

Therapeutic engagement

David Prescott

WELCOME!

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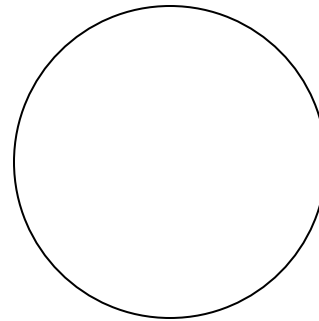
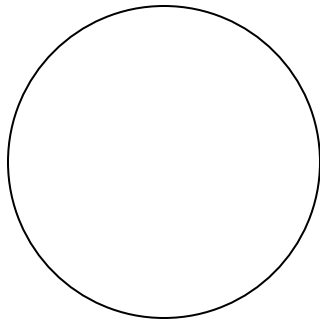
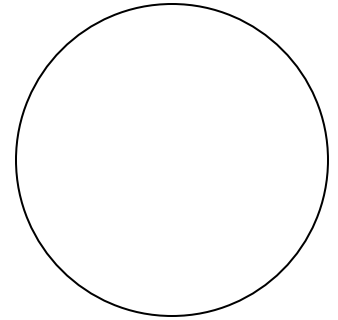
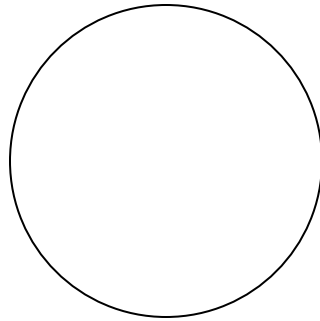
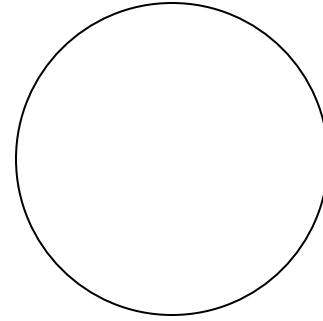
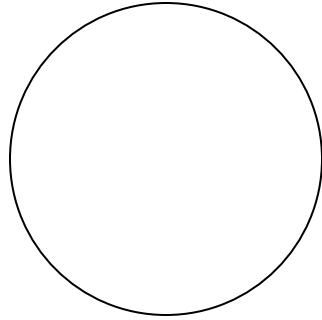
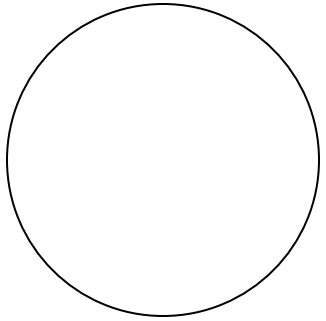
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*Healthy lives,
Safe communities*



Options Menu



When you're with me...

You always have options

Shamai & Buchbinder, 2010

- Examined the treatment experience of violent men
- Most experienced it as positive and made changes
 - especially the acquisition of self-control
- **But... most still had core beliefs of power in** understanding and creating relationships with others, especially with their female partner.

The clients...

- Most described therapists as producing the change
 - **they listened to the men's distress and offered the right suggestions and tools**



Ah, therapy...

- *Everything is due to (the therapist).*
- *it is a pleasure to be with him and to consult with him. He can provide many tools to cope with problems . . . I owe M. everything.*
- *With B. (the therapist) I am like a blind man. I'd follow him with my eyes closed.*

Shamai & Buchbinder, 2010

- *The group.* Most participants described the group as a place that enabled learning. Many of them used school metaphors to describe the group treatment. Some referred to it as a *course* or *workshop*; the sessions were called *classes*.



Self-control

- *As a result of the treatment, I learned to restrain and control myself*
- Is the achievement of control to be the central measure of success?

Schema: relationships are power- and control-based

- *I restrain myself a lot, but at home things are much worse. She thinks that the group puts ideas into my head, and she's constantly picking fights, getting me to lose control to show that the therapy doesn't help at all.*

Techniques and time out

- *I received coping tools*
- *I learned to count to 10, to take a time-out.*
- *When I feel about to explode, I take a time-out; I leave the house for 10 minutes.*
- *Everything changed during the treatment process. I received many things from the group, for example, the time-out option, though in my case, it didn't work.*

Relaxation techniques (?)

- *I have become so relaxed due to the treatment, so whatever she does, yelling, throwing things at me, it doesn't faze me. I sit there and smile, or just get up and go out. This is the time-out we learned here, when you feel that your fuse is short, take some time-out and just get out . . . The most important thing I learned was how to control myself. I try to talk quietly, but if it doesn't work, or if I become aware that something is beginning to aggravate me, I just leave the place to prevent verbal or physical conflict . . . I have learned to be aware of situations in which I might flare up, and I can deal with them.*
- **Avoidance goals**

Progress

- **One day, when I was driving, this woman didn't stop at a stop sign. I don't know what I would've done to her . . . But I took a time-out to think, took a few seconds, got out of the car, came to her and asked her quietly: Excuse me, do you realize what you have just done? She turned white. Nothing would have been achieved by slapping, yelling, or cursing. Because of the therapy, I know how to use other, more effective, methods.**

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**

Take-Home Message

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

Obstacles to SOTP Participation

(Mann, 2009)

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

Improving the context of SOTP's

(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 of SOTP's

(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

2013 Practitioner's definition

- Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.

2013 Technical definition

- Motivational interviewing 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.

The Spirit of Motivational Interviewing

- Partnership
- Acceptance
- Compassion
- Evocation

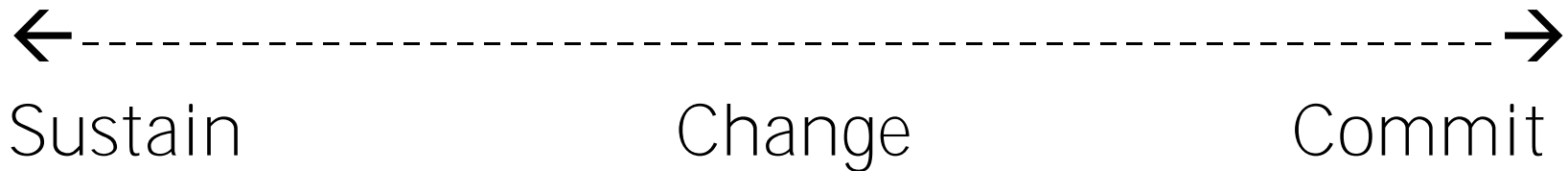
Four Processes

- Engaging
- Focusing
- Evoking
- Planning

These processes are...

- Somewhat linear
 - E.g., engagement comes first
- And also recursive
 - Engaging happens throughout MI
 - Focusing is not a one-time event;
 - Real treatment involves re-focusing
 - “testing the water” on planning helps

Talk



There is no such thing as “resistance”

There is discord and sustain talk

“I’m not gonna; you can’t make me”

Change Talk

- Desire “*I want to...*”
- Ability “*I can...*”
- Reason “*There are good reasons to...*”
- Need “*I need to*”

Responding to change talk

- ***When you hear change talk, don't just stand there!***
- Elaborate (tell me more)
- Affirm
- Reflect
- Summarize

Change Talk Jeopardy

- One person makes a change talk statement
- What is an open question that might have resulted in that change talk?

Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Reflective listening

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

1-2-3-4

- One person makes a change talk statement
- Another person makes a reflection
- Another makes an affirmation
- Another summarizes the discussion

Feedback-Informed Treatment

- Good news:
 - The average client in therapy winds up better off **generally than 80% of those who don't enter**
 - Mandated clients generally respond as well as voluntary clients
- Bad News:
 - Dropout rates range between 40-50%
 - 10% of clients get worse, and clinicians are rarely able to identify them. (Juvenile rates are higher)

Walfish et al 2010 (unpublished)

- No differences in how clinicians rated their overall skill level and effectiveness levels between disciplines.
- On average, clinicians rated themselves at the 80th percentile
- Less than 4% considered themselves average
- No one rated themselves below average
- Only 8% rated themselves lower than the 75th percentile
- 25% rated their performance at the 90th or higher compared to their peers

Dirty little secrets

- ... from outcome studies
 - More difference between the best and the worst therapists **within** any treatment method, than there is **between** treatment methods
 - Some therapists are better than others
 - Hiatt & Hargrave (1995) asked therapists to estimate their effectiveness in a treatment study
 - The LEAST effective therapists rated themselves as being among the most helpful

Are you experienced?

- Paul Clement (2008) analyzed his 40 year career as a therapist
- 683 cases, falling in 84 different DSM categories
- “I had expected to find that I had gotten better and better over the years...*but my data failed to suggest any...change in my therapeutic effectiveness across the 26 years in question.*”

Just one guy?

- 581 therapists
- 6,146 real world clients
- Average sessions = 10
- 46% depression, 30% adjustment disorder, 11% anxiety, plus other diagnoses
- Who got the best outcomes?
 - Training makes no difference
 - Profession makes no difference
 - EXPERIENCE makes no difference
 - Diagnosis makes no difference



Wampold &
Brown (2005)

Proficiency versus Excellence

- Proficiency in most fields can be obtained within 6 months
- The same goes for therapy
 - Most people are at their most effective 1 year after licensing/registration
 - Confidence improves throughout career
 - Competence does not

FIT in Context

Defining “evidence-based”

Evidence-Based Practice

- “**Evidence**-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient **characteristics, culture, and preferences.**”
- *American Psychologist*, May 2006.



FIT defined

- Pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services
- Involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome
- Uses the resulting information to inform and tailor service delivery
- Consistent with and operationalizes the American **Psychological Association's (APA) definition** of evidence-based practice...

To Obtain SRS and ORS

<http://centerforclinicaexcellence.com>

Click the link for “Performance Measures”

Introducing the ORS

- We work a little differently at this agency. Our first priority is making sure that you get the results that you want. For this reason it is very important that you are involved in monitoring our progress throughout therapy. We like to do this formally by using a short paper and pencil measure called the Outcome Rating Scale. It **takes about a minute. Basically, you'll fill it out at the beginning of each sessions and then we'll talk about the results...**

Continued...

- A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement sooner rather than later. **If what we're doing work, then we'll continue. If not, however, then I'll try to change or modify the treatment. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does that make sense to you?**

Introducing the SRS

- At the end of each session, you can fill out one additional form, the Session Rating Scale. Again, **it's very** short, taking about a minute or less to complete and score. This scale helps me to know **how the session went. It takes the “temperature”** of the visit, so to speak. I ask you to fill this out because the research shows your experience of our work together during the visit is a good **predictor of whether we're successful. I'll explain** more about this at the end of the session. Does this make sense?

Let me ask again...

- If you were to establish a deliberate-practice plan to become a better therapist, what is one concrete step you would take?

Exercise

- Write a detailed description of your best work
- Compare your sessions for the next two weeks to it