CHAPTER 14

# Using Motivational Interviewing to Enhance Neuropsychological Practice for Adults with Depression and Neurocognitive Difficulties

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Motivational interviewing (MI) was first introduced in 1983 and has become an internationally utilized and empirically supported clinical application centered on helping people reduce their ambivalence, while simultaneously increasing their internal motivation to make positive changes in behavior (Miller & Rollnick, 2013). Proven efficacious to facilitate changes in a plethora of clinical settings and a span of populations, MI offers emerging evidence of potential clinical utility for practitioners working with persons diagnosed with psychiatric disorders, and neurocognitive difficulties (Miller & Rollnick, 2013).

In this chapter, we present an overview of MI, followed by a review of emerging MI research applications for patients with depressive disorders and neurocognitive difficulties. Core foundational elements of MI, including the four-processes model (Miller & Rollnick, 2013), highlights of several person-centered core interviewing and goal-oriented skills, as well as practical clinical considerations and key tips, will underscore how clinical neuropsychological providers can incorporate MI to enhance their consultation, assessment, and feedback practices with patients coping with depression.

## A BRIEF OVERVIEW OF MI

While a comprehensive review of MI is beyond the scope of this chapter, we primarily focus on the key components and skills that are relevant to clinical neuropsychological assessment and feedback practices of adults with depression and neurocognitive difficulties. (Interested readers can access a more comprehensive review of topics ranging from

adolescents and young adults [Naar & Suarez, 2021] to adults [Miller & Rollnick, 2013] via the *Applications of Motivational Interviewing* series published by The Guilford Press.) MI is a collaborative, goal-oriented style of communication, with particular attention to the language of change, designed to strengthen personal motivation for commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (Miller & Rollnick, 2013). Empirically supported and atheoretically based, MI honors a person's autonomy and embodies a collaborative approach to addressing motivation to change, while concurrently maintaining a goal-oriented focus. Practitioners new to MI often have misperceptions of how it is applied in practice (Miller & Rose, 2009). For instance, MI is not "trickery" that is done "to" a patient. Rather, it is an active collaboration with a person and/or family that can be useful in addressing the ambivalence that often arises during the clinical neuropsychological assessment. It can also help to facilitate discussions to enhance internal motivation for change during therapeutic feedback visits and during consultation with other health care team members (Miller & Rollnick, 2013).

## EMERGING MI RESEARCH APPLICATIONS FOR ADULTS WITH DEPRESSION AND NEUROCOGNITIVE DIFFICULTIES

The efficacy of MI has and continues to emerge in the area of neurocognitive rehabilitation for persons with associated psychiatric disorders, including depression, as well as their families (Miller & Rollnick, 2013; Schoenberg & Scott, 2011; Suarez, 2011). Highlights of recent evidence, presented in the next section, have demonstrated how MI can be applied to enhance clinical neuropsychological diagnostic assessment and feedback purposes, as well as complex and comprehensive cognitive remediation and rehabilitation interventions with this population.

MI has been found to enhance services for persons and families with neuropsychiatric and neurodegenerative disorders, including Alzheimer's disease, traumatic brain injury, and stroke (Bell et al., 2005; Bombardier et al., 2009; Byers, Lamanna, & Rosenberg, 2010; Choi & Twamley, 2013; Watkins et al., 2007, 2011). Further evidence suggests that MI is an effectively adapted intervention for persons with cognitive impairment and associated generalized psychiatric disorders. For example, in a randomized controlled trial, adaptations of MI cognitive rehabilitation interventions relative to sham interventions for persons diagnosed with comorbid cognitive disorder and schizophrenia based on diagnostic criteria in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), have shown more improvements in task-specific motivation, attendance, and compliance rates (Fiszdon, Kurtz, Choi, Bell, & Martino, 2016). Furthermore, large-scale clinical trials indicate MI's superior efficacy, compared to intensive and structured treatments, in individuals with depression, anxiety, clinically significant cognitive impairment, and lower conceptual levels of cognitive functioning (Chien, Mui, Gray, & Cheung, 2016; Ponsford et al., 2016). Specific to depression and medical illnesses, randomized clinical trials have suggested that the application of MI as a stand-alone and augmentation strategy for patient care is efficacious. This effect has been evidenced in patients with major depressive disorder, postpartum depression and anxiety, and depression secondary to cardiac disease, who after receiving an

MI intervention showed decreased depressive symptoms, and better treatment-seeking and adherence behaviors (Holt, Milgrom, & Gemmill, 2017; Keeley et al., 2014, 2016; Navidian, Mobaraki, & Shakiba, 2017). Both MI and cognitive-behavioral therapy have proven efficacious in a variety of comorbid psychiatric and mental health related areas (Naar & Safren, 2017). Overall, these studies provide evidence that MI can enhance the practice of clinical neuropsychology that branches out beyond traditional assessment and diagnostic practices. Indeed, MI has great potential to positively impact a broader scope of cognitive rehabilitation interventions that are effective in patients with both psychiatric and neurocognitive disorders.

## INCORPORATING MI INTO CLINICAL NEUROPSYCHOLOGICAL PRACTICE

In 2013, Miller and Rollnick incorporated and updated MI to include the four-processes model, which involves engaging, focusing, evoking, and planning. The model offers a guide for practitioners to strategically enhance the use of person-centered core-interviewing and goal-oriented skills in MI within each of the processes. We next present the fundamental skills of MI, along with an overview of the processes and clinical examples that illuminate the differences between typical practice versus MI responses. The chapter ends with a summary and a brief list of resources designed to enhance skills in MI.

## THE SPIRIT OF MI: MAINTAIN PACE

MI entails the incorporation of a person-centered spirit that is termed PACE (*P*artnership, *A*cceptance, *C*ompassion, and *E*vocation). Within this framework, the clinician will convey a partnership, acceptance, compassion, and evocative stance in all aspects of the assessment and feedback process. While working with highly complex persons with comorbid depression and neurocognitive difficulties (who often present with difficulties in completing a basic testing battery due to cognitive fatigue and other factors), coupled with limited time demands faced in daily practice, clinicians will find that maintaining the spirit can sometimes be overlooked and/or inconsistently applied. As such, it is essential for them to maintain a PACE (see Table 14.1) and recognize how it can enhance patient outcomes.

**TABLE 14.1. An Overview of PACE**

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| *P*artnership: Collaboration among two experts; specifically, the practitioner as a clinical expert and the patient as an expert of him- or herself |
| *A*cceptance: Regardless of professional agreement, the clinician supports the patients' liberty to make decisions (or not). |
| *C*ompassion: The clinician deliberately commits to actively promote the patient's and family's well-being and needs. |
| *E*vocation: The clinician plans, guides, and tailors the therapeutic responses to facilitate internal motivation and activate action in the change process. |

## PERSON-CENTERED CORE INTERVIEWING SKILLS: USING OARS + I

A core component of MI entails the use of several person-centered and core-interviewing skills, termed *OARS + I*. These skills specifically include open-ended questions, affirmations, reflections, summaries and information, and advice giving. As there are a multitude of variants for how the overarching umbrella of OARS + I skills can be applied, a brief synopsis of these fundamental MI skills and examples are highlighted. Akin to the MI spirit, these person-centered skills will undoubtedly resonate with clinicians. However, *how* these skills are strategically applied, in tandem with goal-oriented skills (described below), offers a unique clinical utility, specific only to MI.

1. *Open-ended question:* A question that does not elicit a one-word or yes/no response.
   - *Example:* "Sometimes you forget, get distracted, and then get bummed out— it's like a vicious cycle. What are your thoughts about how you could better remember to . . . ?"
2. *Affirmation:* Validating, confirming, and positively stating what the person has said using the stem of "you" and excluding the practitioner's use of "I" language.
   - *Example:* "Despite all the inconveniences, you knew how important it is for you and our team to arrive on time today and bring all of your paperwork. You are invested in feeling better."
3. *Reflections:* Restating the message heard; incorporates change-talk language.
   - *Example:* "You want to plan better and know what will work for you."
4. *Summaries:* Pulling together relevant topics in a concise manner; aids in shifting focus and can be followed up with a transitional open-ended question to shift gears in the content of the conversation.
   - *Example:* "Despite the annoyances of being distracted, you were able to come prepared today and have ideas about how to use these assessment results to plan for your next steps. Tell me what you think would help next. . . ."
5. *Information and advice—ask–tell–ask:* Providing information and advice is a necessity in assessment practice, particularly when cognitive challenges are present that can impede clear communication. The ask–tell–ask strategy, adapted from Miller and Rollnick (2013) and Naar and Safren (2017), offers a unique strategy that maintains PACE skills while conveniently allowing the clinician to assess the patient's knowledge, offer information as needed, and facilitate both the assessment and treatment planning process in an efficient manner.
   a. *Ask:* Permission to discuss and clarify needed information.
      - *Example:* "If it's all right, I'd like to discuss next what your cognitive assessment results mean and how you can use some different strategies to help you better remember things."
   b. *Tell:* Information, results, concerns, and/or feedback recommendations using brief (five to seven words) and understandable language.
      - *Example:* "Your results confirm that you have memory difficulties. This means

that when you are trying to remember information, you will benefit from repetition of the information and writing down what you want to remember."

c. *Ask:* Ask for the patient's interpretation and understanding of the information, followed by a reflection of the response.
   - *Example:* "What do you know about memory problems?," "What are some things that you have tried that help you remember better?." "Would it be OK if we discussed some strategies that can help some people with memory problems improve memory?"

## GOAL-ORIENTED SKILLS: THE IMPORTANCE OF CHANGE TALK AND COMMITMENT LANGUAGE

For adults with depression and neurocognitive difficulties, clinical neuropsychological assessment guided and tailored recommendations can help improve functional abilities, instrumental activities of daily living, and quality of life. While discussions tailored to goal setting are common in these practices, issues related to nonadherence to treatment-planning recommendations are common. A complicating factor for adherence and nonadherence of the patient is the impact of the practitioner's use of prescriptive method for advice giving. For example, when parlaying treatment recommendations, we have found in our practice that many practitioners were trained to use a predominantly prescriptive advice-giving feedback style. While this type of interaction can work quite well for patients who actively seek advice and are adherent to recommendations and treatment, it has little to no utility for patients who are ambivalent about making a change (i.e., approximately 80% of patients in the general population; Miller, & Rollnick, 2013).

A fundamental component of MI that differentiates it from other therapeutic interventions and feedback modalities is its focus on how practitioners can help reduce ambivalence in patients by both achieving and sustaining desired outcomes. This approach is based on how the practitioners guide the conversation to elicit and strengthen the patient's own internal motivation for change. Of the over 1,000 clinical trials to date, MI has proven efficacious in showing that when a person is ambivalent and/or experiencing challenges in sustaining new (and often difficult) changes in their behavioral repertoire, the most predictive measure of change involves actively voicing "change talk" and "commitment language" (Miller & Rollnick, 2013). Specifically, change talk entails the person actively voicing statements in favor of change or against sustaining current behaviors. These change-talk statements indicate a desire, reason, ability, and/or need for change and have been proven to predict a person's commitment (the strongest level of change talk) to make actual changes. Commitment language entails a person "committing" to a change and is typified by the use of statements such as "I will."

## CHANGE TALK AND COMMITMENT LANGUAGE: DARN-C

Based on empirical support of change processes in MI, change talk and commitment language are recognized in the encounter when a person specifically expresses certain

statements about change. These statements center on the use of language that reflects a person's: desire, ability, reason, and need, and these statements are clinically predictive of their making a commitment to change. The following highlight samples of change talk and commitment language, which is typically referred to as "DARN-C."

1. *Desire language:* Want, prefer, wish.
   - *Example:* "I have too many difficulties even remembering the simplest of things like I used to since I have felt depressed. I really *wish* I could feel better."
   - *Reflective desire response:* "Part of you knows life could be easier and you *want* to do something different that will help you feel better regarding feeling depressed."
2. *Ability language:* Able, can, could, possible.
   - *Example:* "I maybe *could* do it. I used to be really on top of going to my rehab appointments. It's just sometimes I forget. All these stupid appointments they have me scheduled for all of the time—it's nonstop. No one knows how hard it is to keep track of everything, and then I end up getting mad at myself for missing and not going to appointments."
   - *Reflective ability response:* "You know you have the ability to make the appointments and *can* do it."
3. *Reason language:* Specific arguments and reasons for change.
   - *Example:* "There's just one reason, Doc. I need to get off disability and return back to work. I'm over it. I'm over the meds, talking to weird therapists like you and this depression stuff that everyone keeps telling me that I have."
   - *Reflective reason response:* "You feel like you are wasting your time and money, and you are *ready* to get back to working."
4. *Need language:* Important, have to, got to
   - *Example:* "I really can't keep coming to these appointments and spending a wasted day like today for people like you to ask me questions, make me do all this stuff with blocks and repeating stuff I could care less about. Your questions after questions, they are really getting on my nerves. I'm tired and *have to* take a break."
   - *Reflective need response:* "These tests are long and tedious and you are tired of them. If it's OK, let's talk next about how these tests we are doing next are *important* and could help."
5. *Commitment language:* Going to, will.
   - *Example:* "OK, I *will* make the appointment with that other doctor if you think it will help."
   - *Reflective commitment language response:* "Great. Continuing with recommended treatment can be one of the first steps you can take to start to feel better. With our time that's left for our feedback session today, would it be OK if I offer you a menu of some other things you may or may not find of interest? I could help you plan for how to go about making your appointments for rehabilitation, talk more about how you could communicate better with your other health care providers, something else on the treatment plan or other ideas that you'd like to pursue. For now, what is *going to* suit you best?"

## THE FOUR PROCESSES AND NEUROPSYCHOLOGICAL APPLICATIONS

As previously noted, Miller and Rollnick incorporated and updated MI to include the four-processes model, which involves engaging, focusing, evoking, and planning. The model offers a guide for practitioners to strategically enhance the use of person-centered core-interviewing and goal-oriented skills in MI within each of the processes (see Table 14.2).

### Engaging: The Relational Foundation

*Engaging* the patient during clinical neuropsychological evaluation and feedback sessions sets the stage for establishing a collaborative discussion and provides a clinical environment tailored to supporting the therapeutic relationship and feeling of being understood. Engaging is extremely important during the initial evaluation and assessment sessions because patients may already be hesitant and avoidant to disclose their potentially disturbing private events and/or changes in their lifestyle to the practitioner. Paired with this, a patient's depressive symptoms (e.g., pessimistic thoughts, decreased self-esteem, irrational guilt) can similarly impact a patient's willingness to engage with the clinician. Furthermore, patients arriving at the initial clinical neuropsychological evaluation may not yet have an official diagnosis, and the many fast-paced assessment-driven questions from an essentially unknown practitioner can be intimidating and anxiety provoking for patients. Thus, it is important for the practitioner to continue engaging with patients and families in a collaborative manner by incorporating clinical expertise and recognizing the expertise of the patients and families.

#### MI Tips for Working with Adults with Depression and Neurocognitive Difficulties

- As the patient is depressed and may have difficulties in understanding abstract questions due to limitations in executive functions (e.g., cognitive flexibility), tailor language accordingly to the patient.
- Avoid disengagement traps such as using several closed-ended questions in a row, maintaining an expert only role, prematurely focusing on a behavior change plan, and engaging in idle conversation when the patient may need a break from the lengthy assessment process.



**TABLE 14.2. An Overview of the Four-Processes Model**

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| *Engaging:* The relational foundation |
| *Focusing:* The strategic direction |
| *Evoking:* Preparation for change |
| *Planning:* The bridge to change |

### Motivational Interviewing Practitioner Considerations

- How am I adapting to the patient's and family's limitations and cognitive needs in my communication style?
- How does my use of more concrete or abstract language enhance or, conversely, diminish the patient's engagement?
- How am I helping to make the patient/family feel comfortable?
- Given the cognitive impairments and psychiatric symptoms of the patient, what am I saying to facilitate a collaborative and supportive conversation?

## Focusing: The Strategic Direction

Developing and maintaining a *focused* and *strategic direction* about change is integral to any clinical neuropsychological intervention as patients with depression and comorbid neurocognitive difficulties often present with a complex list of change priorities they may want to address. However, those change priorities may be different from what the practitioner deems to be of most importance. The importance of being mindful of the patient's goals for change and how the practitioner might develop a collaborative plan in a clear and focused manner cannot be underestimated. For example, clinicians are aware of time limitations faced in daily practice to complete a thorough assessment to determine the patients' cognitive strengths and weaknesses, which can often fuel discord in the clinician, maintaining a strategic and planful focus on the specific direction of what is most relevant to the patient and their family.

### MI Tips for Working with Adults with Depression and Neurocognitive Difficulties

- Clinical symptom presentations typical of this population can include broad and common cognitive difficulties, including slower processing speed, compromised attentional processes, executive dysfunction, and poor short-term memory.
- Usually, there are multiple and sometimes competing goals, and maintaining a strategic focus on one or two goals can facilitate small changes that can lead to larger and durable positive health-related improvements.
- Listen, ask, and inform in a relatively equal balance (ask–tell–ask).
- If difficulties in selecting a focus arise, consider whether the patient is actually engaged. If so, help with the use of a summary statement and ask permission to offer a short menu of options, such as those in the treatment planning recommendations.

### MI Practitioner Considerations

- What, if any, are the patient's actual goals for change (i.e., relief from depression, better management of neurocognitive difficulties, both, or something else)?

- How is my use of a guiding style and the specific language used during the assessment and breaks helping to maintain a strategic focus on change ideas and goals offered by the patient and family?

## Evoking: Preparing for Change

Practitioners who provide clinical neuropsychological evaluations bring a unique clinical opportunity to the integrated health care team by offering patients the opportunity to disclose both abilities and functionally objective skills that are quantitatively definable during an assessment, as well as during the more qualitatively therapeutic feedback session. Akin to adolescents and young adults, practitioner efforts to carefully evoke change talk and commitment language, particularly with persons experiencing neurocognitive difficulties, can offer new opportunities within the field. The incorporation of evoking processes in MI in patients with depression and cognitive difficulties can be viewed as an active process in change. This process is often overlooked when typical advice giving and general recommendations in clinical practice fail to correspond with the clinical and/or practical life outcomes sought by patients/families in the treatment quest.

### MI Tips for Working with Adults with Depression and Neurocognitive Difficulties

- Evoking internal motivation for change is central to MI, and it is imperative to evoke, listen, and reinforce any change talk.
- Impairments in higher-order cognitive functioning (e.g., planning, problem solving, cognitive flexibility) can sometimes impede the patient's ability to offer unsolicited ideas about change and/or change talk. Incorporating direct questions that elicit change talk can help maximize the patient's confidence in discussing what they deem to be important to change and to enhance engagement.
- When ambivalence is strong, the use of direct questions may be too overwhelming for the patient and can result in disengagement. In these situations, both the patient and the clinician may become frustrated, particularly given the time limitations and significant amount of feedback that needs to be covered, discussed, and processed during feedback sessions. The use of imagining questions to look in the future or past and discuss how life would be different if changes or more compliance with treatment recommendations were made can help to reduce frustrations. Also, questions tailored to how changes would benefit the patient's interpersonal relationships can help to minimize frustration and facilitate engagement.
- While persons with depression and neurocognitive difficulties may need the assistance of the integrated health care team after the clinical neuropsychological evaluation is completed, inquiring about personal values and how their efforts to change and/or comply with recommendations can help them lead a more productive life and offer a sense of hope that change can occur and quality of life will improve.

### MI Practitioner Considerations

- What are the person's own reasons for change and/or for adherence to treatment planning recommendations?
- What change-talk language am I hearing, and how am I responding to it?
- If I am becoming frustrated with the person's ambivalence or lack of responding during the assessment or feedback session, how can I adjust my responses? Am I being overly prescriptive and how can I alter my responses to elicit and facilitate more engagement?

## Planning: The Bridge for Change

On the one hand, clinicians conducting clinical neuropsychological evaluations face specific practice challenges, namely, time limitations and the termination of the professional relationship once feedback is provided to patients and their families. On the other hand, clinicians have a unique opportunity to facilitate focused and goal-oriented discussions about change planning. This last of the four processes, planning, focuses on collaboratively guiding the discussion to help the patient to commit to a change in behavior and activate a concrete, behaviorally based plan of action. The planning process allows each patient and clinician to maintain their own expertise (i.e., the patient is an expert of themselves and the practitioner is an expert in clinical neuropsychological practice) while maintaining engagement to collaboratively develop plans for embarking on small changes that are feasible, achievable, and, hopefully, sustainable such that these gains will lead to further positive changes in overall health.

### MI Tips for Working with Adults with Depression and Neurocognitive Difficulties

- MI emphasizes the formation of a change plan that includes sufficient detail to increase the likelihood of success while continuing to evoke and ensure the presence of motivation. Common issues of cognitive fatigue can impact motivation and adherence to the testing demands; thus, monitoring fatigue is imperative.
- When higher-order executive functioning skills (e.g., cognitive flexibility, organization, self-monitoring) are compromised, patients may offer change talk and ideas about goals that are in contrast to what the evaluating clinician and treatment team are recommending. Although it may be tempting to ignore such statements by the patient and compromise engagement, the continued use of reflections that reinforce any change-talk language, along with a summary that synthesizes ambivalence (if present), can facilitate the transition to discuss assessment results, treatment planning, and recommendations.
- Independent ideas about planning may be particularly difficult for the patient in the context of their depressive symptoms. Adjusting your responses by making more concrete reflections and offering more tailored, yet open-ended, questions and/or multiple-choice questions can help guide the patient and promote planning.

- Maintaining a guiding stance is imperative. Use of MI skills such as asking open-ended questions that directly elicit language about commitment and taking steps, asking for elaboration, reinforcing and reflecting any change talk, incorporating the ask–tell–ask strategy to provide information, and including advice or a menu of options for change can all help the patient delineate steps to increase the likelihood of adherence with treatment planning recommendations.
- Adults with depression and neurocognitive difficulties may have had prior difficulties with successfully sustaining change. As a result, identifying barriers to overcome potential challenges in the treatment planning recommendations and knowing what to do about them are essential. Using clinician expertise (with permission) and offering options about ideas to overcome potential barriers can be facilitated by using the ask–tell–ask strategy.
- Recognizing and discussing with the patient that change planning may need to be revisited with others in the integrated health care team can facilitate a sense of hope in the patient, particularly if the patient is concurrently completing other medical or psychiatric evaluations and treatments.
- Commitment language, stated by the patient, indicates the likelihood of engaging in a behavioral change. It is important to reinforce and reflect such language, as such language is most predictive of the patient engaging in actual change (Miller & Rollnick, 2013).

### MI Practitioner Considerations

- How are both the development of a commitment to change and formulation of a concrete plan of action being conveyed, incorporating the patient's neurocognitive difficulties and needs as well as the needs of the family?
- How am I offering needed advice or information with permission, and how is my approach different from that of other practitioners the patient has seen?
- As the patient has likely been involved in other treatment settings by the time a clinical neuropsychological evaluation is made, consider how am I using evocation versus a prescriptive planning stance to elicit change talk in treatment planning?
- When I hear commitment language, how am I reinforcing it or negating it by taking a prescriptive stance?



## SUMMARY

Motivational interviewing has emerged as a promising empirically supported, evidence-based intervention that can enhance clinical neuropsychological practice, including diagnostic assessment, therapeutic feedback, and cognitive rehabilitation interventions. MI can assist with optimizing the therapeutic alliance as well as offer an ever growing body of translational applications to help adults with depression and neurocognitive difficulties

make difficult changes that optimize treatment outcomes and maximize their full potential (Miller & Rollnick, 2013; Naar & Suarez, 2021; Steinberg & Miller, 2015; Suarez & Mullins, 2008). MI can help establish patient-centered and goal-oriented approaches that focus on the patient's language and commitment to change during the assessment and feedback processes, as well as strengthen engagement and compliance with treatment recommendations to improve clinical, neurocognitive, functional, and quality-of-life outcomes (Suarez, 2011).

## REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Bell, K. R., Temkin, N. R., Esselman, P. C., Doctor, J. N., Bombardier, C. H., Fraser, R. T., et al. (2005). The effect of a scheduled telephone intervention on outcome after moderate to severe traumatic brain injury: A randomized trial. *Archives of Physical Medicine and Rehabilitation, 86*(5), 851–856.

Bombardier, C. H., Bell, K. R., Temkin, N. R., Fann, J. R., Hoffman, J., & Dikmen, S. (2009). The efficacy of a scheduled telephone intervention for ameliorating depressive symptoms during the first year after traumatic brain injury. *Journal of Head Trauma Rehabilitation, 24*(4), 230–238.

Byers, A. M., Lamanna, L., & Rosenberg, A. (2010). The effect of motivational interviewing after ischemic stroke on patient knowledge and patient satisfaction with care: A pilot study. *Journal of Neuroscience Nursing, 42*(6), 312–322.

Chien, W. T., Mui, J., Gray, R., & Cheung, E. (2016). Adherence therapy versus routine psychiatric care for people with schizophrenia spectrum disorders: A randomised controlled trial. *BMC Psychiatry, 16*, 42.

Choi, J., & Twamley, E. W. (2013). Cognitive rehabilitation therapies for Alzheimer's disease: A review of methods to improve treatment engagement and self-efficacy. *Neuropsychology Review, 23*(1), 48–62.

Fiszdon, J. M., Kurtz, M. M., Choi, J., Bell, M. D., & Martino, S. (2016). Motivational interviewing to increase cognitive rehabilitation adherence in schizophrenia. *Schizophrenia Bulletin, 42*(2), 327–334.

Holt, C., Milgrom, J., & Gemmill, A. W. (2017). Improving help-seeking for postnatal depression and anxiety: A cluster randomised controlled trial of motivational interviewing. *Archives of Women's Mental Health, 20*(6), 791–801.

Keeley, R. D., Brody, D. S., Engel, M., Burke, B. L., Nordstrom, K., Moralez, E., et al. (2016). Motivational interviewing improves depression outcome in primary care: A cluster randomized trial. *Journal of Consulting and Clinical Psychology, 84*(11), 993–1007.

Keeley, R. D., Burke, B. L., Brody, D., Dimidjian, S., Engel, M., Emsermann, C., et al. (2014). Training to use motivational interviewing techniques for depression: A cluster randomized trial. *Journal of the American Board of Family Medicine, 27*(5), 621–636.

Miller, W. R., & Rollnick, S. R. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*(6), 527–537.

Naar, S., & Safren, S. A. (2017). *Motivational interviewing and CBT: Combining strategies for maximun effectiveness*. New York: Guilford Press.

Naar, S., & Suarez, M. (2021). *Motivational interviewing with adolescents and young adults* (2nd ed.). New York: Guilford Press.

Navidian, A., Mobaraki, H., & Shakiba, M. (2017). The effect of education through motivational interviewing compared with conventional education on self-care behaviors in heart failure patients with depression. *Patient Education and Counseling, 100*(8), 1499–1504.

Ponsford, J., Lee, N. K., Wong, D., McKay, A., Haines, K., Alway, Y., et al. (2016). Efficacy of motivational interviewing and cognitive behavioral therapy for anxiety and depression symptoms following traumatic brain injury. *Psychological Medicine, 46*(5), 1079–1090.

Schoenberg, M. R., & Scott, J. G. (Eds.). (2011). *The little black book of neuropsychology: A syndrome-based approach*. New York: Springer.

Steinberg, M., Miller, W. R. (2015). *Motivational interviewing in diabetes care*. New York: Guilford Press.

Suarez, M., (2011). Application of Motivational Interviewing to neuropsychology practice: A new frontier for evaluations and rehabilitation. In M. R. Schoenberg & J. G. Scott (Eds.), *The little black book of neuropsychology: A syndrome-based approach* (pp. 863–-871). New York: Springer.

Suarez, M., & Mullins, S. (2008). Motivational interviewing and pediatric health behavior interventions. *Journal of Developmental and Behavioral Pediatrics, 29*(5), 417–428.

Watkins, C. L., Auton, M. F., Deans, C. F., Dickinson, H. A., Jack, C. I., Lightbody, C. E., et al. (2007). Motivational interviewing early after acute stroke: A randomized, controlled trial. *Stroke, 38*(3), 1004–1009.

Watkins, C. L., Wathan, J. V., Leathley, M. J., Auton, M. F., Deans, C. F., Dickinson, H. A., et al. (2011). The 12-month effects of early motivational interviewing after acute stroke: A randomized controlled trial. *Stroke, 42*(7), 1956–1961.





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