CHAPTER 8

At Our Best:

Motivation and Motivational Interviewing

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Introduction

This chapter reviews the practical application of motivational interviewing in the case of a young adult male whose history and behavior present many challenges for treatment. Rather than using a straightforward case to illustrate the use of motivational interviewing, this chapter shows how motivational interviewing might help in clinically tenuous situations where the way forward is unclear. "Dan" has no basis in any single case and is an amalgamation of challenging situations and clients in the author's experience. Many features of Dan's case will be familiar to readers. In fact, many of the elements in this chapter appear because they have been provocative or mystifying to professionals working at the front lines.

Should We Panic Now?

During a recent case consultation at an inpatient psychiatric treatment program for young adults, two professionals had distinctly different perspectives on a 19-year-old man named Dan. His initial placement followed suicidal ideation and threats while living in his father's home. Dan's current situation was challenging, including a potentially abuse-related fetish (wearing diapers) and overheard conversations suggesting that Dan may have recently molested a number of children. When Dan was 14, he sexually abused an intellectually disabled young man who was two years younger than he was. Following his successful completion aof a treatment program, he returned home, where he had considerable trouble getting along with his father.

Although he had made substantive progress in the treatment program, shortly after his release, Dan stole some diapers and wore them, contrary to the goals of the treatment program he had just completed. An investigation found no evidence that Dan had molested any children since his initial offense years earlier. A previous evaluation found that because Dan had stopped wearing diapers quite some time ago, and had since appeared to display no interest or emotional congruence with children, there

was little reason to fear immediate harm. That was before the stolen-diaper incident. His father, who had long distrusted him, was now distraught and enraged, and had him placed at the inpatient psychiatric program for an evaluation. He and the involved professionals began to wonder: Was Dan now at risk to escalate further? If so, in what ways might he escalate? How should professionals understand Dan?

> ***Evaluator:*** *I'm concerned that this (theft) is an escalation. My earlier evaluation report was based on the fact that his interest in diapers was limited to one environment: his father's home. He's now continuing this behavior despite being in a new environment, despite the program's clear expectations, and despite the fact that he knows how unlikely it is that his father will ever allow him to return home based on this. I'm concerned that this kind of persistence signals more of a long-term proclivity towards covert actions that could include sex with people unable to consent, or who knows what? We should be vigilant for signs of emotional congruence with children, an interest in children's activities, or a desire to be more childlike. I understand this is a difficult case with very little information; my advice is still to take this very seriously.*
>
> ***Therapist:*** *I have a different perspective. We need to remember that this theft happened about a day after his father was downright hostile to him in a meeting. Dan can't say it, but he left that meeting feeling deeply wounded. I see the diaper incident as a clear statement that he knows he's unable to live with his father and that he's not able to tell him directly. Frankly, who can blame him? He has successfully completed a sexual abuse treatment program in the past; an investigation into his overheard statements turned up nothing; he's made many gains in developing his interpersonal capacities and identity as a young man; and even if he stole these diapers, we're still not seeing signs of emotional congruence with children. We also shouldn't lose sight of the fact that wearing diapers is not a crime and that there are other signs of escalation into sexual re-offense that are much more ominous. Certainly, if the diaper wearing is concurrent with other risk factors, then we should re-examine out treatment goals. I think the more immediate concern is to come to some resolution on life with his father. After that, we need to stick to the business of building his strengths, his attachments, his relationships, and his skills.*

Which perspective is accurate? If both perspectives are accurate, is one or the other more conducive to helping Dan change?

A true understanding of the client would likely involve an empathic blend of both perspectives. In multi-disciplinary practice, however, it is common for professionals doing risk assessment to think primarily in terms of risk, and for therapists to think about treatment progress. Depending on the culture of one's practice setting, assessment and treatment might be weighted in the direction of removing risks rather than building the strengths necessary to live meaningfully while managing risks (Willis, Prescott, & Yates, this volume; Yates, Prescott, & Ward, 2010). These differing ways of understanding a client are logical enough: treating people who have sexually abused can be a high-stakes endeavor in which professionals are necessarily vigilant for signs of re-offense. Further, professionals often experience intense legal, policy, and administrative pressures that focus almost exclusively on risks. In the language of motivational interviewing (Miller & Rollnick, 2013), this reactive approach, known as the *righting reflex*, can easily lead therapists to pursue treatment as a series of directions and exhortations rather than as a shared mission towards an abuse-free life. Traditional reactive approaches to treatment can also translate to the client that life is a series of problems to be solved rather than events to be lived. Although problem solving is an important component of risk management, it does not address the full panorama of changes necessary to build a better future.

Ultimately, attempting to persuade and motivate people from the outside rather than awaken clients' internal motivations risks limiting our long-term effectiveness. In studying how people change, for instance, Ryan and Deci (2000) found that change often begins with external pressures, and that clients tend to discover their own reasons for change during the course of treatment. Where Ryan and Deci have emphasized peoples' inherent motivations in the direction of competence, autonomy, and connectedness to others, Emmons (1999) also emphasizes the importance of meaning and purpose in one's life.

Looking more closely at the examples above, it may be useful to ask: which of these professionals would you rather talk to and why? Which of these professionals do we resemble more? In addition to understanding the differences between what we do, perhaps each professional should be conscious of variations in how we speak and listen when we are assessing someone versus when we are working with them. Can each of us discern when someone is listening to us for the purposes of understanding and helping as opposed to the purposes of assessment? It might be helpful to distinguish between listening for the therapist's purposes and listening for the evaluator's needs. When we are listening deeply to a client in therapy, we can appear quite different from when we are assessing them. A helpful self-assessment exercise can be to talk with someone and watch him as he listens. As you talk, is the other person listening fully or is he mentally rehearsing his next response?

As Miller & Rollnick (2013) have observed, motivational interviewing is something done with and for someone, not to or on them (p. 15). People who have sexually abused are often understandably wary of professionals, particularly those who are in close communication with the legal system. While professionals may not want to bother with the details of interpersonal communication, many of the factors that contribute to successful treatment experiences—such as empathy and the therapeutic alliance—are understood most meaningfully from the client's perspective (Duncan, Miller, Wampold, & Hubble, 2010). After all, research has shown that sexual offender treatment providers often believe themselves to be more helpful than their clients do (Beech & Fordham, 1997).

Evaluators and therapists each play important roles in reducing the harm of sexual abuse. Their approaches to interviewing strategies overlap to varying degrees depending on circumstances, and many strategies for interviewing are available. The rest of this chapter examines the best way for therapists to connect with their clients so that clients can sort out why and how they might go about changing their lives. While an important risk assessment question can be, "How many people in the client's life are not paid to be there?" a more evocative question for purposes of treatment is, "How many people do you have in your life who deeply accept you for who you are?"

Moving Parts: What is Motivational Interviewing?

Miller and Rollnick (2013) have offered several ways to understand motivational interviewing (MI) with key points for consideration. At its most fundamental level, motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change. Important considerations include that the overall style of motivational interviewing (MI) is one of guiding, which lies between and incorporates elements of directing and following styles.

Guiding Style

The concept of guiding in this instance is vital. Older definitions of MI described it as a directive approach. Indeed, in his review of the characteristics of effective sexual offender therapists, Marshall (2005) included "directive" as a descriptor. Why the change? Ultimately, many in the MI training, practice, and research community concluded that the term "directive" was open to misinterpretation. "Guiding" implies a working relationship where the therapist figuratively walks alongside the client, exploring and offering ideas about the direction the client can take rather than directing each client to take a pre-determined route. To extend this metaphor, an MI practitioner, researcher, and trainer named Steve Berg-Smith once observed, "I want to put a pebble in the client's shoe." That is, if a client is heading in a particular direction, the therapist can use a carefully crafted statement to have the client stop and consider his or her current course and make adjustments to both the destination and how he or she gets there.

The example of Dan, above, provides fertile ground for understanding this distinction. Imagine two scenarios, each with Dan saying, "I don't care what other people think. If I want to wear diapers, who am I hurting? I'm not breaking any laws." A traditional response from the therapist might include, "Yes, but people are concerned that it can put you at risk for problematic situations, like having a harder time finding a partner, or spending most of your time in child-like activities that will prevent you from being able to relate to adults. Also, it's against the rules of your program to wear diapers, even if it's not against the law." In this instance, the therapist's response to a statement is to give information without first ensuring that the client wants it. In addition, the therapist is tacitly arguing on behalf of change, making it even more likely that the client will argue on behalf of the status quo. The easiest way through this conversation for Dan is to attack the rules as frivolous evidence of the program's inadequacies.

Examples of a more guiding style could include:

> ***Dan:*** *I don't care what other people think. If I want to wear diapers, who am I hurting? I'm not breaking any laws.*
>
> ***Therapist:*** *Your privacy is really important to you.*
>
> ***Dan:*** *Yes. It's none of their business what I do.*
>
> ***Therapist:*** *They should stay out of your life, and at the same time, you're a part of theirs.*
>
> ***Dan:*** *What do you mean?*
>
> ***Therapist:*** *What I mean is that in your father's world, you're a part of his life, and as far as the program is concerned, you're a part of the program's community, as well as the community beyond.*
>
> ***Dan:*** *They should still respect my privacy!*
>
> ***Therapist:*** *It's a tricky situation. They should respect your privacy. At the same time, it sounds like they all want the best for you.*
>
> ***Dan*** *(calming slightly): Well that's true. I still want them all out of my bedroom, though.*
>
> ***Therapist:*** *It really feels like you're under a microscope?*
>
> ***Dan:*** *Yes.*
>
> ***Therapist:*** *Can I share a couple of thoughts?*
>
> ***Dan:*** *Go ahead.*

> ***Therapist:*** *It seems this puzzle has many pieces. One piece is the relationship piece—your father and the program staff—and another piece is your independence. There's another piece that has to do with where the diapers fit into your present and future. And then, there's the piece where others are concerned about the connection between the diapers and the statements you made about children and where all of that might lead. I wonder which of those pieces you might be willing to talk about with me.*

In this way, the therapist is at once guiding the conversation in a direction that will be helpful and away from any confrontation that will only serve to make Dan more upset. Rather than going toe-to-toe with risk factors, the therapist is aware that many positive intentions underlie the current situation. By starting where Dan is and by guiding the conversation in a helpful direction, the therapist is at least engaging in a progressive dialog that might not have been possible previously. In this instance, the therapist is deliberately offering choices, all the while knowing that over time, other options will arise for guiding the discussion in each of these directions. Depending on the client's sense of safety and level of engagement in each session, the therapist might find it possible to guide the discussion into more challenging territory:

> ***Dan:*** *This program is like my dad's house. There are all these rules. I'm sick of these rules.*
>
> ***Therapist:*** *You and rules just don't get along.*
>
> ***Dan:*** *I wouldn't say that. There are lots of rules I follow. Actually, except for these recent incidents, I haven't been in any trouble at all.*
>
> ***Therapist:*** *Yes, and now that you mention it, others have noticed that as well.*
>
> ***Dan:*** *That's right.*
>
> ***Therapist:*** *And yet the program expectations you don't follow are the ones that are most upsetting to others.*
>
> ***Dan:*** *I guess. I hadn't thought about it like that.*

With this discussion, Dan is now thinking about his diaper usage in ways he hadn't considered. In effect, the therapist has put a pebble in Dan's shoe rather than pressuring him into a discussion or change. Ultimately, in this way of working, MI involves evoking that which is already present, not installing what is missing (Miller & Rollnick, 2013, p. 24).

Ambivalence

Also of fundamental importance, MI practitioners view ambivalence as a normal part of preparing for change as well as a place where a person can remain stuck for some time. Both sides of ambivalence (e.g., I want to change my life even as I don't want to reach out to others for help) reside within the client and the task of the therapist is to evoke and explore, and not to direct the client as to how he or she should think or feel. When a therapist uses an overly directive style—arguing for change with a person who is ambivalent—it naturally calls into the client's mind one or more reasons for not changing. Ultimately, people are typically more persuaded by what they hear themselves say (Bem, 1972; Miller & Rollnick, 2013, p. 13).

Ambivalence about change is a common experience for people who have sexually abused. In fact, many treatment programs themselves can be ambivalent about ambivalence. Problems with resource allocation have often led programs to accept only those with the highest motivation rather than clients

who may need treatment the most. A helpful exercise can be to look past the fact that a client is ambivalent and instead, try to identify the components of the ambivalence itself. For example, in Dan's case, ambivalence might take forms such as:

- My interest in diapers is concerning to me as well as others, and I don't want to talk about it with the staff and definitely not with my father
- I very much want to have a normal life, and I know that for now I really need help sorting out my life
- I want to dress and act like others, and the diapers feel really good when I wear them
- I want people to know that I can manage my behavior, even though I'm sometimes a little attracted to children
- I want to get help, and I don't want my privacy violated

A place to get started in using MI can be to identify any area of the client's life where the client feels two ways about his current situation. A key focus can be to ask where the client is, with respect to a given situation, and where the client would like to be. Virtually everyone who has sexually abused and who has come to the attention of the legal system or a treatment program experiences ambivalence or a discrepancy between where he or she is and where that same person would like to be in his or her life. Simply asking, "How would you like your life to be different," can be a helpful start.

Spirit factors

At a more practical level, MI involves an underlying spirit made up of *partnership, acceptance, compassion,* and *evocation* (also known by the acronym PACE). *Partnership* means that professionals view their work as collaboration, a joint commitment to a better future. *Acceptance* includes the four aspects of: absolute worth, accurate empathy, autonomy support, and affirmation. *Compassion* involves actively promoting the client's welfare and placing a priority on the client's needs. *Evocation,* also described above, means eliciting the client's personally meaningful and relevant reasons and methods for change.

In many respects, this underlying spirit is the hardest element to teach and to master. It can be easy to develop what David Burns (2009) has called "the clinician's illusion," which is that we believe we are more effective and connected to our clients than we really are. More recently, a study by Walfish, McAlister, O'Donnell, and Lambert (2012) found that average therapists rated themselves as more effective than 80 percent of their peers. The MI spirit, ultimately, rests on a foundation of humility and of being willing to abandon any pretense at expertise. Therapists may possess expertise in understanding sexual abuse, but only the client is the expert at his or her own self.

In some areas of the world, this underlying spirit of MI will run directly counter to how programs for sexual abuse define themselves. For example, the Texas Department of State Health Services defines sexual offender treatment, in part, as follows: "Sex offender treatment is different than traditional psychotherapy in that treatment is mandated, structured, and victim-centered, and the treatment provider imposes values and limits. Providers cannot remain neutral because of the risk of colluding with, adding to, and/or contributing to the offender's denial" (Texas Department of State Health Services, 2012).

By definition, treatment providers who actively impose values and limits on their clients and provide treatment that prioritizes others over the client in treatment are not engaging in MI. Setting aside ethical questions of who the client actually is in treatment programs, each professional needs to examine his or her beliefs and readiness to act as a genuine partner in change. Even outside of settings that

define treatment as imposing values on clients, many professionals have had the experience of clients in the criminal justice world who seem to interact with professionals in a way that invites a harsh and confrontational style. The challenge in MI is to stick with the spirit; it is possible—even desirable—to provide feedback, information, and advice in a manner adherent with the spirit of MI:

> ***Dan:*** *If people have something to say to me, they should just say it. I don't have time for people who don't come straight to the point. That includes therapists like you.*
>
> ***Therapist:*** *There's a right way and a wrong way to give you feedback.*
>
> ***Dan:*** *Yeah. I have a life to live and don't have time to listen to people whine about their feelings.*
>
> ***Therapist:*** *Your style is your style, and if other people have other styles for talking with you and providing feedback, then they're out of luck with you.*
>
> ***Dan:*** *Well, I wouldn't go that far. What I'm saying is that people should just be direct.*
>
> ***Therapist:*** *You want to know where you stand with others. You want them to be honest with you.*
>
> ***Dan:*** *Yeah, that's it.*

Some newcomers to MI wonder how they can practice acceptance and compassion with someone who has a genuine sexual interest in children. Let's return to Dan, some weeks after the above discussion:

> ***Dan:*** *Look, I do have a sexual attraction to children. I'm not going to lie about it anymore. I am what I am. I'm what you read about in the newspapers, only I haven't done anything about this interest; I just have it. I've spent a lot of time thinking about how I can access kids over the years. I don't need a relationship. It's the smoothness of their skin, that look of vulnerability. I just get off looking at them. Look, I don't want to hurt anybody. But let's call it what it is. I'm a pedophile.*

It is almost inevitable that this statement will invoke strong thoughts and feelings in the therapist. The response that comes immediately to mind is unlikely to come directly from the underlying spirit of MI. In fact, this is why examining the spirit, skills, style, and processes of MI can be so valuable. These elements all provide a framework for responding that the therapist can turn to while searching for a helpful response.

In order to best practice MI, many professionals have found that getting into its spirit can be helpful. This can involve anticipatory planning before walking into an interview or therapy session:

> ***Therapist (self-talk):*** *Okay, I'm about to meet with Dan. He's a straightforward young man, even if he can also be very difficult. I need to slow myself down a bit. After all these years in the field, talking about child abuse is still hard. I guess I'd be pretty ineffective if it didn't bother me. His direct style makes the partnership relatively easy. It's the acceptance component that's always hard with him. On the other hand, I can accept Dan even though I will never accept sexual abuse. Dan didn't ask for this sexual interest any more than I did. Okay, here goes. I can be compassionate, because in this instance I am going to be compassionate towards everyone: Dan, those he has hurt, and me. The best place to start is inside myself. Lower my shoulders, maybe shake out my arms and legs just a bit, allow my breathing to become longer and deeper, and enjoy the moment of working with this person. After all, if I don't, who will? I can think about the impact of abuse later. My first job is to join up with Dan. Then I will evoke whatever motivation I can find!*

In this and other examples, the MI spirit of partnership, acceptance, compassion, and evocation do not equate to excusing or enabling abuse to occur in any way. Rather, the MI spirit is a mindset that enables other mindsets where change is possible and desirable.

Four Processes

Taking the definitions further, MI is—at its most technical level—a collaborative and goal-oriented style of communication with particular attention to the language of change. The MI practitioner's intent is to strengthen personal motivation for, and commitment to, a specific goal. He or she does this by eliciting and exploring the client's own reasons for change within an atmosphere of acceptance and compassion (Miller & Rollnick, 2013, p. 29).

The most recent conceptualization of MI involves four key processes: *engaging, focusing, evoking,* and *planning.* Recognizing that conversations do not always follow a planned or straightforward path, Miller and Rollnick (2013) described these four processes as going beyond earlier descriptions of MI, first by exploring motivation and then by making a commitment to change. Real-life conversations often move forward, backwards, and tangentially as people explore what is and is not important to them. For example, take any life change that you or a client wants to make. In Dan's case, it may be that he has considerable motivation for exploring his diaper usage in treatment until this exploration then leads to examining his sexual interest in children, his relationship with his father, and the possibility of living in his home. Looking at the relationship with his father may influence his overall sense of importance in making changes to his diaper usage and his confidence that he can carry it out. Realistically, the therapist wants to explore several areas of Dan's life before returning specifically to his diaper usage and strengthening commitment to change in this area. To this end, it was inevitable that MI practitioners would evolve from viewing conversation in two stages (exploring motivation and then strengthening commitment to change).

In MI, *engaging* is the process of establishing a helpful connection and a working relationship, both within a single session and across the course of an assessment or treatment. A helpful guideline when practicing MI can be to ensure that one uses the first 20 percent of the total length of contact time to engage with the client (e.g., the first 12 minutes of an hour-long session). *Focusing* is the process by which the therapist develops and maintains a specific direction in the conversation about change. The process of *evocation* involves eliciting the client's own motivations for change and lies at the heart of MI. The *planning* process encompasses both committing to change and formulating a concrete plan of action. It is also important to note that these four processes essentially subsumed the four key principles that Miller & Rollnick outlined in earlier publications (e.g., Miller & Rollnick, 2002). The original four principles included expressing empathy (now considered a part of acceptance), developing discrepancy (now largely subsumed in the four processes describe above, including *focusing*), rolling with resistance (formerly considered one of the most important components of MI and discussed later in this chapter), and supporting self-efficacy (contained largely under acceptance, above).

In Dan's case, the therapist first started by engaging with Dan. As noted above, this can be a challenge in itself. The therapist has many possible areas of focus: the diapers themselves, what diapers mean to Dan, his relationship with his father, his relationship with the expectations of his living environments, etc. At the earliest stages of treatment, Dan's sexual interest in children is still in question. Part of the skill of the therapist in working with Dan will, therefore, be to remain engaging throughout treatment, suggesting and exploring areas of conversational focus in a way that guides treatment forward and does not compromise the therapeutic alliance. Depending on how this conversation proceeds, it may be that

the next task is to move into more fully evoking Dan's motivations for change. It may also be that the conversation is unexpectedly difficult, and the therapist elects to return to ensuring the highest level of engagement with Dan. The task of the therapist, then, is to act as a guide, all the while keeping in mind the possible areas of focus and assessing Dan's readiness to explore them in treatment. Ultimately, the four processes of MI can be linear or can re-occur during the life of a conversation or treatment.

The Language of Change

Now absent from MI is the concept of resistance as a single construct. Many professionals once considered "rolling with resistance" to be central to MI practice. Like many others, Miller and Rollnick (2002, 2013) have long been vocal about their discomfort with the concept of resistance, despite having no replacement. Many professionals have regarded the term "resistance" with skepticism, particularly because it seems to label the client rather than processes within the client, or between the client and the therapist. Many professionals have had the experience of working collaboratively with clients previously described as resistant, or finding that their erstwhile resistant clients had gone on to work very well with someone else. In a recent lecture, author Steven Gilligan stated that if the past 125 years of psychotherapy have considered resistance to be the client's responsibility, it is now time for therapists to take responsibility for resistance for the next 125 years.

In recent years, Miller and Rollnick (2013) have deconstructed resistance so that it now is defined by two components: *sustain talk* and *discord*.

- *Sustain talk* involves statements that favor the status quo (e.g., "I don't want to be in treatment;" "It would be too hard for me to do this exercise;" "Why should I follow the rules here, anyway?").
- *Discord* involves disagreement and not being connected with the therapist (e.g., "This program sucks;" "You people just need to mind your own business;" "I don't want to be in treatment").

As Miller & Rollnick (2013) explain it, "Sustain talk is about the target behavior or change. Discord is about your relationship with the client" (p. 197). Thus, the statement, "I'm not going to do treatment and you can't make me" contains both sustain talk and discord. "I'm not going to" is sustain talk, while "you can't make me" is discord. Although it is easy to understand these words, it is significantly harder to keep the full scope of their meaning in mind when an angry client is directing them (often with highly personalized and inappropriate language) at the professional. Ultimately, Miller & Rollnick caution that, "If you are arguing for change, and your client is arguing against it, you've got it exactly backward" (2013, p. 9).

Putting these ideas into practice with people who have sexually abused can require an entirely new way of thinking. In Dan's case, much of his early presentation in treatment had to do with discord more than with any overt unwillingness to change. Just because he doesn't like people telling him what to do does not mean that he isn't ready, willing, or able to participate in treatment under the right conditions. The specific approach that the therapist can use in early sessions with Dan or someone like him is to say to himself or herself, "This must make sense somehow, but in what way does it make sense?" Indeed, much of the resistance that Dan offered earlier in treatment can be viewed as having natural, appropriate, and pro-social underpinnings. For example, "You people need to mind your own business" speaks to a value of privacy and is easy for a therapist to validate. "It's not my father's concern what I do" speaks to the same value and to independence. Possible topics for further exploration that can prevent discord might include what independence means to Dan and how his family relationships are outside of interactions that he believes to be intrusive.

If sustain talk is language favoring the status quo, *change talk* is any statement reflecting a *desire, ability, reason,* or *need* (often referred to by the acronym DARN) to make a positive change. Research in the past 15 years (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003) found that client statements indicating a willingness, intent, or commitment to make positive changes are particularly important for clinicians to explore and reinforce. Earlier writings on MI have referred to these as self-motivating statements. Change talk signals that the client is at least thinking about the possibility of change.

A helpful way to think about the language of change can be to examine pop songs of the past 50 years. Every therapist would love to have a client as motivated as the central figure in the Beatles' song, Help!:

> *Help! I need somebody. Help! Not just anybody, Help! You know I need someone, Help!*
> *....Help me if you can; I'm feeling down. And I do appreciate your being 'round. Help me get my feet back on the ground. Won't you please, please help me?*

Therapists working with people who have committed sexual crimes quickly learn that clients virtually never present themselves as the Beatles did. Instead, many MI practitioners have observed that a more accurate example of clients in treatment would be Amy Winehouse's tragic, prescient, and autobiographical Rehab:

> *They tried to make me go to rehab, I said no, no, no... (referring to a mental health professional) The man said why you think you're here. I said I ain't got no idea... They tried to make me go to rehab, I said no, no, no... I don't ever want to drink again; I just need a friend... They tried to get me into rehab, I said no, no, no.*

These lyrics are more than an amusing interlude. In fact, Rehab provides an excellent example of the language of change. The most apparent motivation for change ("I don't ever want to drink again; I just need a friend") is surrounded by dozens of "no" statements and anti-treatment language. The work of the MI practitioner is to focus on the change language and to understand "no, no, no" as naturally occurring discord between client and therapist. This acceptance can be harder to accomplish in practice than it is on paper. Human beliefs regarding the importance of reciprocal interactions in relationships can run deeper than people realize, and it can be easy to revert to historical, frustration-based responses. Social psychology research provides many examples of this phenomenon (Cialdini, 2008).

Let's re-examine the earlier example of Dan, when he said:

> ***Dan:*** *Look, I do have a sexual attraction to children. I'm not going to lie about it anymore. I am what I am. I'm what you read about in the newspapers only I haven't done anything about this interest; I just have it. I've spent a lot of time thinking about how I can access kids over the years. I don't need a relationship. It's the smoothness of their skin, that look of vulnerability. I just get off looking at them. Look, I don't want to hurt anybody. But let's call it what it is. I'm a pedophile.*

In this example, the change talk is, "Look, I don't want to hurt anybody." Beyond the potential impact on therapists described above, many avenues for further discussion exist. One possibility is to explore the self-disparaging undertones of, "I'm a pedophile" and "I am what I am." However, this risks turning the conversation into an attempt by the therapist to bolster the client's self-esteem, when really he or she should guide the client in the direction of finding self-esteem. Amid Dan's words above, the MI practitioner might zero in on the desire not to hurt anybody and explore that concept further. The most effective response to change talk can be to reinforce, affirm, ask for elaboration, reflect it back ("so you really don't want to hurt anyone even though it can be tempting"), and make summarizing statements about it.

Therapist: *You're sexually attracted to children, and you also don't want to hurt anyone. It takes a lot of courage to say that.*

Dan: *People thought I was a monster back in my old treatment program and in my neighborhood after I got out. I had sex with a guy who was two years younger than me, but he was disabled. I went through lots of treatment where they told me all about how sexual abuse hurts people. I get it. I don't need to be reminded. I don't want to hurt anyone. I've never wanted to hurt anyone. But still, people look at me like some kind of predator. I admit I'm not always the most trustworthy individual out there when it comes to some of the rules, but everyone seems to think that if I'm breaking my dad's rule or not exactly in line with the program's expectation then I must be some kind of sicko.*

Therapist: *You break rules but you haven't broken the law. People are looking at your actions and then making assumptions about your identity.*

Dan: *Yes. I'm actually a caring person. I mean other people break a few rules here and there, and I don't see them getting put under the microscope.*

Therapist: *... and meanwhile, you've got this sexual interest in children that you've been trying not to act on.*

Dan: *You got it. Now you can see why I'm not talking about it.*

Therapist: *Tell me more about how you stop yourself from acting on it.*

Dan: *Well this might sound crazy, but sometimes it's hard not to notice the possibility. It's like sometimes I'll go into a corner store and notice where the security cameras are. Sometimes I play a little game with myself and try to see if there's a place where the cameras couldn't see me steal something. I never do, but it is kind of interesting. It's the same thing with kids. I see them in the community, at bus stops, or walking to and from school. I notice them when they're alone. I don't do anything, although sometimes I've started a conversation with them.*

Therapist: *So it's almost like looking at something in a shop window that you want. It's great to stare at it, you have some fantasies about owning it, but you can't just take it.*

Dan: *I don't want to hurt anyone. I hope you believe me. I don't want to hurt anyone.*

Dan's statements display a desire not to sexually abuse, as well as some ability and need. Although a therapist whose response is based in the righting reflex might go directly to safety planning, the therapist using motivational interviewing is first finding out more about the strengths and values that Dan will eventually use in managing his life.

Motivational Interviewing in Practice

MI Skills

Five key communication skills are used throughout MI. They include asking open questions, affirming, reflecting, summarizing, and providing information and advice with permission (Miller & Rollnick, 2013, p. 36). Before delving into these skills further, it might help to review the dialog in this chapter. How many questions are there, as opposed to statements that reflect back the client's meaning? In research studies, motivational interviewing competence typically involves a ratio of at least two of these reflective statements to every question.

Developing a facility with reflective statements takes time, and new MI practitioners will do well to attend trainings, watch MI training videos, and—above all—practice as much as possible. As with learning any new set of skills, practitioners can find themselves becoming self-conscious as they observe themselves and the words that they use. This process of self-observation in the service of skill building often interferes with the practitioner's ability to focus on the client as much as he or she would like. In fact, a dilemma can ensue in which new MI practitioners find themselves on the horns of a dilemma: Should they listen genuinely and within the MI spirit, or should they mentally rehearse the MI-consistent skills they are learning? At first, it can seem impossible to do both. For this reason, many MI novices find it useful to practice with friends, colleagues, and family members in low-stakes situations. Professional coaching and supervision by a more seasoned MI practitioner is also invaluable.

Entire books have focused on these skills, and so discussion of application to Dan's case is necessarily brief. In these early stages of Dan's treatment, the therapist has walked a fine line between engaging and focusing. In more traditional practices, the original risk assessment that occurred in the wake of revelations of diaper usage and suspicious statements would have led to a feedback session with Dan. It may well have been that professionals would meet with Dan and prescribe a treatment plan based on lowering the risk of future escalation into more serious behaviors such as child molestation or other illegal and harmful behaviors. Within an MI framework, the therapist chose to elicit more information from Dan, including discussion of what is relevant and meaningful to him. The therapist was aware that there were many possible treatment goals, and was willing to prioritize them according to the goals to which Dan would commit. In this way of working, advice and information would be provided only with permission or if Dan asks. After all, attempts to force assessment results or treatment onto an unready participant risks making matters worse.

Therapist: *Dan, your ability to be so straightforward shows the kind of determination you have. If you're willing to talk about it, I would love to know more about your sexual interest in children.*

Dan: *Well, it's like I said. I would still rather have relationships with adults, but there is this attraction, and some days I wonder how it is that I don't just give in. So much of my childhood was a disaster. Some days I wonder how I ever made it through, and other days I just really want to re-live it. I just want to get a break from growing up. I mean I want to grow up, but some days I just need a mini-vacation from it.*

Therapist: *You really feel two ways about it. On one hand, childhood looks pretty good from here and on the other hand, a lot of times, your childhood seems to have been disastrous.*

Dan: *Yeah.*

Therapist: *Some days it seems like it would be relaxing and feel good to go back to your childhood and live it differently.*

Dan: *Yeah.*

Therapist: *How does the sex fit in with that?*

Dan: *It's mostly just fantasies. The more I talk and think about it, the more stupid it seems. Look, this is going to sound crazy, but those diapers . . . they're a solution to this. Other people see them as a problem. For me, wearing diapers is a way to go back there—I don't know—and be a kid again, but to not actually hurt anyone. That's what it's about.*

Therapist: *So this behavior that's got everyone so upset . . . is how you're preventing things from getting worse.*

Dan: *I don't expect anyone to believe that, but yes.*

Therapist: *It's part of a commitment not to have sex with kids.*

Dan: *You got it.*

Therapist: *I wonder, if using diapers in this way continues, how would that fit into your future relationships with adults?*

Dan: *I have no idea. It's safe to say that a lot of the adults in my life are horrified by it. It's hard to imagine anyone wanting to be with me.*

Therapist: *So the dilemma for you has been to wear them as a way to feel good and have a mini-vacation back to childhood, while still holding out hope for the kind of relationships that others have.*

Dan: *That's right. Is there any way I could get treatment for that? And not the kind of Monsters Anonymous that everyone keeps thinking I need?*

Therapist: *Yes, I believe so.*

Dan: *I would do that. I would do that.*

Therapist: *That's a plan. In the meantime, can I give you some information?*

Dan: *Sure.*

Therapist: *I can't speak for the decisions and behavior of others. Only you are the expert on your life. People who've spent a lot of time working in the field of sexual abuse have found that some people who wear diapers as adults have similar motivations to yours, but that for some of them, wearing diapers is more like a complete immersion into childhood, and can make them more willing to pursue sex, sexual interests, and sexual fantasies. Putting aside all the issues of privacy and independence and everything else, there can be some good reasons why people—including you—express some concern. If we continue to work together, my hope is that we can find the kind of private life for you that will work for a long time into the future.*

What do you think of what I've just said?

Dan: *Okay, I can do that. It makes sense. Maybe we agree more than I thought.*

Conclusion

Dan is an overtly challenging character in many respects. He enters treatment under uncertain circumstances, suspicious of others, and with complicated motivations. In these ways, he is an obvious candidate for motivational interviewing (MI). Many newcomers to MI wonder whether it is necessary to adhere to five skills within four processes resting on a substrate of spirit facts. After all, if what professionals are doing already works, why not keep going? This question is reasonable, and the answer likely resides in the fact that not all clients say everything that is on their mind. Clinical endeavors can certainly appear to work well enough; MI practice can bring therapists to a deeper level of understanding while it also brings clients to a deeper level of feeling understood. This dual approach can assist in preventing client dropout, and can lead to earlier detection when a client's situation or treatment participation is worsening. Further, whatever the circumstances that may have brought a client to treatment, being in sexual offender treatment is a very challenging experience in the best of times. Even the most effective

therapists can miss the micro-blunders that occur routinely in any therapy. Given the stakes involved in providing treatment to people who have sexually abused, MI offers an excellent method for ensuring safer and more effective practices.

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