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Final Integrative Paper: Integrating Motivational Interviewing & Cognitive Behavioral Therapy

Motivational Interviewing & CBT

Motivational Interviewing, commonly referred as “MI” evolved from Carl Roger’s person/client centered approach, to counseling and therapy, as a method to help people commit to the difficult process of change. It was introduced by psychologist William R. Miller, in 1983 and further developed by Miller and psychologist Stephen Rollnick. Motivational Interviewing, (commonly referred to as MI) is a collaborative, goal-oriented style of communication, with particular attention to the language of change. It is designed to strengthen personal motivation for and 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) While MI, has its origins in addiction medicine, it is widely recognized as a multi-faceted, treatment modality. Through, clinical experience, and empirical research/data, the fundamental principles and methodologies of MI, have been applied and tested in various treatment settings, and research findings have demonstrated its efficacy.

MI has four fundamental processes:

- Engaging: This is the foundation of MI-goal is to establish collaborative working relationship through careful listening to understand and accurately reflect the person’s experience and perspective.

- Focusing: An agenda is negotiated, that draws on both the client and practitioner expertise to agree on a shared purpose.
- Evoking: Clinician gently explores and helps the person to build their own “why” of change through eliciting the client’s ideas and motivations.
- Planning: Planning explores the “how” of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person’s own insights and expertise.

Additionally, there are four main principles that guide the practice of MI:

- Express Empathy: Listen rather than talk; communicate respect for and acceptance of client
- Support Self Efficacy: Support client’s capacity to reach goals
- Develop Discrepancy: Clarify how current behavior conflicts with goals
- Roll with Resistance: Avoid confronting denial, encourage client to make progress towards change

It is important to note that application of MI, in therapeutic process, requires the clinician to engage with the client as an equal partner, therefore skilled MI practitioners, “should refrain from providing unsolicited advice, confronting, instructing, directing, or warning.” “It is not a way to “get people to change” or a set of techniques to impose on the conversation.” MI requires time, practice and requires self-awareness and discipline from the clinician. (Miller & Rollnick, 2009)

MI practitioners need to incorporate the following therapy/intervention skills in their work with clients:

Basic Skills of Motivational Interviewing:

- Open-Ended Questions-Client does most of the talking
- Affirmations-Builds rapport, provide validation and support for client
- Reflections-Helps client understand motivations more fully
- Summarizing-Demonstrates listening and understanding of client's perspective

MI Practitioners, should also incorporate the following guiding principles in their work with clients to support overall treatment goals and objectives:

- Express Empathy: listen rather than talk, communicate respect for and acceptance of client
- Support Self-Efficacy: Encourage/Promote client's capacity to achieve goals
- Develop Discrepancy: Clarify how current behavior conflicts with goals
- Roll with Resistance: avoid confronting denial, encourage client to make progress towards change

MI assumes that people with problematic behaviors, have different levels of readiness for behavior

change (Miller & Moyers 2017).

Motivational Interviewing & Stages of Change Model

- Contemplation: Acknowledging problem but not ready or sure of wanting to make a change
- Preparation/Determination: Getting ready to change

- Action/Willpower: Changing behavior
- Maintenance: Maintaining the behavior change
- Relapse: Returning to older behaviors and abandoning the new changes

Cognitive Behavioral Therapy (CBT) is a therapeutic treatment intervention that helps people learn how to identify and change the destructive thought patterns that have negative influences on behavior. It can be a very helpful tool, when utilized either alone or in combination with other therapies, in treating mental health disorders, such as depression, post-traumatic stress disorder, eating disorder, etc. however, not everyone who benefits from CBT has a mental health condition- CBT can be used to help anyone better manage stressful life situations. CBT, is a highly structured form of treatment, where client is required to attend/complete a limited number of sessions weekly, generally, over a two-three, month period. CBT helps clients develop increased awareness of inaccurate/negative thinking so they are able to view challenging situations more clearly, and respond to them in a more effective way.

CBT, combines both cognitive and behavior therapy, its primary goal, is identifying and restructuring maladaptive patterns of thinking, emotional responses, or behaviors and replacing them with more desirable patterns. The major objective of this therapy, is devising practical and realistic solutions to problems/issues. CBT, also highly emphasizes identification and recognition of negative thought patterns and behaviors and reframing them (through skill-learning) to elicit positive change. It is noteworthy, this form of therapy places emphasizes solution of presenting problems without consideration of history/background, perceived origin. It primarily, consists of task-centered activities/exercises which solicit active participation from clients, as through task-

centered exercises; homework assignments, such as journaling to facilitate further exploration of thought patterns and emotions.

Types of CBT

- Cognitive Therapy
- Dialectical Behavior Therapy
- Multimodal Therapy
- Rational Behavior Emotive Therapy

CBT Techniques include/but are not limited to:

- Identifying Negative Thoughts
- Practicing New Skills
- Goal Setting
- Problem-Solving
- Self-Monitoring

Clinical Application of Motivational Interviewing & CBT in Group Work Practice

Motivational Interviewing and Cognitive Behavioral Therapy; Cognitive Therapy & Rational Emotive Behavior Therapy (REBT) are two highly regarded treatment interventions utilized across a multitude of therapeutic settings, and environments. They are both highly effective in treating a wide array of behavioral health concerns. These interventions can be utilized independently or in conjunction with each other depending on the therapeutic setting /approach. This paper will focus on the implementation of both treatment models within a group setting/dynamic. As it pertains to CBT treatment interventions, elements of both Cognitive

Therapy & REBT will be used to guide and inform treatment. Prior, to integration of this treatment model/s/framework, therapist will give special consideration to group characteristics/composition and related influential factors; such as age, sex/gender, race, ethnicity, socio-economic status, etc.-group should promote diversity/inclusivity. Another key consideration is relevant stage/s of group development, and related impact/ implications on perceived outcome/s.

Since, the development and related application of an integrative approach, will require some degree of skillful planning on the part of therapist/group leader, there must be establishment of pre-determined goals and objectives and anticipated measures to achieve desired results. In this regard, pre-planning will be critical element of overall treatment plan. Initial group meeting, should emphasize and reinforce clearly defined goals and objectives for group, relevant guidelines such as norms/rules; attendance/participation, conflict-resolution, treatment modalities to be employed and related advantages/disadvantages. MI, will be used to inform therapeutic rapport/engagement. Group leader/facilitator, will employ use of democratic leadership style, to minimize potential for power struggles. There should also be some level of transparency about perceived limitations of group work practice, goals for termination. CBT, will be the primary treatment modality utilized, however MI, will be used to inform and support overall treatment goals, given time sensitivities around CBT.

MI, continues to be one of my preferred interventions in working with clients as it puts them in the “driving seat” of their treatment. While MI, does have tremendous benefits, it equally poses

some unique challenges for clients and practitioners such as time constraints, however, MI will guide initial stages of group intervention for members with a presenting problem of Major Depressive Disorder (MDD). During, scheduled group sessions group leader will utilize MI techniques to facilitate a supportive stance/ role within group dynamic. In the beginning stages, MI will be helpful in facilitating feedback through the use of open-ended questions. Members, will also be encouraged to actively participate in establishing their own goals for treatment. Leader, should also be cognizant that group dynamic can be an intimidating environment for some individuals and take necessary steps to mitigate this. MI, will also be an effective tool in assessing readiness for change/motivation, to determine if they are a good-fit for group, and whether additional supports may be needed.

As the group continues to undergo the relevant stages of growth and development, group members will eventually be introduced to CBT, to develop/promote increased ability to personally identify irrational thoughts/beliefs thereby influencing “change-goals” with guidance from group leader if/when required., and engage in goal-directed problem-solving. It is imperative members to distinguish thoughts, feelings, and situations are contributing factors in maladaptive behaviors.

Taking the time to identify these thoughts and behavior patterns can pose tremendous benefits to the therapeutic process. Leader, will assist members in differentiating between realistic/unrealistic goals. REBT, will also be introduced to help facilitate cultivation of healthy thoughts and emotions. Additionally, members will identify/explore motivation/steps to promote/maintain change, consistent with CBT techniques-group leader will achieve this through

introduction of task-centered activities and exercises to help restructure and reframe negative automatic thoughts. Members will be assigned home-work exercises to promote increased mastery of skill/s. Further, group leader, will continually impart/reinforce necessary CBT skills and techniques;(reframing/restructuring negative thought patterns, reality testing, etc) to support members in unlearning /dispelling negative thought patterns and belief systems.

CBT, entails more than identifying thought patterns. It uses a wide range of strategies to help people overcome these patterns, therefore, leader will utilize/incorporate fundamental CBT principles such as The CBT Group Interventions to be utilized will include/but not limited to, relapse prevention, monitoring activities, automatic thought records, problem solving, disputing beliefs, socratic questioning, monitoring moods, relaxation methods, etc. Leader, will help support challenging irrational beliefs about oneself, and guide members in developing more positive esteem. Members will be held accountable for completion of home-work exercises, and will be expected to provide personal account/report of self-monitoring activities.

Overall, both treatment modalities were complementary; MI, and CBT are both gradual processes, which emphasize incremental change. Both interventions facilitate self-directed goal attainment, and proved to be effective in eliciting positive change amongst client population.

Classroom Experience

The group to which I've been assigned for the duration of the semester is popularly known/referred as "Zoom Group/Zoomies" given members engage on virtual platform. It essentially functions as "Task-Group"- we are assigned assignments/projects to complete within a group dynamic. Group consists of a diverse group of students/members from varied personal and professional backgrounds, which is a significant strength for the group as a whole (each

individual brings a unique perspective to group interactions which helps to further enhance and support group objectives) however, this proved to be a significant source of conflict, due to the diversity of opinions amongst members. It became apparent at times, group cohesion, may have been an unattainable goal, however, members remain committed to the attainment of overall group objectives.

In the initial stages of group formation, a democratic leadership structure was instituted, however, this quickly changed over time as some individuals were “fighting for dominance.” Since my personality does not lend easily itself to confrontation, I was often a “silent observer” when these conflicts would arise. I largely consider myself an independent leader, however, membership in this group afforded me the opportunity to further develop my leadership skills, as I was able to assume a greater level of responsibility in the administration of group activities, and was instrumental in devising solutions to relevant issues, enabling, members to experience a greater sense of inclusivity in group interactions. In my past/current group experiences, fostering a sense of belongingness, and value amongst group members, promotes increased outcomes.

Over time ,I came to the realization that most group members were impacted by stress/fatigue after having worked a full day and subsequently reporting to class (we obviously had more similarities than differences) so I tried to exercise more sensitivity in my interactions with them, and this proved to be an effective coping mechanism.

The small group process proved to be a rich learning experience for myself and peers, and I’m certainly impressed by the tremendous level of growth we have all experienced as result of this process-the popular saying team-work makes the dream work, comes to mind. Overall, group has reached a level of homeostasis-considered coordinated and well balanced. As we prepare to embark on our respective social work journeys, we have truly become experts in group work

practice and will surely utilize all the teachings to inform/guide our work with clients. However, I must caution aspiring social work graduate students, group work is not as simplistic as initially perceived as it poses unique challenges for both facilitators and members.

In conclusion, I would like to take this opportunity to provide personal feedback about this course-my overall assessment of this course, is it's been extremely effective in imparting the relevant skills needed to effectively conduct group work in both therapeutic/non-therapeutic settings. I must admit, I initially had reservations about group work, however, I thoroughly enjoyed the class-room experience, particularly, the "role-play" exercises. Prior, to my enrollment, in this course, my experience with group therapy was somewhat limited however, this experience has enabled me to develop a greater level of competency in this subject matter.

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