea, 6 OCD patients with a documented history of refusing evidence-based treatment were recruited and provided 4 MI sessions by the first author. The goal of the MI sessions was to enhance motivation for evidence-based OCD treatment. We hypothesized that self-report measures of readiness to change would increase after the 4 sessions and that the use of evidence-based OCD treatment (either medication or EX/RP) would increase by 1 month of follow-up. This study was approved by the New York State Psychiatric Institute Institutional Review Board. Participants provided written informed consent.

Demographic and clinical characteristics of the 6 patients are shown in Table 1. All met criteria for OCD as their principal psychiatric diagnosis as determined by skilled clinicians and confirmed by the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1996). Three patients had a mixture of OCD symptoms, although their primary symptoms included aggressive obsessions and checking rituals (A), symmetry and exactness obsessions with repeating and checking rituals (B), and contamination obsessions and washing rituals (C). Three patients were primary hoarders (D, E, F). Only one patient (C) was receiving psychiatric medication at the time of participation, although all had received prior SRI trials with variable response as well as other psychiatric medications. All had also previously tried EX/RP with a skilled therapist. However, they had dropped out of treatment (B, D), did not participate fully in treatment (e.g., refused certain exposures and did not stop all rituals, A, E, F), or did well during treatment but relapsed once contact with the therapist stopped (C).

Patients received 4 weekly sessions that each lasted 1 hour. The 4 sessions used MI strategies and were conducted in an MI spirit (Miller & Rollnick, 2002). At the same time, the sessions were structured as follows. In Session 1, the therapist began by engaging patients in a discussion of what patients identified as their main problem (without assuming a priori that it was OCD, or that the patient would call it OCD). After developing a shared perspective about the problem, the therapist then elicited how this problem affected patients' lives, with the aim of increasing motivation for change by developing discrepancy between how they would like their life to be and how it was. The therapist also assessed how important patients felt it was to make a change in their OCD symptoms and worked to increase the importance of change as needed. Assuming that the patient expressed that change was important, Session 2 focused on assessing and building confidence for change. This included reviewing patients' prior attempts at change. In the process, the therapist was attentive to patients' expressed ambivalence about OCD treatments, specifically eliciting patients' perspective on any negative aspects as well as why the treatments failed (Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007). The therapist's goal was to build confidence in change by reflecting what had worked in the past, providing a different perspective on past failures where appropriate (e.g., attributing disappointing outcomes to factors other than the efficacy and appropriateness of evidence-based treatments or patients' inability to succeed), and offering key information about evidence-based treatments in an MI-congruent way when asked. Inevitably, ambivalence not only about treatments but also about change emerged in these discussions, and the therapist shifted between building importance for change and building confidence in being able to effect change as necessary. Assuming that

the patient expressed that change was necessary and possible, Session 3 focused on what options for change patients were considering now, if any. This entailed discussing both evidence-based and non-evidence-based treatments that patients were considering. The goal was to help those patients who appeared ready (as indicated by their level of change talk in Sessions 1 and 2) to express not only a desire to change but also a commitment to change through engaging in evidence-based treatment. If a commitment to change was enunciated by the patient, Session 4 was used to make a specific change plan. This entailed evoking from patients the specific change they wanted to make in their OCD, reasons for making that change, steps they planned to take to achieve that goal (i.e., what treatment), hurdles they anticipated and potential solutions to address these obstacles, and signs of progress. Appropriate referrals were offered if requested. If a patient continued to express ambivalence about change or remained noncommittal to treatment in Session 3, Session 4 was used to continue to evoke change talk with the goal of moving the patient closer to commitment. One month after the Session 4, the therapist called patients for a follow-up. The intent was to assess patients' current perspective about their OCD and their need for change as well as to determine whether they had sought (or planned to seek) additional treatment for OCD.

Before and after the 4 MI sessions, symptom severity was evaluated by independent evaluators using the Yale-Brown Obsessive Compulsive Scale (Goodman, Price, Rasmussen, Mazure, Delgado, et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann, et al., 1989) for OCD and the Hamilton Depression Rating Scale (HAM-D, 17-item Hamilton, 1960) for depression. At the same time points, patients also completed the University of Rhode Island Change Assessment (McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983). A composite "readiness" score (range −2 to 18), reflecting a second-order factor of the URICA (DiClemente & Prochaska, 1998), was calculated by subtracting the Precontemplation subscale score from the sum of the Contemplation, Action, and Maintenance subscales (Carbonari, DiClemente, & Zweben, 1994); a higher score indicates greater readiness to change. This composite score at baseline was the most powerful predictor of drinking outcomes in Project MATCH (Project MATCH Research Group, 1998). The use of MI procedures was evaluated using the Motivational Interviewing Treatment Integrity scale (MITI 3.0; Moyers, Martin, Manuel, Miller, & Ernst, 2007). Two 20-minute segments from each patient's 4 MI sessions were randomly sampled and rated on five global scales by another trained MI therapist who had no other contact with study patients and who was trained by the MITI developer in its use. Mean MITI ratings (standard deviation) of these five scales (range 1–5) were: evocation, 3.2 (0.8); collaboration, 2.8 (0.8); autonomy/support, 3.3 (0.9); direction, 4.1 (1.1); empathy, 3.0 (0.9).

Clinical ratings at baseline and after the 4 sessions are shown in Table 2 for each of the 6 patients. The overall group means (SD) and descriptive statistics are also presented. After 4 sessions, there was no significant change in OCD severity as measured by the Y-BOCS, a clinically small but significant decrease in depressive symptoms as measured by the HAM-D, and a clinically small but significant increase in quality of life as measured by the Q-LES-Q. There was no significant change in the composite readiness score from the URICA.

At the 4th session, none of the 3 people who compulsively hoarded (D, E, F) committed to pursuing evidence-based treatment with a mental health provider. All had previously tried and failed SRI treatment, and none wanted EX/RP, primarily because they did not want to participate in bulk discard of their clutter. Two expressed the intention to take smaller steps toward change by stopping acquiring and starting to organize their possessions, but they had great difficulty constructing a concrete change plan given the enormity of the task they faced (e.g., apartments full of clutter such that entire rooms were inaccessible) and their inability

to decide where and how to start. Qualitatively, despite their strong expressed wishes for their life to be different, all three continued to value highly the perceived benefits of hoarding (e.g., ensuring that objects with potential use did not go to waste, increasing a sense of security that they would not be without material resources, maintaining ties to the past).

At follow-up, none of the 3 people who compulsively hoarded reported engaging in evidence-based treatment for the hoarding behavior (i.e., medication or EX/RP treatment) or made significant progress in self-directed activities to address their hoarding. At the same time, all expressed an ongoing desire to change their behavior and wished to continue to work with the MI therapist. As one patient said: “You are the first person whom I feel really understands my dilemma. I feel hopeful when I speak with you, and I can see that keeping all this stuff is ruining my life. My mind is clear in your office. The problem is when I go home, I seem to forget everything I learn here.”

In contrast, the other OCD patients did shift in their willingness to pursue evidence-based treatment. One (A) committed to EX/RP treatment in the 4th session and was receiving EX/RP at 1-month follow-up. Another (B) did not commit to evidence-based treatment at the 4th session and was not pursuing treatment at 1-month follow-up; however, 2 weeks later, she spontaneously called the therapist to say that she had sought and received medication treatment for OCD. Finally, one (C) committed at the 4th session to continue his SRI medication and to implement EX/RP procedures on his own; at follow-up, he continued on his SRI, and reported progress in his self-directed efforts. These cases are described in more detail below.

Case A

At the start of Session 1, Case A stated that he had tried all evidence-based treatments for OCD, and none had worked. At the same time, he described his OCD symptoms (obsessions about harm and checking compulsions) as an “addiction” and detailed how his symptoms crippled his social and work functioning. Ardently expressing a wish that his life could change (rating the importance of change as a 10 on a scale from 0 to 10), he communicated little confidence that it could (rating his confidence as 3 of 10).

In Session 2, as the therapist and patient discussed his prior treatment efforts, the patient revealed that he never fully stopped his rituals during his prior EX/RP trials or did homework exposures as instructed. The therapist elicited several reasons: he didn’t like the anxiety he experienced, he was not sure the procedures would work for him, and he felt vigilance about harm made him an ethical person.

In Session 3, after empathizing with the patient’s sense that his OCD kept him and others safe, the therapist elicited from the patient how his checking was “exaggerated” and unrelated to the real level of threat; exploring this discrepancy, the patient spoke with increasing conviction how the checking, instead of generating safety, was simply ruining his life. This seemed to help the patient reconsider treatment. However, he was adamant that he did not want the sexual side effects of SRIs. He also continued to express doubts about EX/RP; from his perspective, exposures merely “replicated” the anxiety he already felt. Here, the therapist elicited the patient’s understanding of how EX/RP works, uncovering several key misperceptions that appeared to contribute to his prior partial adherence and ultimate failure. A key moment appeared to be when the patient mentioned that there were areas of his life in which he did not feel compelled to minimize risk. When the therapist asked for an example, the patient recalled training in the military how to leap from an airplane with a parachute and stated that he successfully completed this training because he knew his life might depend upon it one day. The therapist reflected that he was the sort of person who did

what needed to be done when there was no other option. Shortly thereafter, the patient expressed the view that EX/RP was his "only option," and he began to wonder whether this time it might work. The therapist asked what would make a difference, and the patient was clear: an EX/RP therapist who gave him explicit directions and a "clear path," so that there was no option of failure.

In Session 4, the patient asked for a referral to such an EX/RP therapist and committed to a change plan that included adherence to homework and completing exposures at the top of his hierarchy. At follow-up, the patient had entered EX/RP treatment. He completed a standard treatment course (2 introductory sessions and 15 exposure sessions), adhered with the homework, and conducted exposures at the top of his hierarchy. Before and after the 4 MI sessions, there was no change in OCD severity (Y-BOCS=23 and 22, respectively). After EX/RP treatment, his Y-BOCS was 8.

Case B

Case B expressed myriad reasons to change in the first session, complaining especially about the constant level of anxiety she lived with and stating: "I don't want to look worn by the time I am 40." She endorsed the importance of changing as an 8 out of 10. In Session 2, when discussing her prior treatment attempts, the patient dismissed medications as never working for her and focused only on the possibility of EX/RP, which she had tried unsuccessfully for a few months a few years ago. However, as the therapist and she spoke more about EX/RP and what it would entail, she began to give reasons not to change ("I would feel weird if I didn't have my OCD. What would I do? What would drive me? I would lose my structure.").

In Session 3, the patient continued to express the many ways in which her OCD interfered with her life and how much she wanted treatment. However, when asked what options she was considering, she expressed the belief that her current life was better than it had been in a while and the concern that EX/RP would make her more anxious than she now was and thereby disrupt her life.

In Session 4, she was adamant: although OCD interfered with her life, EX/RP treatment would too. Thus, she did not want to commit to treatment at this time. The importance of change was now a 7 out of 10. At follow-up, the patient remained adamant that she did not want to do EX/RP, and she gave several reasons: the time commitment; the lack of a guarantee of success; and the fact that the treatment in the short run would make her more anxious. The patient stated, "I need change, but this is not the right time." Affirming her right to not seek treatment, the therapist elicited what would make it the right time. The patient was crystal clear: she wanted a provider to whom she did not have to tell her whole story ("I am tired of talking about OCD") and a treatment that did not start by making her more anxious ("I am anxious enough to begin with").

Two weeks later, she spontaneously called the therapist and reported that she had taken action after the last call. Clear that she needed change but did not want EX/RP (for fear it would make her too anxious), she began to reconsider medications and revealed for the first time that she had never stuck to an SRI trial. So, she met with her internist (a clinician who would not talk too much), asked for and received alprazolam (an anti-anxiety medication), and accepted the SRI he recommended for her OCD. Excited about taking steps toward change and less anxious on the alprazolam, she said her plan was to "stick it out" this time with the SRI. Five months later, she called to say she remained on medication for OCD, reported that it was helping her, and expressed confidence that she had made the right decision for herself.

Case C

In Session 1, Case C described how OCD was ruining his family and social life, and endorsed the importance of change at a 10. However, given his many prior failed treatments (including relapsing after a successful course of EX/RP, multiple medication trials, and an experimental trial of transcranial magnetic stimulation), he felt no one could help him (including the current therapist). What he needed, he said, was simply "willpower."

In Session 2, the patient continued to talk about the importance of change, his relapse after successful EX/RP, and what he had to do differently (e.g., having to "bite the bullet" to do exposures and to stop ritualizing). The therapist opened Session 3 with the observation that the patient ardently spoke about the need for change and yet found it difficult to "will himself" to do exposures and to stop ritualizing. Instead of joining with the patient's view that this was his personal failure, she invited the patient to talk instead about what was good about the OCD that might explain why it was hard to "will himself." Startled at first, the patient then revealed his belief that the OCD kept him aware of his surroundings and protected him. In addition, he expressed how much pleasure he got from the relief the rituals brought to him. When asked to imagine what it would be like to give up that pleasure voluntarily, the patient laughed in surprise, and said he had never thought about that before. He then spoke about how in his prior therapy he did ritual prevention for his therapist rather than for himself ("I didn't want to let him down. But when I stopped seeing the therapist, I was released from this pressure, and I started doing rituals for the relief again."). Other obstacles to ritual prevention were elicited, including periods of depression that sapped his self-confidence.

The patient began Session 4 stating that he was where he had started in Session 1: needing to do it himself. However, the difference was that he no longer expressed hopelessness but instead had a change plan in mind. This included continuing his SRI medication ("Initially, I didn't like the idea of being dependent on a medication, but I now accept that I need it, and it helps"). He also expressed his intent to use the EX/RP procedures ("I know the procedures work—I just have to use them, even when I feel depressed"). In the office, in front of the therapist, he committed to using the EX/RP procedures during the day; at the same time, he acknowledged that his hardest time was at night. There, he said he wanted to "wait and see" what he was able to do. He did not want a referral to a therapist ("I'm a control freak. It is best if I set myself up for the challenge.").

At follow-up, the patient said that he was "maintaining things day-to-day." He remained on medication and reported complete success during the day doing exposures and stopping rituals. He continued to have intrusive thoughts at night (which the therapist clarified included both obsessions and mental rituals). However, he had stopped getting out of bed to do behavioral rituals and expressed pride in his progress. He asked for additional "tricks" for expediting his progress, and he and the therapist discussed how to identify and handle mental rituals at night. He did not want a referral to a therapist because he felt his biggest problem was the fear of relapse: if successful on his own, he felt he would no longer fear relapse.

Summary

Together, these six cases illustrate several points. First, OCD patients who are unwilling to seek a referral with a mental health professional for evidence-based treatment were willing to participate in this protocol that offered them an opportunity to speak about their ambivalence but did not require them to commit a priori to any specific treatment for OCD. All completed every session, and those who compulsively hoarded asked for more. Second, although each patient expressed clear reasons for change, they also enunciated many reasons

for not changing. The latter were intricate and idiosyncratic, took some time to elicit, and would be difficult to capture on a standardized measure. Third, as expected, the MI intervention alone did not lead to a significant change in OCD severity; even the two patients with the largest individual decreases on the Y-BOCS were still left with moderate OCD. Fourth, the MI intervention also did not lead to clear increases in the patients' readiness for change as measured by the URICA, despite the fact that at least some of the patients displayed clear shifts in their behavior. One possible explanation is that the readiness measure may not have been used at the right time point (e.g., administered at the 4th session instead of at follow-up); another is that the composite readiness score may not be a valid measure of the likelihood of behavior change in this population. Finally, the MI intervention appeared to help some of these treatment-refractory OCD patients commit to the use of evidence-based treatment at short-term follow-up. None of these were hoarders.

Future Directions

MI has been used in different ways to foster treatment participation in OCD patients. As reviewed above, the study by Maltby and Tolin (2005) indicated that a multimodal intervention that includes MI procedures provided prior to EX/RP can increase acceptance of EX/RP, but is insufficient to prevent subsequent dropout. Preliminary data from Simpson and colleagues (2008) suggest that MI can be integrated into standard EX/RP and used during the introductory sessions of EX/RP as well as during exposure sessions as needed. Whether this integration leads to better adherence and outcome than standard EX/RP is currently being examined in a randomized controlled trial. Finally, we describe an MI intervention that appeared to foster treatment participation in 3 of 6 OCD patients who had previously failed or refused evidence-based treatment. All studies had small samples and two were open trials, precluding any firm conclusions about the effectiveness of MI in OCD.

At the same time, these studies raise key issues that future research will need to address. First, it is not clear how best to measure the impact of MI. For example, MI is often used to enhance adherence. However, adherence can be measured in different ways, including rates of entry into treatment, rates of treatment completion, or degree of adherence with treatment procedures. Moreover, an MI intervention could also be considered successful if people who are very unlikely to adhere with treatment procedures decide not to enter treatment. When MI is used as a prelude to treatment, perhaps it is not a behavioral action (e.g., starting treatment) that is the most sensitive outcome, but the process of deciding and committing to a course of action.

Second, MI theoretically should be most useful in those who are ambivalent about treatment by helping them resolve this ambivalence and readying them for change. However, testing this hypothesis requires valid and reliable measures of these constructs. Although the URICA is a common measure of change in the field, it was not sensitive to change in our recent study. Whether other measures (e.g., the change questionnaire [Miller & Johnson, 2008] or the Anxiety Change Expectancy Scale [Dozois & Westra, 2005]) prove more useful remains to be seen. Another question is when to measure change in readiness. It may be that shifts in long-standing ambivalence require time to consolidate.

Finally, the interventions described above were assumed to be MI-congruent. However, only our most recent study formally monitored MI integrity using an established scale: the MITI. Our MITI mean global ratings ranged from 2.8 to 4.1; ratings of pure MI sessions are expected to average 3.5 for practitioners with beginning proficiency and 4 for those exhibiting full competency (Moyers, Martin, Manuel, Miller, & Ernst). There are two implications. First, when MI is integrated, as it was in our study, with information and advice-giving about treatment procedures, MITI ratings can be expected to be lower than

ratings of pure MI sessions. At the same time, how much MI can be diluted before it is ineffective remains an open question. Second, to develop proficiency in MI requires careful training (Madson, Loignon, & Lane, 2009). This may be especially true if clinicians have been trained in highly structured treatments (e.g., CBT or medication management) that differ from the client-centered approach of MI (Cook, Schnurr, Biyanova, & Coyne, 2009). For example, to learn MI, the therapist (the first author) attended a standard 2-day MI training workshop, reviewed the MI text (Miller & Rollnick, 2002) and training tapes (Miller & Rollnick, 1998), participated in two day-long in-person small-group MI skills-building sessions, and received supervision of audiotaped sessions from the second author, a member of the Motivational Network of Trainers (MINT). Learning MI takes time and effort.

For clinicians, MI should be considered a promising but unproven approach for enhancing treatment outcome in OCD. As illustrated above, MI can be used to encourage entry into any treatment, to encourage entry into a specific treatment, or to encourage fuller participation in treatment if adherence wanes. At the same time, there are challenges of integrating MI into practice with OCD patients. In part, this is because the evidence-based treatments that currently exist for OCD (i.e., EX/RP and pharmacotherapy) are highly structured and expert-driven, whereas MI relies upon the therapist supporting patient autonomy and evoking motivation from patients rather than instilling it. Shifting back and forth can be difficult. In addition, knowing when focusing on ambivalence is necessary for patients to move forward (because the patient is stuck in it) and when focusing on ambivalence is counterproductive (because it is residual and the patient is primarily leaning towards change) requires practice, especially in OCD patients with trouble making decisions.

When successful, we believe it was because MI helped address two related but different decisional conflicts that can lead to ambivalence about treatment in OCD patients. The first is whether the advantages of change in OCD symptoms outweigh those of sustaining the status quo. Here, what seemed helpful was eliciting what values the OCD behaviors reflected (e.g., carefulness about the well-being of others, cleanliness) and contrasting these with the values that could be expressed if the OCD behaviors were reduced (e.g., improved intimate relationships, mastery of one's own destiny). The recognition that giving up OCD behaviors was not just compatible with, but facilitative of, living out cherished values appeared to fuel the desire for change. The second conflict centered around whether the aversiveness of treatment (i.e., the intense anxiety inherent to EX/RP, the side effects associated with medications) was outweighed by the potential relief from debilitating symptoms. Here the key appeared to be the therapist's ability to empathize with patients' fears while enhancing motivation for change (e.g., through eliciting and reinforcing talk about the importance of change and building confidence in patients' strengths and capacities for meeting difficult challenges) and to provide a nonjudgmental space for patients to think out loud about all possible options for achieving change. In those cases where OCD patients sought or participated more fully in evidence-based treatment after an MI intervention, patients appeared to come to an acceptance of the reality and limitations of current treatment options and committed to short-term pain for long-term gain because change was so essential.

Acknowledgments

This work was funded by a 2005 NARSAD Young Investigator Award and by NIMH (R34 MH071570) to Dr. Simpson. We thank Ms. Jessica McCarthy and Rena Staub for patient management, Mr. Andrew Schmidt for data management, Dr. Ivan Balan for conducting MITI ratings of therapist sessions, Dr. Frank Schneier for helpful comments on an earlier draft, and Stephen and Constance Lieber for supporting the first author as a NARSAD Lieber Investigator.

References

American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. American Journal of Psychiatry. 2007; 164(Suppl):1–56. [PubMed: 17202533]

Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. Journal of Consulting and Clinical Psychology. 2003; 71:843–861. [PubMed: 14516234]

Carbonari, J.; DiClemente, CC.; Zweben, A. A readiness to change scale: Its development, validation, and usefulness. Discussion symposium: Assessing critical dimensions for alcoholism treatment. Presented at the 28th annual convention of the Association for Advancement of Behavior Therapy; San Diego, CA. 1994 Nov.

Connors GJ, Walitzer KS, Dermen KH. Preparing clients for alcoholism treatment: effects on treatment participation and outcomes. Journal of Consulting and Clinical Psychology. 2002; 70:1161–1169. [PubMed: 12362966]

Cook JM, Schnurr PP, Biyanova T, Coyne JC. Apples don't fall far from the tree: Influences on psychotherapists' adoption and sustained use of new therapies. Psychiatric Services. 2009; 60:671–676. [PubMed: 19411356]

DiClemente, CC.; Prochaska, JO. Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In: Miller, WR.; Heather, N., editors. Treating addictive behaviors. New York: Plenum Press; 1998. p. 3-24.

Dozois DJ, Westra HA. Development of the Anxiety Change Expectancy Scale (ACES) and validation in college, community, and clinical samples. Behavior Research and Therapy. 2005; 43:1655–1672.

First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JB. Structured Clinical Interveiw for DSM-IV Axis I Disorders-Patient Edition. New York, NY: Biometrics Research Department, New York State Psychiatric Institute; 1996.

Foa EB, Liebowitz MR, Kozak MJ, Davies S, Campeas R, Franklin ME, et al. Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. American Journal of Psychiatry. 2005; 162:151–161. [PubMed: 15625214]

Goodman WK, Price LH, Rasmussen SA, Mazure C, Delgado P, Heninger GR, et al. The Yale-Brown Obsessive Compulsive Scale. II. Validity. Archives of General Psychiatry. 1989; 46:1012–1016. [PubMed: 2510699]

Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. Archives of General Psychiatry. 1989; 46:1006–1011. [PubMed: 2684084]

Grote NK, Zuckoff A, Swartz HA, Bledsoe SE, Geibel S. Engaging women who are depressed and economically disadvantaged in mental health treatment. Social Work. 2007; 52:295–308. [PubMed: 18232240]

Habib S, Morrissey S, Helmes E. Preparing for pain management: A pilot study to enhance engagement. Journal of Pain. 2005; 6:48–54. [PubMed: 15629418]

Hamilton M. A Rating Scale for Depression. Journal of Neurology, Neurosurgery, and Psychiatry. 1960; 23:56–62.

Hettema JM, Steele J, Miller WR. Motivational interviewing. Annual Review of Clinical Psychology. 2005; 1:91–111.

Huppert JD, Franklin ME. Cognitive behavioral therapy for obsessive-compulsive disorder: an update. Current Psychiatry Reports. 2005; 7(4):268–273. [PubMed: 16098280]

Huppert JD, Simpson HB, Nissenson KJ, Liebowitz MR, Foa EB. Quality of life and functional impairment in obsessive-compulsive disorder: A comparison of patients with and without comorbidity, patients in remission, and healthy controls. Depression and Anxiety. 2008; 26:39–45. [PubMed: 18800368]

Kozak, MJ.; Foa, EB. Mastery of obsessive-compulsive disorder: A cognitive-behavioral approach. San Antonio, TX: The Psychological Corporation; 1997.

Madson MB, Loignon AC, Lane C. Training in motivational interviewing: a systematic review. Journal of Substance Abuse and Treatment. 2009; 36(1):101–109.

Maltby N, Tolin DF. A brief motivational intervention for treatment-refusing OCD patients. Cognitive Behavior Therapy. 2005; 34(3):176–184.

McConnaughy EA, DiClemente CC, Prochaska JO, Velicer WF. Stages of change in psychotherapy: A follow-up report. Psychotherapy: Theory, Research, Practice, Training. 1989; 26:494–503.

McConnaughy EA, Prochaska JO, Velicer WF. Stages of change in psychotherapy: Measurement and sample. Psychotherapy. 1983; 20:368–375.

Miller WR. Motivational interviewing with problem drinkers. Behavioural Psychotherapy. 1983; 11:147–172.

Miller, WR. Motivational factors in addictive behaviors. In: Miller, WR.; Carroll, KM., editors. Rethinking substance abuse: What the science shows, and what we should do about it. New York: Guilford; 2006. p. 143-150.

Miller WR, Johnson WR. A natural language screening measure for motivation to change. Addictive Behavior. 2008; 33:1177–1182.

Miller, WR.; Rollnick, S. Motivational Interviewing: Professional Training Series. Albuquerque: CASAA: University of New Mexico; 1998.

Miller, WR.; Rollnick, S. Motivational Interviewing. 2. New York: The Guilford Press; 2002.

Moyers, T.; Martin, T.; Manuel, JK.; Miller, WR.; Ernst, D. Motivational Interviewing Treatment Integrity 3.0. 2007. Unpublished measure. Retrieved April 16, 2010, from http://casaa.unm.edu/download/MITI3_1.pdf

Murray, CJL.; Lopez, AD. The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard School of Public Health, Harvard University Press; 1996.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research. 1998; 22:1300–1311.

Simpson HB, Foa EB, Liebowitz MR, Ledley DR, Huppert JD, Cahill S, et al. A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. American Journal of Psychiatry. 2008; 165:621–630. [PubMed: 18316422]

Simpson HB, Huppert JD, Petkova E, Foa EB, Liebowitz MR. Response versus remission in obsessive-compulsive disorder. Journal of Clinical Psychiatry. 2006; 67:269–276. [PubMed: 16566623]

Simpson HB, Zuckoff A, Page JR, Franklin ME, Foa EB. Adding motivational interviewing to exposure and ritual prevention for obsessive-compulsive disorder: an open pilot trial. Cognitive Behavior Therapy. 2008; 37:38–49.

West DS, DiLillo V, Bursac Z, Gore SA, Greene PG. Motivational interviewing improves weight loss in women with type 2 diabetes. Diabetes Care. 2007; 30(5):1081–1087. [PubMed: 17337504]

Westra HA, Dozois DJA. Preparing clients for cognitive behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. Cognitive Therapy & Research. 2006; 30:481–498.

Zweben, A.; Zuckoff, A. Motivational interviewing and treatment adherence. In: Miller, WR.; Rollnick, S., editors. Motivational interviewing: Preparing people for change. New York: Guilford Press; 2002.

Table 1

Sociodemographic and Clinical Characteristics

Case	Age	Gender	Ethnicity	Marital Status	Employment Status	Primary OCD Symptoms	Current OCD treatment
A	69	Male	Caucasian	Single	Part-time	Aggressive obsessions and checking rituals	None
B	21	Female	Caucasian	Single	Part-time	Symmetry and exactness obsessions with repeating and checking rituals	None
C	38	Male	African-American	Single	Full-time	Contamination obsessions and washing rituals	Fluoxetine 80 mg/day for > 16 months
D	62	Female	Caucasian	Divorced	Unemployed	Hoarding	None
E	54	Female	African-American	Single	Part-time	Hoarding	None
F	63	Female	Caucasian	Single	Unemployed	Hoarding	None

Table 2

Outcome

Case	Y-BOCS		HAM-D		Q-LES-Q		URICA Readiness score		OCD treatment at follow-up
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	
A	23	22	6	4	77	80	10	9	EX/RP
B	29	20	5	2	55	68	9	12	SRI
C	29	22	6	1	61	68	11	12	SRI and self-EX/RP
D	27	26	18	15	18	25	10	8	NONE
E	25	27	5	3	29	36	12	12	NONE
F	20	21	5	5	64	71	8	8	NONE
Mean (SD)	25.5 [a] (3.6)	23.0 [a] (2.8)	7.5 [b] (5.2)	5.0 [b] (5.1)	50.7 [c] (22.5)	58.0 [c] (22.0)	10.0 [d] (1.6)	10.1 [d] (2.3)	

Note. EX/RP=exposure and response prevention; HAM-D=Hamilton Depression Scale; Pre (Before first session); Post (after 4th session); Q-LES-Q=Quality of Life and Enjoyment Questionnaire; SD=Standard Deviation; SRI=Serotonin Reuptake Inhibitor; URICA=University of Rhode Island Change Assessment; Y-BOCS=Yale-Brown Obsessive Compulsive Scale.

[a] Paired Samples Test: t=1.4, df=5, p=0.22.

[b] Paired Samples Test: t=3.7, df=5, p=0.01.

[c] Paired Samples Test: t=−5.6, df=5, p=0.002.

[d] Paired Samples Test: t=−0.06, df=5, p=0.95.