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Contrasting decisional balance to eliciting change talk: Considerations for therapist training

John Paulson[1*]
[1]Social Work Department, University of Southern Indiana, USA; ajpaulson@usi.edu (J.P.).

Abstract: Decisional balance and evoking change talk are therapeutic strategies designed to increase the likelihood of individuals deciding to make changes, especially when they feel ambivalent. While these approaches overlap, decisional balance is traditionally associated with the Transtheoretical Model (TTM), or stages-of-change model, whereas evoking change talk is central to Motivational Interviewing (MI). There has been ongoing debate about which method is more effective or appropriate for resolving ambivalence and promoting change. Some evidence suggests that decisional balance might even hinder behavior change, raising questions about its clinical relevance. This article aims to address these issues conceptually and explore how aspects of decisional balance—such as its structure, stepwise facilitation, and guiding principles—can benefit the education, training, and supervision of psychotherapists. It emphasizes that learning decisional balance can positively impact psychotherapist training by encouraging engagement, exploration, and elaboration. Additionally, it helps new clinicians avoid rushing into prescriptive interventions prematurely, fostering a more thoughtful, client-centered approach to facilitating change.

Keywords: *Decisional balance, Motivational interviewing, Transtheoretical model.*

1. Introduction

Motivational Interviewing (MI) (Miller & Rollnick, 2023) and The Transtheoretical Model (TTM) (Connors, DiClemente, Velasquez, & Donovan, 2013), often referred to as the stages-of-change (SOC), is a prominent psychotherapeutic framework that emphasizes client engagement and the facilitation of behavior change. These approaches have been widely adopted across various helping professions, including clinical social work, clinical psychology, mental health and addiction counseling, marriage and family therapy, and other allied disciplines. In fact, both the TTM and Motivational Interviewing (MI) are now integral parts of behavioral health and social service interventions, extending their influence throughout the broader healthcare system. Both models underscore the importance of recognizing and respectfully responding to client ambivalence, or uncertainty about changing or one's capacity to change. MI addresses this through strategies designed to elicit and respond to what is termed change talk, comments made by the individual that express a desire or capacity for change, versus sustain talk, which supports maintaining the current behavior. MI employs the acronym DARN CAT to specify the types of change talk targeted: statements reflecting desire, ability, reason, or need to change (DARN), as well as comments indicating commitment to change or activities supporting change, including steps the individual plans to take or is currently undertaking (CAT). This structured approach facilitates effective communication and enhances motivation for behavioral change, making it a valuable tool in diverse clinical settings (Miller & Rollnick, 2023). Clinicians intentionally eliciting and amplifying change talk is incredibly important, as research suggests that individuals who engage in more change talk during therapy sessions are more likely to change (Miller & Rollnick, 2023; Miller & Rose, 2015).

The TTM (Connors et al., 2013) focuses on several stages of change that occur as individuals progress toward making substantive behavioral modifications. Each stage is characterized by the individual's

* Correspondence: ajpaulson@usi.edu

current position in the change process and the most effective strategies for engaging with them at that point. In the precontemplation stage, the individual does not yet recognize a need to change and does not express a desire or intention to do so. Clinical interventions at this stage typically focus on consciousness-raising by highlighting potential or current problems resulting from the behavior and creating discrepancies between the individual's values and their current actions. During the contemplation stage, the individual recognizes a problem and the need for change but remains ambivalent. The recommended intervention is to help address this ambivalence in a non-confrontational manner. In the preparation stage, the individual begins planning to change, and clinicians assist by identifying potential strategies and resources. During the action stage, the individual actively implements change strategies. The maintenance stage involves ongoing monitoring of change efforts, reinforcing successful strategies, revising less effective plans, normalizing any return to previous behaviors, and facilitating a recommitment to change efforts in response to relapse. The Transtheoretical Model (TTM) emphasizes that the change process is cyclical rather than linear. It is crucial for clinicians to accurately assess the individual's current stage to tailor interventions effectively, thereby improving treatment outcomes. Adjusting strategies to meet the needs of each stage helps facilitate movement from lower to higher readiness levels, especially in resolving ambivalence (Connors et al., 2013; Krebs, Norcross, Nicholson, & Prochaska, 2018).

Both MI and the TTM place significant emphasis on skillfully responding to ambivalence. Each approach notes that ambivalence is a natural and necessary aspect of the change process. Historically, however, most therapy models have interpreted expressions of ambivalence as representing client defensiveness, denial, or resistance, which often lead therapists to respond in ways that impede the therapeutic relationship and process (Connors et al., 2013; Miller & Rollnick, 2023). MI and the TTM have often recommended similar yet differing strategies for addressing and responding to ambivalence. Miller and Rose (2015) compare these by discussing the common MI practice of eliciting change talk and the TTM strategy of decisional balance (DB). They outline defining characteristics of decisional balance as identifying pros and cons of a choice in an unbiased manner while maintaining a neutral stance towards change (i.e., not attempting to advocate for or influence a particular choice). Miller and Rose (2015) briefly describe that this process commonly involves a decisional matrix of advantages and disadvantages for both change and maintaining the status quo. They then contrast this approach to MI eliciting change talk, and whereas decisional balance actively identifies reasons for maintaining the status quo and not changing (which MI would describe as sustain talk), the MI stance consists of respectfully acknowledging sustain talk when it arises (while not eliciting or encouraging it) and actively eliciting change talk.

Although both MI and the TTM emphasize the importance of addressing and resolving ambivalence as an essential aspect of treatment, Miller and Rose (2015) suggest that the aspects of decisional balance that actively elicit sustain talk do not seem to contribute in any positive or meaningful way to the resolution of ambivalence, and they propose that including such a focus might be detrimental and lead clients to be less likely to change than the MI approach of only eliciting change talk. Their criticism is supported by a review of several empirical studies indicating that a focus on decisional balance appears to make it less likely for individuals to change, both when used as a standalone practice and when combined with MI. They state, "the theoretical rationale is unclear, however, for why constructing a DB would be expected to resolve ambivalence and promote a decision to change unless the pros heavily outweigh the cons, in which case the person is already well along in readiness to change (Miller and Rose, 2015). This raises the question of whether there is any utility to DB as an intervention generally or for inclusion in graduate training for therapists. This article explores the potential benefits of learning to use DB as an educational exercise for therapists completing graduate training that Miller and Rose do not acknowledge.

2. Therapeutic Implementation of Decisional Balance

Characterizing decisional balance as merely the development of an unbiased pros and cons list guided by a sense of neutrality is understandable, especially since many of the main MI and TTM texts offer

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little description and development of the DB method. The four-quadrant approach is often briefly discussed in TTM texts (Connors et al., 2013; Velasquez, Crouch, Stephens, & DiClemente, 2016). IIt is rarely described in detail, and little to no explanation or instruction is given concerning the function of the quadrants generally or specifically for the rationale of the order of the quadrants. Connors et al. (2013) offer a one-page general description of decisional balance and the importance of eliciting and clarifying pros and cons for the behavior for clients at the contemplation stage; however, their main emphasis in this discussion is on linking reasons for change and against continuing the behavior to the individual's values. They include a diagram of a decisional balance worksheet, which does contain each of the quadrants; however, there is no description of the quadrants or their order. This is in a treatment manual for using the TTM in group therapy settings (Velasquez et al., 2016). Decisional balance is included as an intervention for those at the precontemplation, contemplation, or preparation stages of change. Their description in the treatment manual does make a brief reference to acknowledging the importance of both the pros and cons of substance use and the positives and negatives of changing. Their instructions to clinicians state,

> Instruct them to first write their pros and then their cons for using, and then write the pros and cons for changing. The rationale for this ordering of the activity is that clients will end by thinking about the not-so-good things about using and the benefits of changing. In other words, each segment of the exercise concludes with the clients writing down and reflecting on their change talk (e.g., their desire, reasons, needs) for making a healthy decision about their substance use and not their sustain talk (how they cannot or do not want to change) (Velasquez et al., 2016).

However, this process in their group intervention is not directly guided by a clinician, as members are asked to complete a worksheet. Both in the instructions to therapists and on the worksheet, significant time and emphasis are placed on assigning a weighted importance to each point listed. They highlight in their discussion the importance of the therapeutic rationale for the technique, especially in the precontemplation and contemplation stages, of tipping the relative weight of pros over cons, and that doing so often leads to behavior change. This reflects the criticism mentioned by Miller and Rose (2015) and their suggestion that if eliciting change talk is key to change, then strategies for evoking that seem sufficient, and any efforts to do otherwise (i.e., identify advantages to the behavior or doubts about changing) risk hampering this endeavor.

MI texts have also presented DB in a way that lacks detail and guidance. In the third edition of *Motivational Interviewing: Helping People Change*, Miller and Rollnick (2013) dedicate half a page to discussing DB as a neutral approach to exploring ambivalence. While they include an illustration of the four-quadrant decisional matrix, they offer little commentary or guidance on the implementation or utilization of DB, commenting,

> The basic process in counseling with neutrality is to explore both the pros and the cons of the available alternatives, and to do so in a balanced way. A common practice is to systematically evoke the advantages and disadvantages of each option being considered… the point is to give equal attention to each of the boxes by evoking the client's full list in each, exploring each element by asking for elaboration and reflecting (Miller & Rollnick, 2013).

Their description of DB is also not very encouraging, as they point out that their experience suggests people often get confused by similar quadrants, and that one might be better off using a simple pros and cons list. In the most recent fourth edition of their seminal text Miller and Rollnick (2023) offer brief comments on DB and an illustration of the matrices; however, they continue to characterize it as a pros and cons approach, emphasize the role of neutrality, and even suggest that there are some circumstances where clinicians cannot be neutral and that attempting to do so would be unethical.

Each of these descriptions is vague and lacking in its development and description of DB as a clinical intervention. Matulich (2012) offers further clarity on the process and practice of DB, discussing each of the quadrants, the nature of details addressed in each, and the prescriptive order of movement through the quadrants through which the clinician guides the client and the rationale for doing so. The first two quadrants address the status quo (i.e., what the person is currently already doing), and the remaining two

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quadrants address change. The process begins in quadrant one with exploring the advantages of the status quo, or the good things about what they are currently doing. Quadrant two explores the disadvantages of the status quo, the not-so-good aspects of their current behavior. Quadrant three then addresses possible disadvantages of change, followed by quadrant four's consideration of the advantages of changing.

There is an important and often overlooked rationale for addressing each of these quadrants, but also in this guided order. Quadrants one and three are important yet often overlooked, neglected, dismissed, or shunned aspects of change considerations. It is important to address these with genuine sincerity and curiosity. Most people are accustomed to being lectured on the negative aspects of their behavior or being told what to do, so starting with an acknowledgment of positive aspects of the behavior can help reduce defensiveness and support collaborative engagement. Even maladaptive behaviors fulfill certain functions for individuals that need to be acknowledged. Recognizing these benefits both helps the individual to feel as though they are not being lectured to or demeaned while also identifying potential targets for successful behavior change. If someone's substance use, for example, helps them to feel less anxious and more social, then helping them to develop more adaptive strategies and skills for addressing these important needs would be an important part of change efforts. Rarely are the possible disadvantages of changing noted, so giving voice to those in quadrant three is also important. This conversation also helps to identify doubts, hesitancy, and uncertainties that the individual might have about attempting to change, allowing clinicians to help individuals develop plans for successfully identifying and addressing obstacles to change (Matulich, 2012). Quadrants two and four both actively elicit change talk, and as Velasquez et al. (2016) note, ending with the advantages of change means that the DB process concludes with eliciting change talk.

3. The Primacy of Therapeutic Alliance

Establishing a collaborative alliance based on security, trust, and respect is seen as vital in psychotherapy. Such a relationship is characterized by clients experiencing the therapist as safe, trustworthy, and competent, but also that clients believe or predict that the therapist is generally engaged, cares for them, wants them to do well, and that both therapist and client come to a generally agreed-upon understanding of what is occurring and how best to intervene. Studies on what is termed role induction show that when clients receive information on and express a greater understanding of the nature and function of the therapeutic relationship, the roles and responsibilities of those involved, the purpose of the intervention, and are allowed and encouraged to ask questions and express concerns, they are generally less likely to drop out of treatment, more likely to complete treatment, and have better outcomes (Swift, Penix, & Li, 2023). Decades of psychotherapy outcome research have also substantiated that it is not the specific theory or modality utilized but the common factors associated with the quality of the helping relationship that most significantly predict positive outcomes in treatment (Duncan, Miller, Wampold, & Hubble, 2010; Wampold & Imel, 2015).

The significant contribution of therapeutic alliance to outcomes emphasizes the importance of the relationship established and maintained by the therapist, as well as the skills utilized to foster this relationship. Central to this process is cultivating a sense of curiosity in exploring and elaborating on client experiences and dynamics, and doing so collaboratively. This can be challenging, as many behavioral health and social service interventions are action-oriented, focusing on identifying problems and prescribing solutions. While this corrective approach is necessary, it can lead clinicians to prematurely jump into problem-solving, solution-seeking, and change planning before fully engaging the individual and meeting them where they are. This may create a disconnect in the therapeutic relationship and process. Research by Prochaska and Velicer (1997), based on the stages of change, found that approximately eighty percent of individuals seeking services are in the precontemplation or contemplation stages. Therefore, emphasizing early engagement over action-stage interventions is especially important when individuals are mandated into services (De Jong & Kim Berg, 2001).

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Miller and Rollnick (2013) describe this tendency of jumping to action as what they call the expert trap and engaging in the righting reflex (the fourth edition (2023) now refers to this as the fixing reflex). They describe the motivations, characteristics, and consequences of the righting reflex as follows,

> Often, people become helpers for selfless reasons based on good intentions and a genuine desire to help alleviate the suffering of others. Ironically, these very motives can lead to the overuse of a directing style in an ineffective and even counterproductive way when the task is helping people to change. Helpers want to help, to set things right, to get people on the road to health and wellness, and it is done with the best of intentions, the desire to fix what seems wrong. Consider next that most people who need to make a change are ambivalent about doing so. They see both reasons to change and not to. Ambivalence is simultaneously wanting and not wanting something. Now, consider what happens when an ambivalent individual meets a helper with the righting reflex. Arguments both for and against change already reside within the ambivalent person. The helper's natural reflex is to take up the good side of the argument, explaining why change is important and advising how to do it. There is a rather predictable response when a person who feels two ways about something hears one side of the picture being emphasized: argue for one side, and the ambivalent person is likely to take up and defend the opposite. This sometimes gets labeled as denial, resistance, or being oppositional, but there is nothing pathological about such responses. It is the normal nature of ambivalence (Miller & Rollnick, 2013).

To counter this tendency towards the righting reflex, they emphasize the importance of engagement and using therapeutic communication strategies that foster exploration and help the individual to elicit their own motivations for change.

4. Deliberate Practice

Learning effective psychotherapeutic communication strategies and how and when to apply therapeutic techniques is challenging, especially initially for those in graduate education and training. Deliberate practice is an emerging approach to therapist training that aims to increase therapeutic competence and effectiveness (Miller, Hubble, & Chow, 2020; Rousmaniere, Goodyear, Miller, & Wampold, 2017). The principles of deliberate practice are based on psychological studies concerning skill acquisition and the development of expertise. When translated to psychotherapy, deliberate practice refers to work done outside of the actual session (referred to as direct practice) and involves efforts that occur before and after sessions (Rousmaniere, 2017). A foundational aspect of deliberate practice is providing feedback based on the direct observation of performance by someone with expertise. While this observation can occur live, reviewing recordings is preferred as a recording allows a unique vantage point, the ability to pause and rewind, and the opportunity to review portions of sessions and not only the sessions in their entirety. Reviewing a recording also avoids selective attention and memory biases that can occur with self-report descriptions of what was said or occurred during a session. Following the review of performance, the trainer identifies skills that are just outside the ability of the trainee to successfully perform. This is often referred to as the zone of proximal development or being on the edge of one's skill set. As opposed to focusing on the skills that one can already reliably perform or those that are currently vastly outside of one's ability to successfully implement, deliberate practice prioritizes those skills that are just outside one's current ability to consistently apply successfully. Once those skills are identified, methods are assigned to help the trainee rehearse and practice the skill, which is then implemented and reevaluated.

Two important aspects of deliberate practice are initially challenging for trainees. The first involves being recorded, reviewing one's performance, and receiving feedback. Many trainees report an initial reluctance to see and hear themselves on recordings and to watch their performance. Another difficulty arises from receiving feedback. Even when recognized as important and necessary, many trainees find it difficult to have their work scrutinized and corrected, especially if such evaluations are linked to a grade for a class project. This discomfort with being recorded appears to be more specific to clinicians than clients, as research indicates that clinicians generally have a greater reluctance to have their performance

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recorded than clients do to the recording of their sessions (Briggie, Hilsenroth, Conway, Muran, & Jackson, 2016). A second challenge to effective deliberate practice is the ability to identify and target specific clinical skills for practice. Ongoing development of deliberate practice methods and technologies is contributing to improvements in these areas for therapist training and supervision (Miller et al., 2020; Rousmaniere et al., 2017) and the first recently published randomized controlled trial of deliberate practice supports its ability to enhance the therapeutic effectiveness of trainees not only in responding to challenging interactions in therapy but also to promote the generalizability of those skills through receiving specific feedback and coaching (Chow et al., 2024).

5. Decisional Balance and Therapist Training

While Miller and Rose (2015) importantly point out that engaging clients in decisional balance might not resolve ambivalence or make clients more likely to change, or might not do so in any additive manner beyond merely eliciting change talk, and that studies suggest that the active eliciting of sustain talk might impede deciding to change. There are still justifications for utilizing decisional balance in ways that are beneficial both therapeutically and in therapist training. They acknowledge as much in their article, stating:

> If clients are more likely to change when counselors evoke more change talk and less sustain talk, then giving equal weight and airtime to pros and cons would be contraindicated if the goal is to promote change. Behavior change is not, of course, the only relevant outcome measure. When counseling with neutrality, the goal is often to help clients make a choice or decision with which they are satisfied and at peace, in a way that minimizes post-decisional regret and its biopsychosocial consequences (Miller & Rose, 2015).

Miller and Rose (2015) correctly describe the historical spirit of decisional balance from its developers as a neutral approach; however, assuming that it must be inherently and entirely neutral is mistaken. Decisional balance does not always, as they say, give equal weight and airtime to pros and cons in a completely neutral manner.

Although facilitating change is a primary focus of behavioral health and social service interventions, it is not the only focus of psychotherapy. There appear to be three primary benefits that training in the utilization of decisional balance offers, especially to trainees.

5.1. Decisional Balance Elicits and Amplifies Change Talk

Decisional balance helps people elicit more informed and developed reasons and considerations for change by developing information in all four quadrants of advantages and disadvantages of the status quo and changing, while also intentionally emphasizing change talk. The strategic placement of quadrants two (the disadvantages of the current behavior) and four (the advantages of changing) following sustain talk is an intentional strategy to elicit and emphasize change talk. While not completely neutral, decisional balance does engage an increased sense of general neutrality and nondirective nature by acknowledging quadrants one and three.

The inclusion of and focus on quadrants one (the sustaining factors and relative payoffs of the current behavior) and three (the potential problems or challenges created by change) are important aspects of any intentional conversation about considering or making significant change. Suggesting that eliciting details for quadrants one and three necessarily makes an argument against change is an incorrect conclusion. Clinicians are not encouraging clients to make an argument that supports their current behavior and that argues against change. What it does reflect is a commitment to a more complete consideration of natural dynamics (that are already present) that helps people to make more informed, developed, intentional choices.

In fact, overlooking or dismissing these essential aspects of change consideration could lead to suspicions from clients that the clinician is trying to strongly influence them or convince them to agree with a particular perspective or adopt changes prioritized and recommended by the clinician (in their third edition Miller and Rollnick (2013) noted this concern, emphasizing the importance of the spirit of MI to

ensure that practitioners are not using the structure and mechanics as a form of persuasion or manipulation). Although Miller and Rose (2015) point out that MI respectfully acknowledges sustain talk (without engaging it) while evoking and emphasizing change talk. A passing and placating response to sustain talk could come across to clients as the clinician not being truly neutral.

The notion that any form of psychotherapy is, can, or should be completely neutral is mistaken. Helping relationships, while they aspire to be less directive, are psychosocial interventions. There are definitely scenarios and potential choices where such absolute neutrality would not be indicated or beneficial. When a sense of neutrality is suggested, what is meant is a general stance of openness and an aspiration and commitment to not enter the relationship with dogmatic commitments to certain ideas or assumptions or insistence on their adoption. Many forms of psychotherapy and much therapeutic practice unintentionally end up being such. It means being open to and considering multiple perspectives and preferences without automatically dismissing or rejecting views. It does not mean that ultimately clinicians must agree with, affirm, and endorse any and all choices, priorities, or perspectives.

5.2. Decisional Balance Encourages a Collaborative and Respectful Relationship

The less directive nature of DB and its attitude and approach of respect and genuine curiosity serve an additional function and benefit of DB beyond whether it results in behavior change or not, that being the type and nature of the relationship and interaction being encouraged, cultivated, and maintained. The process of decisional balance promotes a collaborative interaction that sincerely affirms the dignity, worth, autonomy, and self-determination of the individual. These priorities attempt to prevent, or at least counterbalance, tendencies towards being more critical, argumentative, or directive in one's approach and aspire to reduce defensiveness and resistance. The more neutral, less directive approach of DB identifies, validates, and honors clients' doubts, hesitancies, and uncertainties while exploring the function of a behavior and the needs it fulfills in a way that can help develop strategies to address them.

As mentioned previously, the nature and quality of the therapeutic alliance are consistently noted in outcome studies to be the most significant predictors of positive outcomes in psychotherapy (Duncan et al., 2010; Wampold & Imel, 2015). Any efforts, therefore, that attempt to engage clients and strengthen the therapeutic alliance hold significant potential benefits for improving therapeutic services. Given the way that DB invites clients to discuss potential changes in a respectful, sincere, and collaborative manner, it fosters such a connection. The ability and potential for DB to allow for genuine conveyance of acceptance, regard, and empathy for individuals and their circumstances also means that it reflects aspects of therapy that have consistently been shown to improve the outcomes of therapeutic services (Miller & Moyers, 2021).

The more neutral, less directive approach of DB can also help to counterbalance the tendency of clinicians to move too quickly to action-oriented interventions, thus reducing an overreliance on the righting or fixing reflex (Miller & Rollnick, 2013, 2023). This dynamic holds especially true for trainees and early-career clinicians who are especially prone to focusing on change and corrective interventions prematurely, particularly for clients who are at precontemplative or contemplative stages of change. Taking a more neutral posture can help to support engagement, exploration, elaboration, and the establishment and strengthening of the relationship over prescriptive interventions. This approach is especially important and beneficial for clinicians, especially those in training or early in their careers, who are more likely to encounter individuals who are not only precontemplative or contemplative but also less engaged and more defensive due to being mandated to services (De Jong & Kim Berg, 2001).

5.3. Decisional Balance Facilitates Deliberate Practice

Trainees and early-career clinicians often find it challenging to learn new therapeutic techniques and approaches. Understanding the reasons for the technique, when and why it is used, and the steps for how to implement it offers a blueprint for skill acquisition. DB has a clear, clinical rationale for when and why it is utilized, which involves helping individuals to explore dynamics concerning a potential significant change in a way that attempts to engage multiple considerations, elicit meaningful details, and to do so in

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a complete, fair, and balanced manner while still strategically highlighting the pros of changing problematic behaviors. The clinician also plays an important role in guiding the exploration through quadrants in an intentional and deliberate order. This structured, stepwise intervention lends itself well to deliberate practice (Miller et al., 2020; Rousmaniere et al., 2017).

Students and trainees can be instructed on the nature, purpose, and order of quadrants. This provides a structure of what to do, when, and why. Throughout the facilitation of the quadrants in their guided order, trainees can also focus on the development and use of defined, targeted therapeutic communication strategies such as open-ended questions, affirmations, reflections, and summarizations, commonly referred to as OARS in MI (Miller & Rollnick, 2023). This is especially true for the intentional use of questions in each quadrant to explore and elaborate upon elicited details and the use of reflections in each quadrant, as well as summarizations across quadrants before progressing in the process. Ideally, this practice should be recorded and reviewed by both the trainer (who will provide feedback) and the trainee (Briggie et al., 2016; Rousmaniere, 2017) so that performance on facilitating the quadrants in the assigned order while utilizing intentional OARS skills can be observed and evaluated.

6. Conclusion

Despite the benefits of DB identified in this article, it is important that educators, trainers, and supervisors still be cognizant of and emphasize to their trainees times when DB might be less indicated or appropriate. As Miller and Rose (2015) point out, if behavior change is the desired outcome, then a variety of studies do suggest that including DB might slightly increase the likelihood that ambivalent people might not choose to change, and that MI's strategy of focusing only on change talk might be more effective. Miller and Rollnick (2023) also highlight that certain dynamics and circumstances encountered in psychotherapy cannot be treated in a completely neutral manner, and doing so would be unethical and potentially malpractice.

The previously mentioned limitations aside, decisional balance offers several benefits both to therapy practice and for clinical training, especially when it is facilitated in the structured, guided manner outlined by Matulich (2012) of starting with eliciting and exploring the often-neglected advantages of the status quo, followed by the disadvantages of the status quo, then moving to explore potential disadvantages of changing and concluding with elaborating the advantages of changing. Though DB has historically been guided by a sense of commitment to neutrality, this prescriptive order helps to both acknowledge and honor aspects of sustain reasoning while also amplifying change reasoning and does so in a way that encourages a collaborative therapeutic alliance based on exploration and elaboration as opposed to overly focusing on corrective interventions.

Advantages for trainees include helping them to learn a more neutral, less directive approach that can foster a robust therapeutic alliance, especially with people who are lower in motivation to change or mandated to services. It also helps trainees learn a technique with a defined clinical rationale for the intervention that has a stepwise structure and order that allows for the targeting of discrete clinical skills to be engaged and implemented, thus making it an ideal focus for deliberate practice strategies. Given these attributes, decisional balance represents a good tool for not only therapeutic intervention but also for the training of therapists.

Transparency:

The author confirms that the manuscript is an honest, accurate, and transparent account of the study; that no vital features of the study have been omitted; and that any discrepancies from the study as planned have been explained. This study followed all ethical practices during writing.

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