

Examining Miller and Rollnick's Motivational Interviewing approach through the "Ways Paradigm"

Introduction

Pressuring clients to change can have a paradoxical effect – the greater the force applied, the more clients resist, resuming or redoubling their undesired or destructive behaviours. Counter intuitively, external encouragement can actually decrease motivation (Arkowitz et al, 2008).

Motivational Interviewing (MI) is a framework for using clients' own drives and resources to motivate change. MI has been successfully applied in the treatment of substance abuse, sex offences, gambling addiction, and depression and anxiety (Markland et al, 2005) (Arkowitz & Westra, 2004). MI works best without a structured manual (Miller & Rollnick, 2009); and can be used as preparation for brief counselling, as a technique for dealing with decisional ambivalence, or integrated with CBT or psychodynamic therapies (Miller & Rollnick, 2002, pp 28).

This essay evaluates MI through Sharon Cheston's 'Ways Paradigm', which categorises counselling methodologies by their *way of being* in the interpersonal dynamic, their *way of understanding* mental functioning, and their techniques for *intervening* to reduce distress and treat disorder (Cheston, 2000).

Motivational Interviewing as a Way of Understanding

MI is humanistic, directive, person centred and inter-relational, and based on clinical and research experience (Miller & Rollnick, 2002, pp 34). According to MI, the core components of change motivation are clients' willingness to change, perceived capacity to change, and the priority change has for them (Miller & Rollnick, 2002 pp 16).

MI sees resistance as a way of maintaining autonomy and integrity in the face of perceived control or manipulation (Moyers & Rollnick, 2002). Rather than lacking motivation, clients may be motivated towards goals that conflict with those imposed on them (Miller & Rollnick, 2002, pp 18).

MI works to decrease ambivalence, the contradictory appeal and repulsion we feel towards aspects of a choice, by increasing the perceived benefits of desired behaviours and costs of undesired behaviours.

Prochaska's Transtheoretical Stages of Change Model (SOC) (Arkowitz et al, 2008) includes five stages of behavioural change – 'precontemplation, contemplation, preparation, action, and maintenance' (West, 2005). MI is often employed to motivate clients at the pre-contemplative or contemplative stage; as both MI and SOC share an emphasis on the level of client readiness for change and the importance of ambivalence in preventing change (Arkowitz & Miller, 2008, pp 3). However, MI is not based on SOC, nor is it a theory of how change occurs in general, but rather a clinical methodology and communication style (Miller & Rollnick, 2009, pp 130).

Self-determination theory (SDT) may offer an underlying theoretical framework for MI (Markland et al, 2005). SDT posits that autonomous motivations towards growth, self-integration and psychological consistency are more powerful, persistent and effective than externally imposed motivations. Since MI works to increase autonomy, competence, and relatedness between clinician and client, it facilitates the core components of SDT. SDT offers a method for experimental validation and improvement of MI's component techniques (Markland et al, 2005).

Motivational Interviewing as a Way of Being

The interpersonal qualities of the 'spirit' of MI have an independent impact on treatment efficacy (Arkowitz et al, 2008, pp 331). These include acknowledging clients' autonomy in choosing (or refusing) to change, encouraging clients to develop their own goals, and collaborating with clients in a supportive and empathic partnership (Rosenberg, 2009, pp 13). The spirit of MI guides a humanist way of being, centred around the person and their intrinsic desire to improve (Arkowitz et al, 2008, pp 330). The principles of MI are: clients' motivations appear rational from their perspective, the evocation and selective reflection of 'change talk', and the acceptance of clients' reluctance to change.

Motivational Interviewing as a Way of Intervening

Clients' perception of their current behaviour, their desired behaviour, or the gap perceived between them can be modified to motivate behavioural

change. To increase these discrepancies, MI practitioners selectively reflect ‘change talk’ about the negative consequences of current behaviours, the benefits of altering behaviour, the practicalities and possibility of altering behaviour and their willingness to modify behaviour (Miller & Rollnick, 2002, pp 24). Key skills of MI include provoking ‘change talk’, ‘rolling with’ talk that argues against change, and integrating MI with other methodologies like CBT (Arkowitz et al, 2008, pp 18).

MI employs OARs; open questions, affirmations, skilled reflections (of cognitive and affective change talk), and summaries (collecting thoughts, linking with past material and transitioning topics, sessions or phases) (Miller & Rollnick, 2002, pp 72).

‘Readiness rulers’, 1 – 10 self-ratings of aspects of client behaviour (e.g.: desire to change), can be used to initiate change talk (Rosenberg, 2009, pp 98).

‘Decisional balance sheets’ of positives and negatives associated with decisions are sometimes used to elicit the pros and cons of a choice. However Miller & Rollnick now suggest limiting use of decisional balance approaches, since they have been found to elicit and develop ‘sustain’ talk. They should be used where clients are unwilling to even begin talking about a behavioural change, or where counsellors do not wish to influence a decision (Rosenberg, 2009, pp 199) (Miller & Rollnick, 2009, pp 133).

The Personal Values Card Sort (VCS) offers clients a set of cards representing beliefs and values, to rank by order of their importance (Miller et al, 2001). Counsellors elicit elaboration of the highest rated values, how they are being implemented, and how new behaviours might better and accord with them (Rosenberg, 2009, pp 199).

Delays in transitioning from Phase 1 of MI (increasing clients' motivations to alter behaviour) to Phase 2 (planning and increasing commitment to new behaviours) (Arkowitz & Miller, 2008, pp18), may reduce clients' readiness to change. Premature transitions can increase clients' reluctance to change (Rosenberg, 2009, pp 255). To judge when to transition, MI practitioners observe the markers of change. These include reduced problem focused talk, and increased self-initiated efforts towards change (Rosenberg, 2009, pp 256).

Beginning Phase 2, the counsellor provides a transitional summary, including reflections of the clients' own change talk and feelings of ambivalence.

'Key questions' about clients' preferences on how to proceed help develop a 'change plan', client and counsellor together elaborate to make practical, achievable and desirable (Rosenberg, 2009, pp 257).

Conclusion

This essay evaluated MI under Sharon Cheston's 'Ways Paradigm' (Cheston, 2000). MI is a person-centred approach that values client autonomy, and employs techniques that increase motivation and promote

change by eliciting and selectively reflecting client talk. MI has been applied as part of the Stages of Change approach to addiction treatment, and understood according to Self-Determination Theory. Future MI developments could focus on increasing relatedness (e.g.: including positive social outlets in change plans), and developing new ways of eliciting client values and paring them with client generated behavioural strategies.

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