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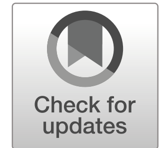
SEXUAL DISORDERS (LE MARSHALL AND H MOULDEN, SECTION EDITORS)



Motivational Interviewing: as Easy as It Looks?

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Abstract

Purpose of Review This paper explores how motivational interviewing (MI) can be useful to practitioners working with people who have sexually abused. Research has found that the most effective practitioners working with these clients are warm, empathic, rewarding, and directive. Putting these characteristics into practice, however, can be challenging for professionals in treatment settings. Despite a wealth of information regarding MI practice generally, its use with people who have sexually abused has received little attention.

Recent Findings Motivational interviewing has been found to be effective in helping people change a wide range of problematic behaviors. Although it has been found to assist in treatment engagement with people who have engaged in intimate partner violence, it has not been subjected to rigorous examination in the treatment of sexual aggression. Nonetheless, it has received increasing attention within criminal-justice circles and can help clients of all backgrounds become involved in many of the treatment services available to them.

Summary The most effective practitioners working with these clients are warm, empathic, rewarding, and directive. The practice of motivational interviewing can benefit clients directly and can help professionals to develop the characteristics found to work with people who have sexually abused.

Keywords Motivational interviewing · Empathy · Sexual abuse · Criminal justice · Responsivity principle

Introduction

Motivational interviewing (MI) has come into increasingly widespread use since its inception [1, 2••]. One of the first published applications of MI to the treatment of sexual abuse was a case example of a person who denied his offense [3]. Since then, numerous studies and meta-analyses have provided evidence that MI can be a useful approach across a broad range of therapeutic interventions [4, 5]. Unfortunately, to date, there has been no high-quality study of MI with people who have sexually abused. Perhaps a related area of empirical study is in intimate partner violence, where MI has consistently been found to improve engagement in treatment, session attendance, and homework compliance [6••].

Despite the dearth of empirical study involving people who have sexually abused others, there has been no shortage of interest in the topic within criminal-justice circles, most recently culminating in a book on the topic [7]. This interest may stem, in part, from research into the principles of an effective correctional intervention [8]. In particular, MI can be a means for professionals to adhere to the *responsivity principle*, which holds that interventions should be tailored to the individual characteristics and learning style of each client. Another reason for the emergence of interest in MI may be a body of research conducted and summarized by Marshall [9••], which has found that the most effective treatment providers are a balance of warm, empathic, rewarding, and directive (often known by the acronym WERD). As described in the next section, learning and practicing MI can be an excellent method for mastering these qualities.

What Is MI?

MI has evolved since its first introduction [1]. As Miller and Rollnick [2••] now define it, "MI is a collaborative, goal-

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oriented style of communication with a 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" (P. 29). Its key qualities include that:

- MI is a guiding style of communication that sits between following (minimal intervention from the clinician) and directing (imposed intervention from the worker).
- MI is designed to empower people to change by drawing out their own strengths, meaning, importance, and capacity for change.
- MI is based on a respectful and curious way of being with people, which facilitates the natural process of change and honors client autonomy.

It is important to note that MI requires the clinician to engage with the client as an equal partner and refrain from giving unsolicited advice, confronting, instructing, directing, or warning. It is not a way to "get people to make change" or a set of techniques to impose on the conversation. MI takes time and practice and requires self-awareness and discipline from the clinician [2••].

One crucial element of MI is attention to the language of change. MI practitioners listen for evidence of change talk (statements related to a desire, ability, reason, or need to change in a particular area) and commitment talk (which involves discussion of steps taken towards change or an overall commitment to change). Just as important are efforts in the direction of softening sustain talk or statements favoring a problematic status quo [10].

Ultimately, becoming proficient at MI is no small endeavor. In the author's experience, many people believe they are proficient at MI when they are not. Often this takes the form of professionals believing that they "know all about" MI, or that they "have attended MI trainings," but as in any other field, these states of knowledge are not the same thing as actual proficiency in its regular use.

Why Use MI in Treating People Who Have Sexually Abused?

Professionals may have different reasons for learning, practicing, and implementing MI in their work and agencies. For program administrators, ensuring the use of MI can help to decrease variability between professionals at the front lines. In other words, when every member of a team is skilled in the same approach, it can be easier to assess professional development and identify areas for improvement. This can take place through a variety of means, including helping the practitioner to develop better skills for expressing accurate empathy, engaging in reflective listening, or improving the quality of their questions [7].

Another reason MI can be useful is its strong focus on understanding the client's perspective and evoking his or her internal reasons for change. That understanding, in turn, can serve as a kind of early-warning system for ruptures in the professional's working alliance with the client. In other words, MI's spirit of collaboration means that rather than subtly (or explicitly) imposing treatment goals onto a client, the practitioner is working in a style of partnership, acceptance, compassion, and evocation to establish mutually agreed-upon goals and tasks of treatment. In this context, it can be easier for the practitioner to identify challenges in establishing an agreement in these areas.

Yet another reason MI has garnered such an appeal is because of the large number of studies finding it to be effective with diverse populations [4, 5]. This places it at or near the top of the list of evidence-based practices. In the author's experience, this fact has occasionally resulted in skepticism that MI has not been tested specifically with people who have sexually abused. A common response to this concern is that although it has not been subjected to empirical scrutiny, many MI practitioners find that it aids client responsivity, even in the most challenging cases. Furthermore, when faced with this concern, many professionals respond with questions such as "Do people who abuse not benefit from a provider style involving partnership? Do they not respond to acceptance and compassion? Don't all clients benefit from exploring their internal motivations for change?" These rhetorical questions stem from MI's underlying "spirit" of partnership, acceptance, compassion, and evocation [2••]. To some degree, this question of applicability may be misguided, because MI is simply an approach or means for conducting treatment; it is not a comprehensive treatment package or curriculum. It neither adds financial cost nor time to existing treatment practices and, properly implemented, may actually result in savings in both of these areas [4].

Finally, in the author's experience, many professionals study and practice MI because it can be a way to actuate the qualities of WERD outlined by Marshall [9••]. In this way, practitioners are bringing themselves more in line with what research shows work with individuals who have sexually abused others. Important to note is that MI is designed to be delivered in an individualized and not in a manualized fashion. Indeed, one meta-analysis found that MI delivered in a manualized way was not any more effective than any other approach [4].

What Kind of Barriers Exist to Proficiency in MI?

There can be many barriers to becoming proficient in MI. In the author's experience, the most serious barriers tend to arise

when efforts to learn and implement MI are only partially supported by the leadership of an agency or institution. In some cases, this can take the form of sending practitioners to a conference about MI but not supporting efforts at implementation afterward. It can also involve bringing in a trainer but not engaging in the follow-up consultation that would ensure proficiency.

At an administrative level, there is an entire body of research into how effective treatments come to grief when attempts at implementation are not successful [11, 12]. These challenges can include such problems as staff alienation and turnover, non-adherence to treatment protocols, and a broad array of other variables. Practitioners will therefore wish to be familiar with this research in order to prevent problems from emerging.

Furthermore, when practitioners only learn the most fundamental aspects of MI, it becomes easy to overlook critical junctures in treatment with people who have sexually abused. For example, trainees often do not learn about how to provide feedback or have difficult conversations in a style that is consistent with MI. Not surprisingly, many practitioners can feel unprepared when beginning to use MI with people who for whom treatment is mandated, the legal stakes are high, and the threat of further involvement with the criminal justice system is real. Learning to provide clear and direct feedback in a manner that is consistent with WERD and MI takes time and practice, and the lack of opportunity for this can lead practitioners and lay professionals to conclude that MI is only effective with their least challenging clients.

Yet another challenge for practitioners can be to adopt the spirit of partnership and collaboration at a deep level. In the author's experience, many practitioners must first overcome an unspoken (but nonetheless present) attitude of moral judgment and/or role confusion. Although difficult to quantify, the successful use of MI (and treatment in general) often involves viewing clients as fellow travelers in the world rather than moral strangers [13]. This can be disconcerting to many professionals. There is little question that clients in treatment have often committed serious moral transgressions. However, when professionals view their clients through this lens (rather than also seeing and accepting the human being beyond), MI practice is much less likely to be effective.

Similarly, in the author's experience, newer MI practitioners face challenges in how to truly support each client's autonomy within the limitations that each experiences in their daily life. These limitations on client autonomy can be as diverse as conditions of release into the community and lack of community resources to assist in their community reintegration (e.g., housing, employment). Practicing MI involves supporting realistic client autonomy under even the direst of circumstances.

Perhaps most perniciously, in an important but often-overlooked study, in which Steven Walfish and his colleagues found that psychotherapists almost unanimously rated themselves as more effective than their peers [14]. In their study, no one rated themselves as below average. Known as self-assessment bias, the authors based this study on an extensive literature finding similar results across numerous professions. Among the implication of this study is that, on the one hand, all professionals want to become better and, on the other hand, many believe that they are already more effective than most. Walfish and his colleagues demonstrated that professionals viewing themselves as more effective than others is itself one hallmark of being average. Implications for those working with people who have sexually abused include that many professionals may view themselves as embodying the WERD characteristics when in reality they may not. In a study of group treatment climate, Beech and Fordham [15], for example, found that therapists treating people who had sexually abused believed themselves to be more helpful, friendly, and concerned than did their clients.

The research on self-assessment bias leads to further questions as to how professionals arrive at their conclusions regarding their own effectiveness. For example, it may be that as one gains experience and learns to prevent mistakes, it is easy to conclude that one is more competent at the work. However, preventing mistakes is not necessarily the same thing as becoming an excellent practitioner. In this way, learning and practicing MI can be extremely helpful because its practitioners can seek out and work with a coach or supervisor who can provide specific feedback on their MI delivery.

Suggestions for MI Practice with People Who Have Sexually Abused

Once practitioners have received enough training to become proficient at the basics, one place to begin with clients is to actively imagine areas where they experience ambivalence about treatment, change processes generally, and their lives. In contrast to more traditional approaches, in which the practitioner assumes an expert role, the MI practitioner can explore the client's ambivalence about making changes in various areas of his or her life. For example:

- On the one hand, you desire a close connection to others and on the other hand, your sexual interests are primarily in children.
- On the one hand, you really hope for a long-term relationship and on the other hand, you often feel that women are out to get you.
- On the one hand, you want to complete this treatment program and on the other hand, your life experiences have left you uncertain that you can trust anyone.

Readers will note that the first two of these relate to common risk factors for re-offense (sexual interest in children and adversarial attitudes towards women), while the third relates to efforts at change and risk management. By exploring, rather than tackling these issues, the MI practitioner opens a conversational space that allows the client to understand and make his or her own case for change rather than the status quo.

One possible means for deepening one's use of MI can be by discussing goals that clients can approach rather than avoid. For example, in addressing the areas outlined above (sexual interest in children and adversarial attitudes towards women), the practitioner can focus on the *approach goals* that are often implicit within the risk factors (in this case, the desire for close connection and long-term relationships). A practice skill specific to MI with people who have abused can be to establish the approach goals that underlie each risk factor.

The above points regarding approach goals highlight the close relationship that MI practice can have with the good lives model of rehabilitation (GLM) [13, 16]. In essence, the GLM posits that sex crimes often reflect the use of inappropriate means to meet otherwise legitimate underlying goals shared by all human beings. These universal "approach goals" are listed below, alongside ambivalence about them that people who have sexually abused might experience:

- Life (living and surviving, a critical challenge for many clients, especially after release from an institution). As an example of ambivalence: *You're committed to living safely in the community. At the same time, you are often tempted to return to old behaviors that did not end well.*
- Knowledge (learning and knowing, sometimes contributing to clients whose crimes were of a naïve or experimental nature). As an example of ambivalence: *On one hand you wanted to know what it was like to have sex with children and on the other hand, if you'd known how harmful it would be to yourself and others, you might not have done it.*
- Excellence in play (people who do not have ways to occupy their free time are often at risk for turning to problematic leisure activities). As an example of ambivalence: *You want activities in your life that you are good at; ways you can spend time that do not risk getting you back into trouble.*
- Excellence in work. As an example of ambivalence: *You're trying to get a stable job even though the employers out there are looking at your record.*
- Excellence in agency (including autonomy or independence). As an example of ambivalence: *Your whole life has been about making your own decisions, and now you are living under intensive supervision.*
- Inner peace (or states in which the person experiences calm or peace of mind). As an example of ambivalence: *You've learned a lot about what you can do to stay calm. Putting these skills into practice when you are anxious can be a challenge.*
- Relatedness (being connected to others). As an example of ambivalence: *You're longing for more people in your life. At the same time, it sometimes seems safer just to go it alone.*
- Community (being part of a group of people). As an example of ambivalence: *You really miss being a part of a team and you also worry that others will reject you if you try.*
- Spirituality (having a sense of meaning or purpose in life). As an example of ambivalence: *You've spent so much time feeling lost and adrift in your life. At the same time, you have not given up hope on figuring out what your life's mission is all about.*
- Creativity (including having new or novel experiences). As an example of ambivalence: *Sometimes you really just want to cut loose and try something new. At other times, you are acutely aware of how many people are monitoring your behavior and you wonder what they might think.*
- States of happiness and pleasure (including simply having fun). As an example of ambivalence: *You really want to have some fun in your life. At the same time, a voice inside you is reminding you that having fun is what got you into trouble in the first place.*

By exploring client ambivalence about change in each of these areas (for example, a client who wants to re-enter the community and who has rarely been successful within it), the MI practitioner can help clients determine for themselves the most effective way forward with their lives. At the same time, many of the above goals directly underlie the risk factors addressed in treatment with people who have sexually abused (for example, many crimes have been committed in attempts to gain inner peace, happiness, and pleasure, or relatedness with non-consenting people). By understanding and exploring risk factors as means by which clients have attempted to achieve the same goals that others share, professionals can potentially gain more agreement on the nature of the goals and tasks of treatment (for example, achieving overall well-being over and above simply managing risk). The end result can therefore be the development of a lifestyle in which sex crimes are undesirable and unnecessary.

Ultimately, exploring and resolving client ambivalence in the above overarching life goals, or towards change in general, can be an excellent place to start in demonstrating warmth and empathy, and being both rewarding and directive (WERD) with clients. By actively seeking to understand these areas of a client's life, and the conflicts they experience around them, MI practitioners have an opportunity not only to display warmth but also to demonstrate empathy by reflecting back an understanding of the complexities and nuances of a client's life. By understanding the otherwise unassailable goals they

were trying to achieve through harmful behaviors, the clinician has a chance to provide affirmation and be rewarding to the client. After the clinician becomes familiar with the techniques as well as the style and spirit of MI, he or she can become more proficient in selecting skills that enable a directive approach that does not come at the cost of setting aside warmth, empathy, and affirmation.

Conclusion

Professionals can face many challenges in understanding, learning, implementing, and becoming excellent at practicing MI. Just as human beings and sexuality are complex, so are the methods that professionals must use to build healthier lives and safer communities for all. Disclosing and exploring the most unpleasant details of one's sexual behavior is a difficult work under the most favorable circumstances. These are discussions where virtually all clinicians will do well to keep themselves grounded in specific empirically sound principles and techniques. By starting with understanding and describing the client's ambivalence, the clinician has an excellent starting point for therapeutic work. By demonstrating this understanding with warmth and empathy, the clinician can understand more deeply who the client is and what strengths they have in their lives that can be affirmed and built upon. Then by mapping out the client's experiences through the lens of MI (and aided by the GLM), the clinician can better chart a course of treatment. This treatment is in a better position to proceed at a reasonable pace, and the clinician better poised to use a more directive style because of the initial work done through the more basic work of listening with a goal of deep understanding. As an approach, MI offers a structured approach to those clinicians wishing to be more WERD.

Compliance with Ethical Standards

Conflict of Interest David S. Prescott is sometimes paid to provide trainings on some of the content in this paper.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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