Building Motivation to Change in Sexual Offenders

David Prescott

WELCOME!

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

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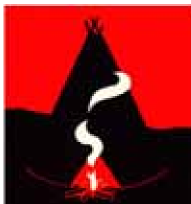
Healthy lives,
Safe communities



Focus

- Review a few basics
- Discuss who we are and who we can be
- Talk about application

Focus

- Historical overview
- Issues and controversies inherent in civil commitment
- Current perspectives
  - Assessment-driven treatment
  - Phase model

My head hurts just thinking about it…

From the ATSA list-serve (with tongue in cheek):

- *Since the research indicates that most children are at risk from being sexual abused by someone they know and that offenses often take place in the offenders' residence, it is important that appropriate and rational residency restrictions be put in place that have the potential to reduce the number of sexual crimes. Thus, an effective residence restriction would require that sex offenders cannot reside within 2000 ft. of their residence. Additionally, they should not reside within 2000 ft. of anyone they know, or anyone they may come to know in the future.*

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 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).

Points to consider, *continued*

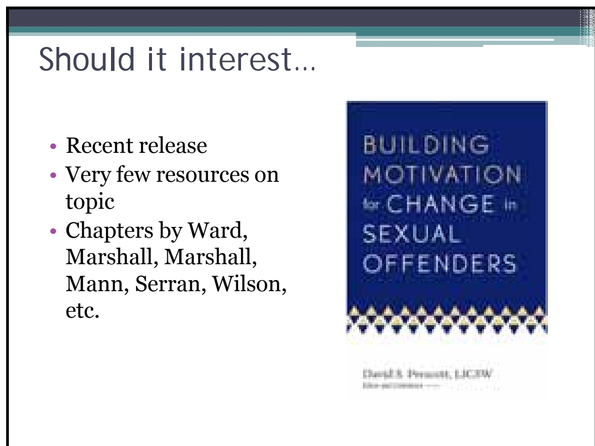
- Sex offender treatment has a long history of confrontational and punitive approaches
- Research shows that failure to complete treatment not only predicts re-offense, but can elevate level of risk (Hanson & Bussiere, 1998)
- Studies show that confrontational style results in poorer treatment outcome (Marshall, 2005)

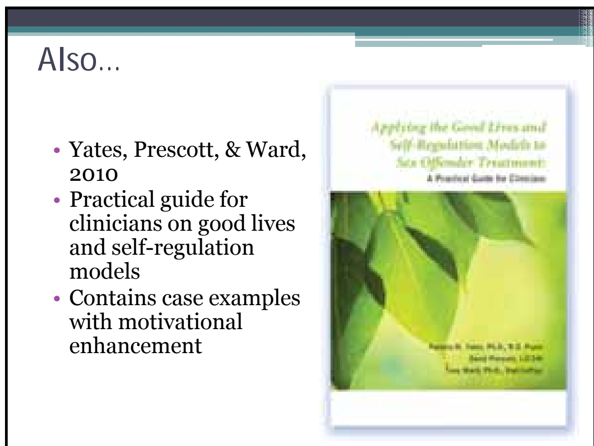
Treatment Plan

- 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
  - Cialdini, 2001

Lambert/Hubble et al.

- Analysis of treatment outcome studies isolated a "big 4 factors"
  - Model/technique factors 15%
  - Placebo, hope, and expectancy 15%
  - Relationship factors 30%
  - Client/extra-therapeutic factors 40%!





Anchor Points

- Risk
- Need
- Responsivity

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 of human communication

What works?

- Do we want them to re-offend or not?
- What can we do?
- Who should we be?

Core Message

- We can make our communities safer by building healthier lives for all

Best result

- A balanced, self–determined lifestyle

(Wilson, 2009)

Let's face it

- Across time, place, and culture:
- Humans are most influenced by each other, not technologies
  - PPG, Polygraph, etc.
  - Facebook and Twitter facilitate; the medium is not the message

In other words…

- It's about people, not just programming
- It's about connection, not just their conviction
- It's about changing peoples' states, not locations

Ask Yourself

- How many people are there in my life that aren't paid to be there?
- How about our clients?

Ask Yourself

- How many people are there in your life who deeply accept you for who you are?
  - Would you like more?
- How about your clients?

Problems

- We get seduced by technology and forget our people skills
- We become rightfully concerned about future sex crimes and forget our people skills
  - The righting reflex

RESPECT

Ask

- When was the last time you heard someone ask how they could be a better professional?
- When was the last time you heard someone ask how to get a better professional tool?

Ask

- What would happen if professionals got together and shared what they did that really worked in treatment?

The key

- We should all work together to build <u>willing partners in change</u>.

The dream

- We can be helpful even as we prevent re-offense. Our voice should go with the client as a source of success. (Erickson)

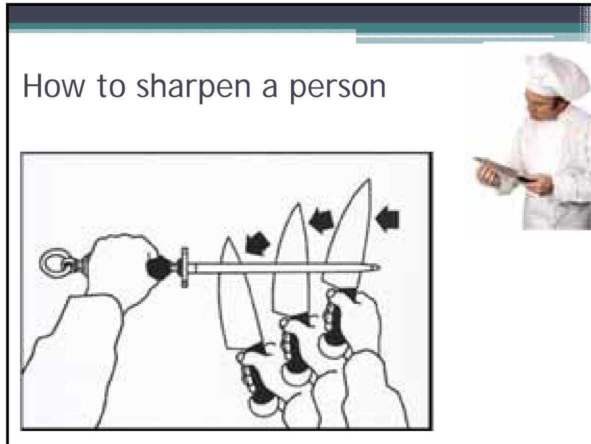
Waypoint

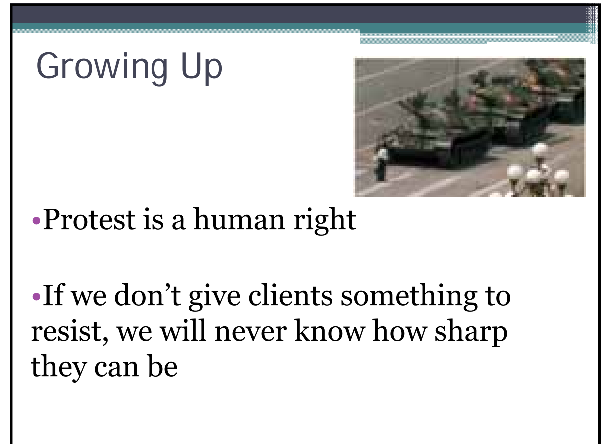
At each decision point, ask:

- How will this action help create a willing partner in change?

Contexts

- Get the context right for change (Mann, 2009)
- Get ourselves *ready* to *help* other people change
  - Motivational enhancement, goal-setting, interviewing





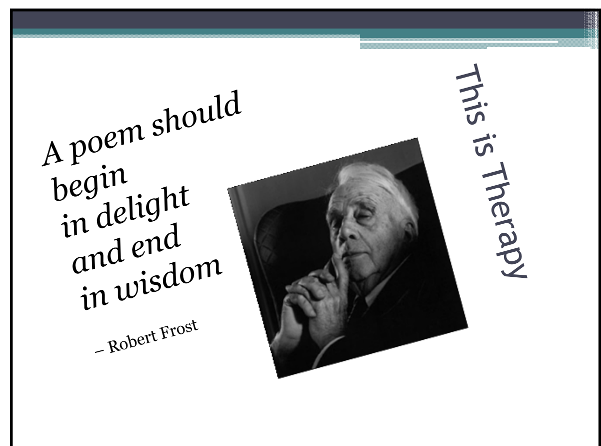
Active ingredients

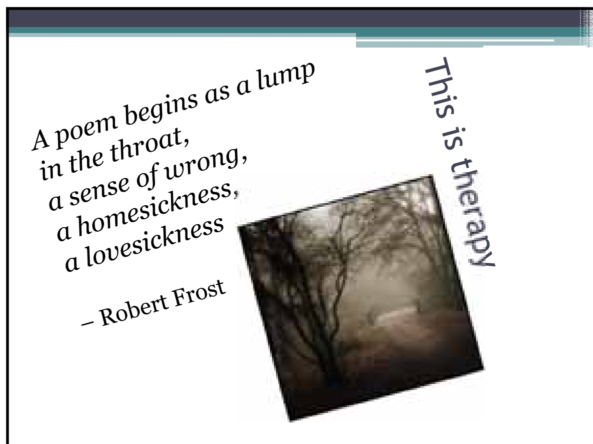
- Peace
- Compassion (for all people)
- Motivation
- Persistence

Underneath all goals

- Competence
- Autonomy
- Relatedness

(Deci & Ryan, 2002)





Therapist self-talk

- Oh, Cool!

Not…

- Oh S*#*

Motivational Interviewing
Best-known Definition

Motivational interviewing is
a person-centered,
directive
method of communication
for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Steve Rollnick, 2/28/10

- Motivational interviewing involves helping patients to say why and how they might change, and is based on the use of a guiding style

Bill Miller, May 2011

- Motivational interviewing is something done "with" and "for" clients, not something done "to" and "on" them.

The Spirit of Motivational Interviewing

- Collaboration
- Evocation
- Autonomy

Four General Principles

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

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

Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Feedback

- Ask – Provide – Ask
- Affirm – Provide – Affirm

Offer - Explore

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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

Take-Home Message

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

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

How Dolphins Learn

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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

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)

Amrhein et al. (2003)

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Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Reflective listening

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

This is empathy

For Better or For Worse

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?

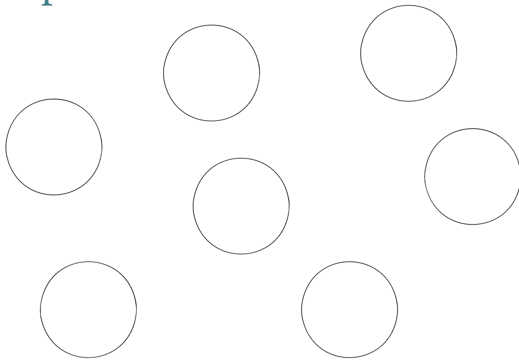
Phase Three

- 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

Individualized treatment group (ITG)

- Alternative group for those demonstrating:
  - 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