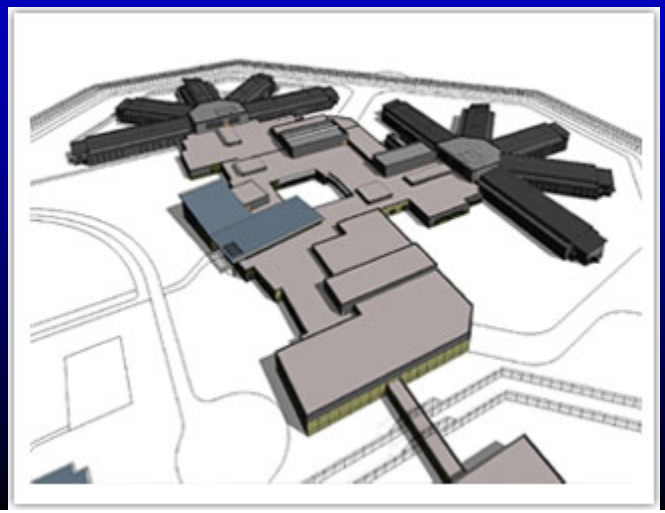
# Resistance at the ICA…

# Welcome!!!

David S. Prescott, LICSW

September 2009

# David Prescott: Friend or Foe?



# Welcome newcomers!

# Preconditions

- Show up
- Beginner’s mind

# Take-Home Message

- Change Talk
- Acceptance
- Less Is More
- Righting Reflex
- Michelangelo Belief
- Autonomy and Choice

# Take-Away Message

- People change
  - We have proof
- Punishment alone does not reduce recidivism
  - We have proof
- When all else fails, get back to the basics
  - Effective treatment gets young people to change the way they think and gets families to support those changes
  - **We will never change the way they think; they have to**

A man convinced against his will is of the same opinion still.

German Proverb

# How ready are you?

**0 1 2 3 4 5 6 7 8 9 10**

Motivation = importance + Confidence

# Some background...

# Predicting the future: a rich tradition

- Astrology
- Palm-reading/phrenology
- Tarot cards
- Crystal balls
- Tea leaves
- Bones, coins, yarrow sticks, I Ching, etc.
- Clinical opinion

# Healing people: A rich tradition

- Leaches
- Bloodletting
- Trepanning
- Lobotomy
- Some early 20th century “cures” for alcoholism contained alcohol
- Etc.....

# 1974

- Martinson
- *Nothing Works*
- Later discredited
- Long since replaced by “what works”
- … But the damage was done!

# Robert Martinson

- New York criminologist
- He believed that the apparent lack of success of rehabilitation in prison predicted the end to prisons as we know them. Martinson was one of the researchers involved in a survey of 231 studies on offender rehabilitation entitled *The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies*, which became the most politically important criminological study of the late 20th century. His views that "nothing works" to prevent recidivism were enthusiastically embraced by the national press. Conservatives used his results to justify a campaign of removing education and social programs from prisons. Martinson committed suicide in 1980.

# Smith, Goggin, & Gendreau, 2002

- Meta-analyzed 117 studies since 1958 (n = 442,471 criminal offenders)
- No sanction studied reduced recidivism (including juveniles)
- “Prisons and intermediate sanctions should not be used with the expectation of reducing criminal behaviour.”
  - Includes intensive surveillance, electronic monitoring, DARE, Scared Straight, etc.
  - Some indication of increased risk for low-risk criminals
  - http://www.ccoso.org/library%20articles/200201_Gendreau_e.pdf

# The Big Question

- *Do we want them to re-offend or not?*
  - What works?
  - What're the key ingredients?
  - One thing in common for all patients:
    - Punishment didn't work

# Can we cure criminals?

- Treatment won't work equally well for everyone, and 100% success should not be expected.
- Treatment, like many other types of medical and mental health interventions, doesn't focus on a cure but on a reduction of symptoms.
- Treatment for diabetes doesn't cure the disease, it manages the disease. Likewise, entering weight watchers with the expectation that simply being in the program will create weight reduction won't work. It takes collaboration and commitment.
- Auto Mechanic versus Home Depot manager
  (from Kevin Creeden)

# Beyond "does treatment work"

- Can people change?
- Under what conditions can they change?
  - Ward's readiness model
- Under what conditions can they maintain change?
  - Containment models, etc.
- Some approaches appear more effective than others, and it is unconscionable to do nothing.

# Effective Programs

## RISK Principle

- effective programs match the level of treatment intensity to the level of risk posed by the offender
- high risk = high intensity
- mismatching can result in increased risk

# Effective Programs

## NEED Principle

- effective programs target identified criminogenic needs
- sex offenders require sex offender specific treatment programming
- other programs may result in some ancillary gain, but risk for sexual recidivism likely will not be reduced

# Effective Programs

## RESPONSIVITY principle

- effective programs are those which are responsive to offender characteristics
  - cognitive abilities
  - maturity
  - motivation
  - mode of intervention
  - scheduling concerns

# Effective Programs

## PROFESSIONAL DISCRETION

- in every effective correctional intervention, there must be a coordinated plan which takes risk, need, and responsivity into consideration
- someone must be “driving the bus”
- sometimes, exceptions to the first three principles can be justified based on global perspectives

# Treatment of Sexual Offenders

- Historically, many types of treatment interventions applied to sexual offenders
- Current effective practice:
  - Adherence to principles of risk, need, responsivity
  - Assessment of risk factors/criminogenic needs
  - Cognitive-behavioral intervention
  - Treatment that targets identified risk factors/criminogenic needs
  - Post-treatment maintenance/follow-up programming

# Treatment of Sexual Offenders

- Treatment is cognitive-behavioral:
  - Change patterns of affect, cognition, behavior
  - Development of pro-social/non-offending attitudes and beliefs
  - Acquisition and rehearsal of skills
- Targets dynamic risk factors (e.g., deviant arousal/fantasy/preference, attitudes/cognitive distortions, intimacy deficits, etc.)
- Most common type of intervention presently is relapse prevention (RP), but...
  - Professionals are increasingly adopting the good lives and self-regulation models

# Obstacles (Mann, 2009)

- Believing treatment is ineffective
- Competing priorities
- Concerns about side effects
- Concerns about poor program responsivity
- Distrust of key professionals
- Expectation of hostile responses
- Pressure from friends or family
- Fear of stigma

# Improving the context (Mann, 2009)

- Listen
- Empathize with offenders' perspectives
  - (Empathy is not an endorsement)
- Building relationships (collaboration, trust)
- Identify and counter myths
  - (Sometimes offenders have poor information)
- Communicate strength-based treatment aims
- Make referrals quickly and respectfully
- Offer clear and transparent information about treatment and outcomes

# Improving the context (Mann, 2009)

- Ensure that risk assessments take account of treatment progress
- Educate non-treatment staff
- Clear leadership to promote prosocial modeling and supportive environment
- Work with families and support networks
- Use intrinsic motivators
- Use treatment graduates
- Provide choice
- Explore and monitor Rx staff motivations

# Tony Ward and "Readiness" (2004/2009)

- Internal Readiness:
- Cognitive
- Affective
- Behavioral
- Volitional
- Personal identity

*(To which DP would add psychiatric comorbidity)*

- External Readiness:
- Circumstance
- Location
- Opportunity
- Resource
- Support
- Program/Timing

# Tony Ward and "Readiness" (2004/2009)

- Motivation of low readiness:

- Modify the client
- Modify the therapy
- Modify the setting

# Beech & Fordham, 1997

- *From the abstract:*
- A successful group was highly cohesive, was well organized and led, encouraged the open expression of feelings, produced a sense of group responsibility, and instilled a sense of hope in its members. A helpful and supportive leadership style was found to be important in creating an atmosphere in which effective therapy could take place Over-controlling leaders were seen to have a detrimental effect upon group climate.

# Beech & Fordham, 1997

- Other findings suggest that leaders tend to overestimate the help they provide in groups, perceive that they are more in control than members do, and see the group as facilitating diversity and change much more than do the members. It is not unusual for there to be differences between perceptions of members and leaders... Those who have responsibility for running groups tend to perceive the social climate more positively than do members ... Some group leaders have an overly optimistic view of the work they were accomplishing...

# Beech & Fordham, 1997

- Some group leaders seemed unaware of the power of the group process itself in instilling change, and perhaps more importantly, they failed to recognize their own role in setting group norms. A better knowledge of group dynamics may help some leaders to use the group process to facilitate change. More training in this area for those engaged in sexual offender treatment programs seems appropriate. This should focus not only on the content of treatment but also on the leadership style.

# How Dolphins Learn

# Smith, Goggin, & Gendreau, 2002

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  - Includes intensive surveillance, electronic monitoring, DARE, Scared Straight, etc.
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http://ww2.ps-sp.gc.ca/publications/corrections/200201_Gendreau_e.pdf

# Myth: Treatment Doesn't Work
# Facts: Treatment can help

- Furby, Weinrott, & Bradshaw (1989).
  - Combined analysis of numerous studies that was unable to detect a significant treatment effect due to methodology variability.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002).
  - 17% untreated
  - 10% treated

  -Equivalent to a 40% reduction
- Losel, F., & Schmucker, M. (2005).
  - Recidivism reduced by nearly 40%
- SOTEP:
  - No overall differences between treated and untreated groups, but:
- Sex offenders who successfully completed the SOTEP treatment program reoffended at lower rates than those who did not demonstrate that they "got it" (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

# Can they be cured?

- Treatment won't work equally well for everyone, and 100% success should not be expected.
- Sex offender treatments, like many other types of medical and mental health interventions, don't focus on a cure but on a reduction of symptoms.
- Treatment for diabetes doesn't cure the disease, it manages the disease. Likewise, entering weight watchers with the expectation that simply being in the program will create weight reduction won't work. It takes collaboration and commitment.
- Appendix removal versus weight loss
- Auto Mechanic versus Home Depot manager

  (from Kevin Creeden)

# Can they be cured?

- Treatment for schizophrenia doesn't cure psychosis, it reduces symptoms and allows people to function more adequately.
- Chemotherapies may not ultimately prevent all cancer fatalities but may increase life expectancy and quality of life for many patients.
- Sex offender treatment teaches clients how to change their thinking and their behavior, and many are able and willing to do so and avoid reoffense.
- Treatment is just the road map; meaningful personal change is the goal (-- Sand Ridge patient)

# You would think . . .

- that having had a heart attack would be enough to persuade a man to quit smoking, change his diet, exercise more, and take his medication
- that hangovers, damaged relationships, an auto crash, and memory blackouts would be enough to convince a woman to stop drinking

# You would think . . .

- that the very real threats of blindness, amputations and other complications from diabetes would be enough to motivate weight loss and glycemic control
- that time spent in the dehumanizing privations of prison would dissuade people from re-offending

# Yet so often it is not enough!

# Client Motivation is Greatly Influenced by the Counselor

- Clients' motivation, retention and outcome vary with the particular counselor to whom they are assigned
- Counselor style strongly drives client resistance (confrontation drives it up, empathic listening brings it down)
- That is, the *counselor* is one of the biggest determinants of client motivation and change

## If it's not personality, then what *behaviors* cause counselors to perceive clients as being "in denial"?

- Disagreeing with the counselor
- Resisting a diagnosis/label
- Declining help
- Showing little distress
- Disavowing a need for counseling or change
- Being non-compliant with treatment prescriptions

and

- Not changing

## In contrast, counselors tend to perceive clients as being "motivated" when they:

- Agree with the counselor
- Accept the counselor's diagnosis/label
- Express a desire for help
- Show distress
- Voice a need for the counselor/counseling
- Comply with the counselor's treatment plan

and

- Change

# Client motivation is evident in:

- Low resistance
- Openness and collaboration
- Expressing emotion
- Adhering to a change plan, and
- Changing

All of which are strongly influenced, for better or worse, by what the counselor *does*

# Ambivalence

The Dilemma of Change

# Helpful hints

- Use “on the one hand you... and on the other hand you...”

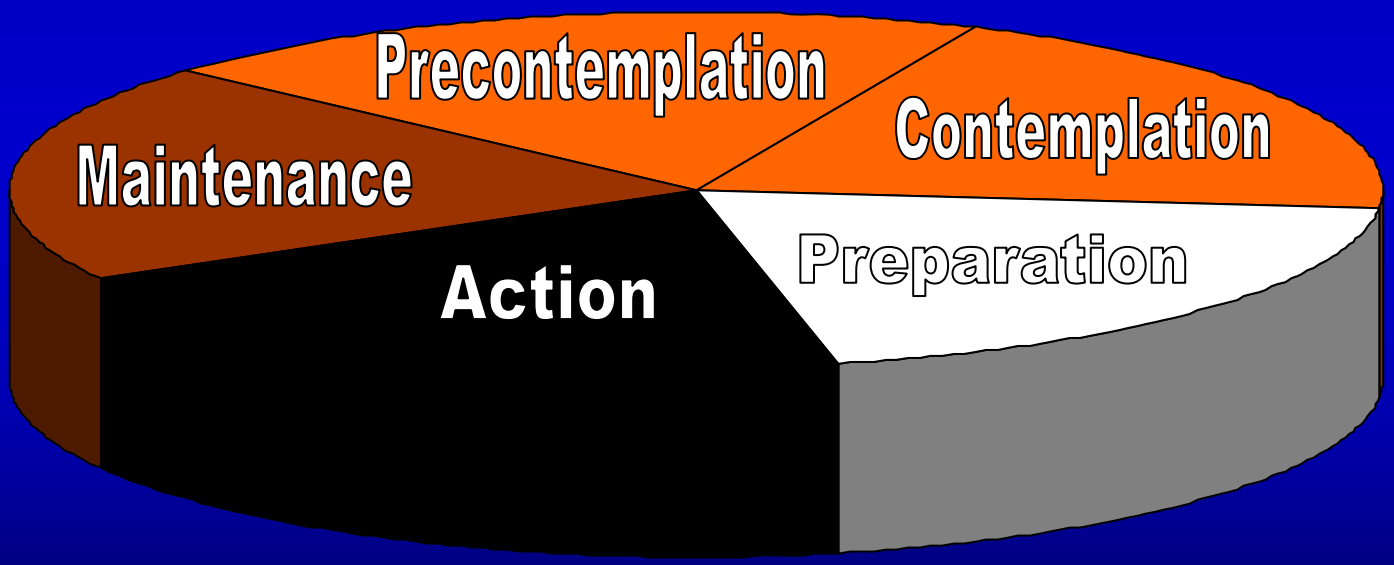
- Reject using “but”
- Reject using “It sounds like...”
- Never use the word “why”

# Discrepancy

- The difference between where you are and where you want to be

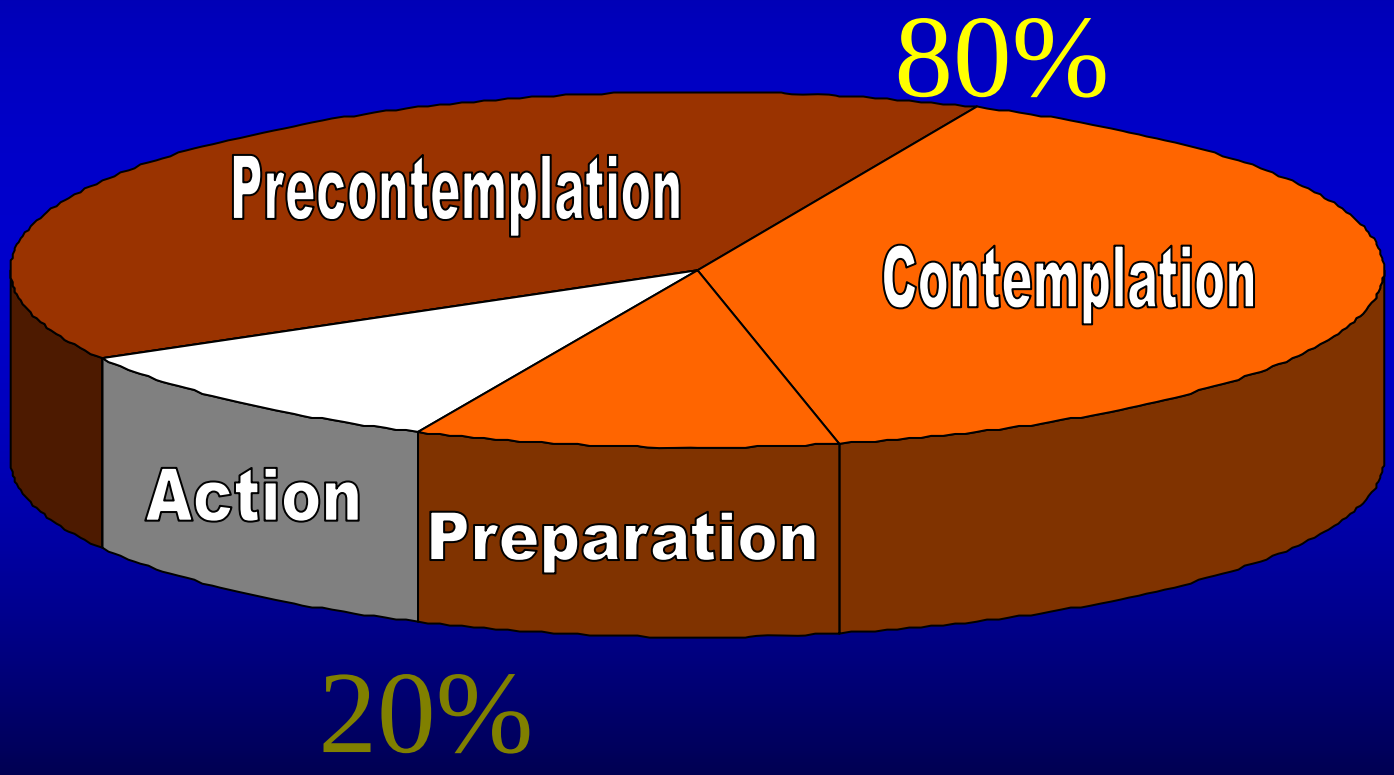
# Stages of Change

## Prochaska & DiClemente



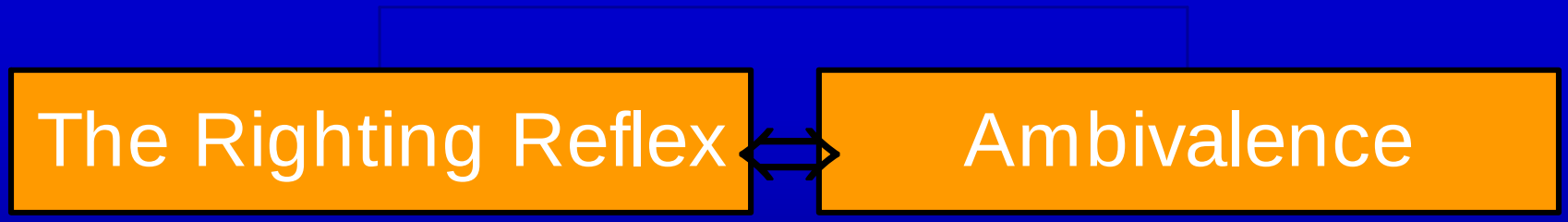
# Stages of Change

## Prochaska & DiClemente



# The Righting Reflex

# When Worlds Collide



# Common Human Reactions to the Righting Reflex

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard
- Procrastinate

- Afraid
- Helpless, overwhelmed
- Ashamed
- Trapped
- Disengaged
- Don’t come back – avoid
- Uncomfortable
- Resistant

# A Continuum of Styles

Directing <=> Guiding <=> Following

# Motivational Interviewing

## A Definition

Motivational interviewing is

a person-centered,

directive

method of communication

for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

# Eight Stages in Learning MI

- 1. The spirit of MI
- 2. OARS – Client-centered counseling skills
- 3. Recognizing and reinforcing change talk
- 4. Eliciting and strengthening change talk
- 5. Rolling with resistance
- 6. Developing a change plan
- 7. Consolidating client commitment
- 8. Shifting flexibly between MI and other methods

Miller, W. R., & Moyers, T. B. (in press). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*.

# The Spirit of Motivational Interviewing

- Collaboration
- Evocation
- Autonomy

# Two Phases of MI

- Phase 1: Building Motivation for Change
- Phase 2: Strengthening Commitment to Change

# Four General Principles

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-Efficacy

# Good listening is more than being silent and paying attention

So what do you say?

# What Good Listening Is *Not*

(Roadblocks: Thomas Gordon)

- Asking questions
- Agreeing, approving, or praising
- Advising, suggesting, providing solutions
- Arguing, persuading with logic, lecturing
- Analyzing or interpreting
- Assuring, sympathizing, or consoling

# What Good Listening is *Not*

(Roadblocks, from Thomas Gordon)

- Ordering, directing, or commanding
- Warning, cautioning, or threatening
- Moralizing, telling what they “should” do
- Disagreeing, judging, criticizing, or blaming
- Shaming, ridiculing, or labeling
- Withdrawing, distracting, humoring, or changing the subject

# Why are these "roadblocks"?

- They get in the speaker's way. In order to keep moving, the speaker has to go around them
- They have the effect of blocking, stopping, diverting, or changing direction
- They insert the listener's "stuff"
- They communicate:
  - One-up role: Listen to *me*! I'm the expert.
  - Put-down (subtle, or not-so-subtle)
- *Roadblocks are not wrong. There's a time and place for them, but they are not good listening.*

# Therapeutic Empathy

- Empathy is not:
  - Having had the same experience or problem
  - Identification with the client
  - Let me tell you my story
- Empathy is:
  - The ability to accurately understand the client's meaning
  - The ability to reflect that accurate understanding back to the client

# Empathy as a Hiring Criterion

- If the counselor's degree of empathy is the best predictor of successful client outcomes
- Then why not select new counselors on the basis of demonstrated empathic skill?
- Self-reported empathy does not predict skill
- Skill in reflective listening can be specified as a criterion for hiring
- Set up a role-play and ask the candidate to demonstrate his/her best reflective listening

# Hope Theory

- Agency Thinking
  - Awareness that a goal is attainable
- Pathways Thinking
  - Awareness of how to do it
    - See works by C.R. Snyder
- *"Therapists who are burned out or otherwise fail to convey hopefulness model low agency and pathways thinking."* (in Hubble, Duncan, & Miller, 1999)

# Amrhein et al. (2003)

- Change Talk (Miller & Rollnick, 2002)
  - Desire *"I want to..."*
  - Ability *"I can..."*
  - Reason *"There are good reasons to..."*
  - Need *"I need to"*

  - Taking Steps (e.g., *"I've been..."*)
  - Commitment talk

# Change talk

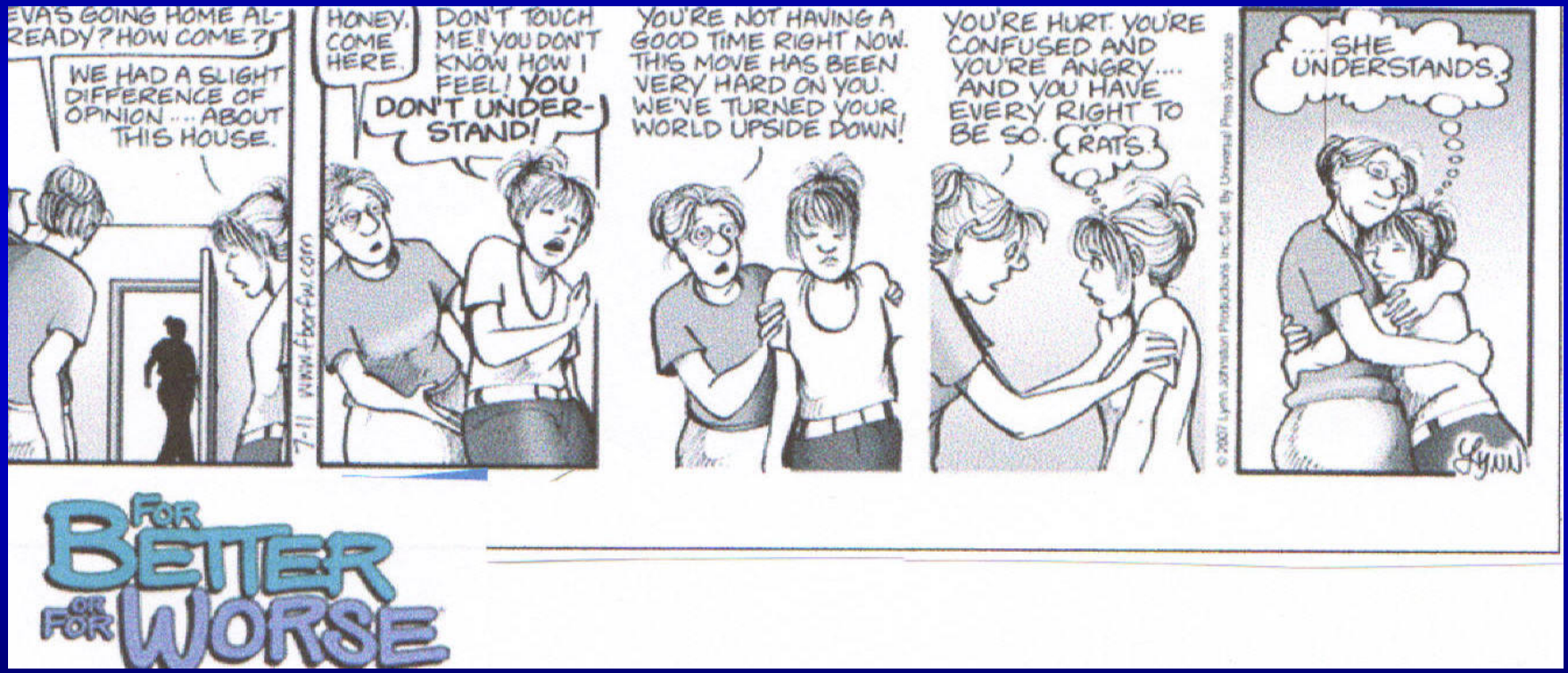
- ***When you hear change talk, don't just stand there!***
- Reflect
- Reinforce
- Ask for more

# Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

# Reflective listening

- Simple Reflection
  - Exact words
  - Closely related words
- Complex Reflection
  - Continuing the paragraph
  - Reflecting emotion


EVA'S GOING HOME AL-READY? HOW COME?
WE HAD A SLIGHT DIFFERENCE OF OPINION.... ABOUT THIS HOUSE.
HONEY, COME HERE.
DON'T TOUCH ME! YOU DON'T KNOW HOW I FEEL! YOU DON'T UNDER-STAND!
7-11 www.fborfw.com
YOU'RE NOT HAVING A GOOD TIME RIGHT NOW. THIS MOVE HAS BEEN VERY HARD ON YOU. WE'VE TURNED YOUR WORLD UPSIDE DOWN!
YOU'RE HURT. YOU'RE CONFUSED AND YOU'RE ANGRY.... AND YOU HAVE EVERY RIGHT TO BE SO.
RATS!
© 2007 Lynn Johnston Productions Inc./Dist. By Universal Press Syndicate
... SHE UNDERSTANDS.
Lynn
FOR BETTER OR FOR WORSE

# Robben Island

# Hope Theory

- Agency Thinking
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# Phase Model

- Phase One: Self-management issues, including managing treatment-interfering factors.
- Some areas of ambivalence:
  - Do I really want to change?
  - Do I really want to give up Old Me?
  - Do I really want to work with others?
  - Do I really want to depend on others?

# Phase Two

- Developing an understanding of one's life and an agreed-upon history of sexual offending
- Some areas of ambivalence:
  - Do I want to understand my life differently?
  - Do I want to look at the harm I've caused?
  - Do I want to discuss shameful aspects with others?
  - Do I want to develop new attitudes?

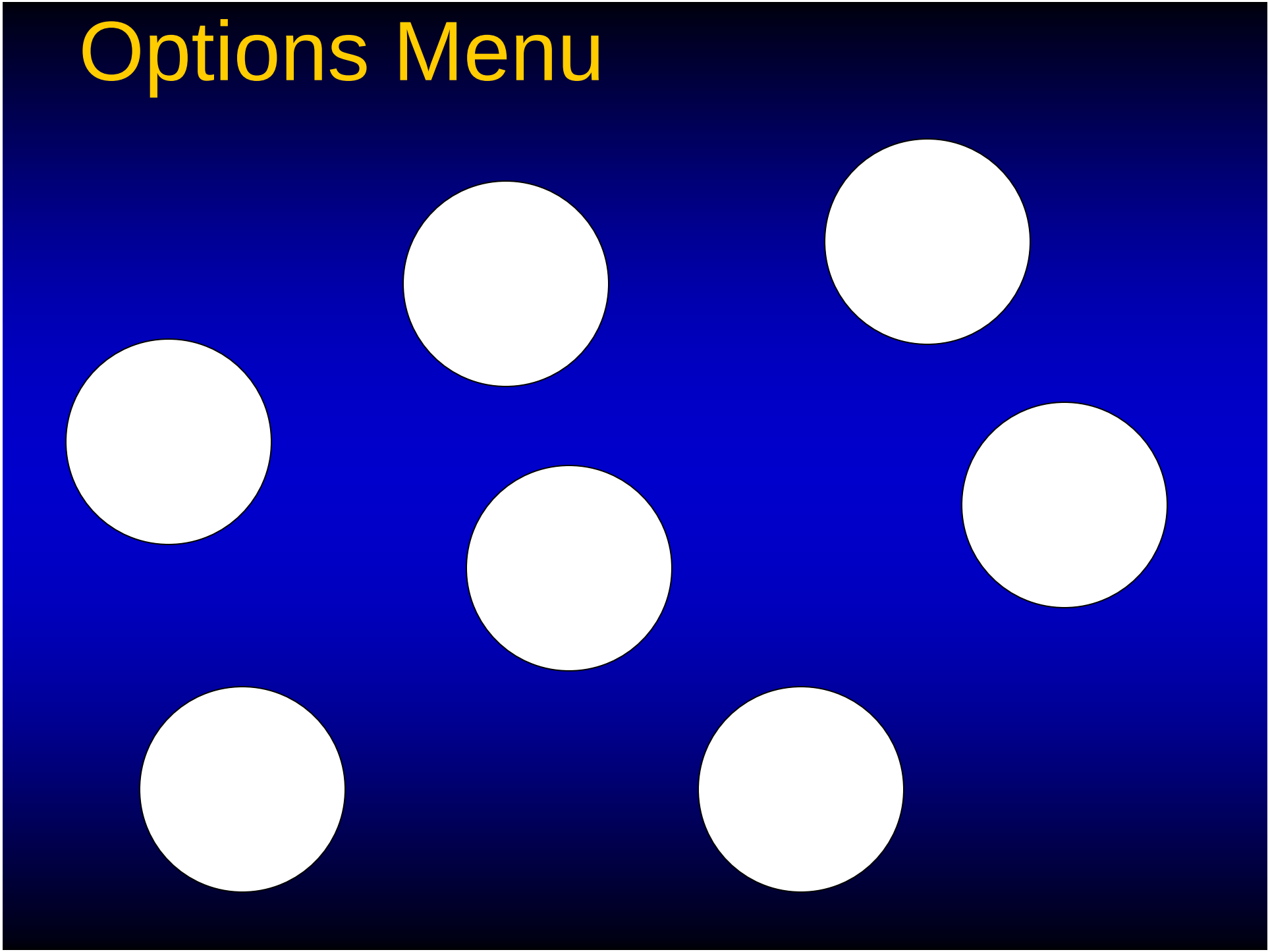
# Phase Three

- Refine understanding of factors that contributed to offending and manage them in daily life, in the here and now.
- Some areas of ambivalence:
  - Do I really want to develop new skills?
  - Do I really want to give up old ways?
  - Do I really want to give up my fantasy repertoire?

# Applications group

- Establish an “options menu” of areas where the client is having difficulty moving forward
- Offer the client a choice of which area he would like to explore
- Explore good and not-so-good things about the status quo and change

# Options Menu



# Good/not-so-good things about change

| + | - |
| --- | --- |
| | |

# Guidelines for Offering Feedback

- Ask permission
- Encourage self-assessment
- Limit the amount of feedback
- Be specific
- Include the client's agenda
- Respect readiness
- Avoid personal affronts
- Balance the feedback

# Discussion

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

# Individualized treatment group (ITG)

- Alternative group for those who demonstrate:
  - Persistent disruption and disrespect
  - No application of treatment material to daily life
  - Low motivation for change
- Target behaviors must have persisted despite attempts to re-engage, and psychological testing rules out other potential confounds

# ITG

- Open-ended
- Intended to be brief
- Not a substitute for treatment program
- Patients use open-ended questions; harsh & confrontational stance not allowed

# Format

- Client and treatment team outline issues to address
- Client enters these into a non-hierarchical options tool and chooses which issues he will address first
- Facilitator begins exploration of first focus issue using readiness ruler
- Facilitators begin to develop discrepancy
- Group members offer support and feedback

# Format

- Cost-benefit analysis
- Exploration of ambivalence
- Beginning action planning and practice
- Feedback, etc.

- Fundamental value: ITG exists for *discussing* issues, not *debating* them.

# Discussion includes

- How has this issue played a role in your past behavior?
- How does this issue play a role in your current behavior?
- What kinds of payoffs do you get from this?
- And on the other hand, what kinds of difficulties is it bringing you?

# It might also include…

- What is happening when you decide to engage in this behavior?
- What do you want to happen and what do you get?
- How might this issue affect others?
- How might one approach situations where this issue might arise and get what you need without this issue happening?
- If you were in my (or someone else's) shoes, what might you think about this issue? (other patients often have a number of contributions to add to this question)

# Potential traps

- Debate (instead of dialog)
- Unrealistic expectations (wanting too much)
- Focusing on one patient to the exclusion of others (some patients ask for more attention than others)
- Negative spotlight (it can be easier to highlight problems than successes with this population)
- Etiology (understanding the origins of a problem are not the same as resolving it)

# When the client won't stop

- *Sometimes people keep repeating themselves precisely because they do not feel acknowledged. I have sometimes literally interrupted "to make sure I understand," and offered a summary reflection. I've never had anyone resent being interrupted to make sure that I understand them.*

  -- Bill Miller, 8/28/09

# When the client won’t stop

- OK, you‘re saying a lot of really interesting stuff there, so if I can just check to make sure I'm getting what you're saying... [summary of what has been said, linking this to x issue]
- So it sounds as if the main thing that's bothering you is... [If 'yes'] OK, so how does this fit in with your.. [x issue].

# When the client won’t stop

- What you're saying is really interesting. Let's not lose that in all the other stuff we're talking about. How about we put it in the in the parking lot, and make sure we come back to it before we finish?
- You're feeling/wondering/thinking.... and that has an impact on....[x issue]

# When the client won’t stop

- That sounds important but I'm not sure we have the time to do it justice today…
- You really need to talk about this (reflecting emotion/intensity)
- You have a lot of thoughts about this or it sounds like you haven't had a chance to think/talk about this with someone else
- My memory is kind of limited and to give more of the attention and help you deserve I will have to interrupt you periodically.  Would that be OK with you?

# When the client won't stop

- You are saying some pretty darn interesting stuff there and if we have time at the end, you can tell me more. And right now, I am wondering if it would be OK to get back to the medication problem you first talked about. What is going on with that?"
- I think I'm getting a good understanding of _____(the issue), tell me a little bit more about _____ (new topic).

# When the client won’t stop

- I hate to cut you off because I can tell this is something very important and something on which you are working very diligently, but would it be all right if.. (I switched gears a little and_____, took a little time to ask you about_____, summarized what we've talked about to make sure I'm understanding things, etc.).

# When the client won't stop

- Above all, Remember:

- *If we act as though we have only fifteen minutes, it will take all day; however, if we act like we have all day, it only takes fifteen minutes.*

-- Monty Roberts