Motivational Interviewing: Adolescents and Group Treatment

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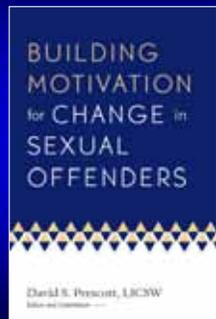## David Prescott: Friend or Foe?

Don't worry!

- I won't call on you for answers

- I won't ask you to role play

- I won't put too much research into each slide

Should it interest...

- Recent release
- Very few resources on topic
- Chapters by Ward, Marshall, Marshall, Mann, Serran, Wilson, etc.
- Safersociety.org

BUILDING MOTIVATION for CHANGE in SEXUAL OFFENDERS

David S. Prescott, LICSW

Points to consider, *continued*

- Sex offender treatment has a long history of confrontational and punitive approaches

- Research shows that failure to complete treatment not only predicts re-offense, but can elevate level of risk (Hanson & Bussiere, 1998)

- Studies show that confrontational style results in poorer treatment outcome (Marshall, 2005)

A brief history of treatment...

- 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
  - -Youth do best with community treatment
  - -See Surgeon General, 2001
- Losel, F., & Schmucker, M. (2005).
  - Recidivism reduced by nearly 40%
- SOTEP:
  - No overall differences between treated and untreated groups, but:
- Sex offenders who <u>successfully completed</u> 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).
  - Client or patient?

Thornton, Beech, & Marshall, 2004

- Pre-treatment self-esteem and recidivism
- 53 beginning community treatment
- 172 beginning prison treatment

  - *Lower levels of self-esteem were associated with higher sexual recidivism rates with similar trends being apparent in both samples. The linear main effect of self-esteem was significant at beyond the .Ol level in a logistic regression analysis. Receiver operating characteristics analysis was used to assess the strength of this association and an area-under-the-curve coefficient of .69 was obtained.*

The problem:

- Hojat et al 2009 on empathy among doctors *(Academic Medicine, 84 (9):*

- *Statistical analyses showed that empathy scores did not change significantly during the first two years of medical school. However, a significant decline in empathy scores was observed at the end of the third year which persisted until graduation. Findings were similar for the matched cohort (n 121) and for the rest of the sample (unmatched cohort, n 335). Patterns of decline in empathy scores were similar for men and women and across specialties.*

Hojat et al 2009

Conclusions

It is concluded that a significant decline in empathy occurs during the third year of medical school. It is ironic that the erosion of empathy occurs during a time when the curriculum is shifting toward patient-care activities; this is when empathy is most essential. Implications for retaining and enhancing empathy are discussed.
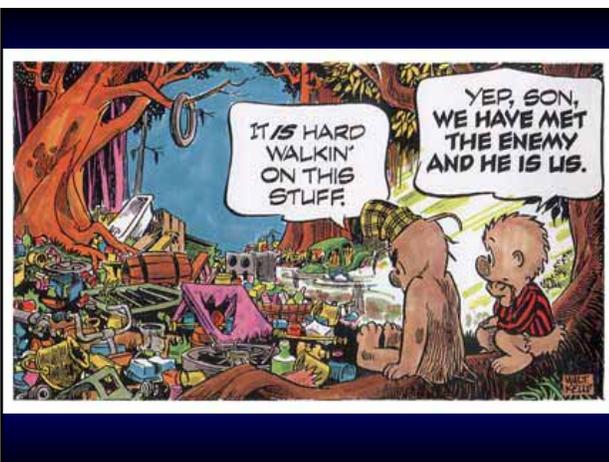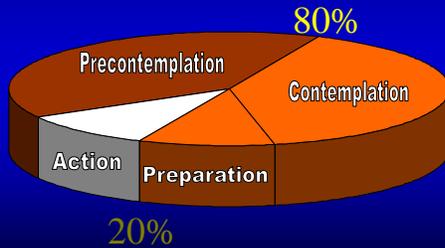

Stages of Change
Prochaska & DiClemente

Stages of Change
Prochaska & DiClemente

80%

Precontemplation
Contemplation
Action
Preparation

20%
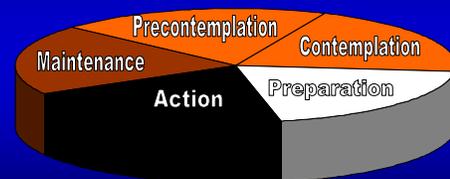
Case example

Meet Ethel

What makes kids so special?

- Youthful idealism
- Lopsided development
- The "I'm not gonna you can't make me" sandwich

Remember…

- *The cake of contemplation is frosted with precontemplation!*

- SOC model nice in theory, but doesn't adequately account for developmental or contextual factors (e.g., Sutton, 2001)

Implications

- Aligning with natural developmental processes
- Teaching accountability rather than holding kids accountable
- Eliciting <u>internal</u> motivation for change
- Encouraging kids to stand up for what is right rather than fighting their efforts to do this.

Returning to the basics

- Not everyone is ready to change, and some people change despite our efforts

- Readiness
- Responsivity

3 authoritative texts for understanding youth...

Runaway Bunny

- Ambivalence
- Discrepancy between current and desired states
- Developmental aspects of relationships
  - Safety, predictability
- Etc.
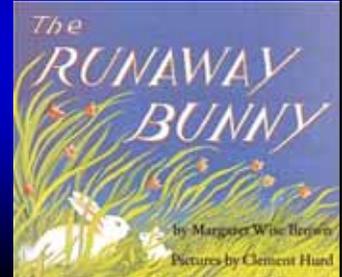
A calm and soothing approach
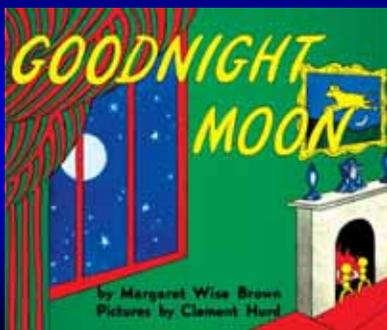
Communication problems

- Closed ended questions
- Persistent persuasion guaranteed to build resistance
- Just plain irritating
- Worth a closer look...
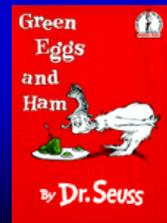
Robben Island

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)

MI: Two recent perspectives

- *Motivational interviewing involves helping patients to say why and how they might change, and is based on the use of a guiding style* – Steve Rollnick, 2/28/10

- *Motivational interviewing uses a guiding style to engage with patients, clarify their strengths and aspirations, evoke their own motivations for change, and promote autonomy of decision making* – Rollnick et al, 2010

The Spirit of Motivational Interviewing

- Collaboration
- Evocation
- Autonomy

Four General Principles

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

Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Reflective listening

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

Assessment-Driven Treatment

- Sexual deviance
- Contributory attitudes
- Socio-Affective functioning
- Self-management
- (Influential others)

Treatment planning

- Laundry list of risk factors?
  - Are we teaching to the test?
- Personally meaningful goals
- Combine phase goal matrix with SMART goals that client can work on

Treatment Plan

- Problem: Coercive measures rarely work
  - Smith, Goggin, & Gendreau, 2002
  - Andrews & Bonta, 2003

- Goal: Efforts at change work best from within
  - Bem, 1972
  - Ryan & Deci, 2000; Deci, 1980
  - Miller & Rollnick, 2002
  - Jenkins, 1990; 1994; 2006

Perspectives

- "It is the truth we ourselves speak rather than the treatment we receive that heals us."

  - Mowrer

- "People are generally better persuaded by the reasons which they themselves have discovered than by those which have come into the minds of others"

  - Pascal's Pensees, 17th Century

| Imposed avoidance goals: No more offending | Shared-Vision approach goals: Healthy lives, safe communities |

A comparison of imposed client-only goals and shared-vision goals: The best treatment plans are collaborative

Parallel Process

- Professionals and clients alike are often more willing to learn new skills than to throw out the old ones that don't work. Worse, sometimes our negative skills actually do work sometimes...

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 Mentee'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)

Potential traps

- *The negative spotlight trap*. With no spotlight on success, clients have fewer avenues for exploring what has worked in their attempts to get back on track.
- *Discrepancy hurdles.* Clients are sometimes ambivalent about discussing the discrepancies between their current and desired statuses.

Potential traps

- Adverse experiences and trust
- Adverse experiences with authority
- Therapist gender and abuse-related cognition
- Superficial participation
- Not sticking with the style
- Group engages in the "righting reflex"

For more information

- www.davidprescott.net
- Click on publications and scroll down through articles
- Or simply email me