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Motivational Interviewing in the Treatment of Sexual Abusers: An introduction

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"Always give the patient every opportunity to resist"

- Milton Erickson

In his later years, celebrated hypnotherapist Milton Erickson recalled growing up on a Wisconsin farm and encountering a resistant calf:

One winter day, with the weather below zero, my father led a calf out of the barn to the water trough. After the calf had satisfied its thirst, they turned back to the barn, but at the doorway the calf stubbornly braced its feet, and despite my father's desperate pulling on the halter, he could not budge the animal. I was outside playing in the snow and, observing the impasse, began laughing heartily. My father challenged me to pull the calf into the barn. Recognizing the situation as one of unreasoning stubborn resistance on the part of the calf, I decided to let the calf have full opportunity to resist, since that was what it apparently wished to do. Accordingly I presented the calf with a double bind by seizing it by the tail and pulling it away from the barn, while my father continued to pull it inward. The calf promptly chose to resist the weaker of the two forces and dragged me into the barn.

People who have sexually abused are not cattle, yet they can be equally reluctant. While some people who have sexually abused make it all the way through treatment and find real value along the way, others drop out or even cheat their way through. Clearly, individual disposition is important, but how can clinicians help clients stay the course? How can professionals help build healthier lives as well as safer communities?

Rick, aged 29, enters his first individual session with his clinician. He was convicted of molesting his 11-year-old niece. He accepted a plea agreement to avoid what could have been a lengthy prison sentence. While there is little question that Rick committed the acts that brought him into the legal system, he has mixed feelings about being in treatment. While he is motivated to live a better life and avoid further trouble, he also wants to keep his family together. He wonders what would happen if he entered treatment and acknowledged having caused sexual harm. He believes he is different from the mug shots he has seen on television news programs. While his motivation to change will wax and wane throughout treatment, his initial commitment to entering a treatment program will be

particularly important. Motivation can change throughout the treatment experience. While Rick's initial motivation is to meet the demands of the legal system and not lose his family, he may well find that changing becomes more important as he moves further into a treatment program.

For Rick, treatment will be like a swimming pool. He will enter carefully before venturing beyond where his feet touch the bottom, and he is more likely to need help when things get difficult. In fact, any attempt to impose change on him will prompt resistance. Research on personal change clearly shows that clients like Rick who enter treatment may not necessarily be thinking about genuine change. Yet many sexual-abuser treatment programs behave as if they are.

Motivational interviewing is a person-centered counseling approach in which the practitioner uses a guiding style to enable the client to build and strengthen his or her own motivation for change. Although Miller (1983) and Miller and Rollnick (1991) first coined the term, many others have helped to develop motivational interviewing into its current form (e.g., Moyers, Martin, Manuel, Miller, & Ernst, draft manuscript). This article is by no means the final word on the topic, but should encourage readers to explore this topic further through training and other venues.

On the surface, motivational interviewing appears easy to do, but it becomes more complex in actual practice. Professionals commonly believe they already know how to do it, which is usually true. Unfortunately, many professionals who know how to use motivational interviewing do not actually use it in practice as much as they think. As a result, they may be helping clients less than they believe.

Before pursuing motivational interviewing further, a bit of self-assessment may be helpful. Many trainees find this establishes an understanding of how they respond differently before and after exposure to motivational interviewing. Divide a piece of paper in half and, on the left side of the page, write down your responses to these typical statements that indicate client resistance. . Later, you can write out your new responses on the right-hand side and compare them, having studied (and hopefully practiced) the motivational interviewing style and skills described below:

1. I'm only here because of the court. I don't believe in treatment.
2. I attended a treatment program in prison and it was no good.
3. My private life is none of your business.
4. You can't change me. No one's going to change me.
5. Go ahead and do what you're going to do; you're going to do it anyway.
6. I don't think I belong in treatment. I'm not like your other clients.

Style and Spirit

Central to motivational interviewing is the professional's capacity for collaboration, evocation, and support of the client's autonomy. This is more challenging than it might seem, especially with clients who appear to have little investment in change or willingness to participate in treatment. Under these conditions, professionals understandably might resort to tactics that gain short-term compliance with treatment or supervision expectations; but harsh, confrontational approaches are more likely to meet the momentary needs of the professional than the long-term needs of the client and community (Garland & Dougher, 1991). These short-term tactics may come remarkably easily to professionals; however, research has found them to be less effective than warm, empathic, rewarding, and directive therapeutic styles (Marshall, 2005).

People in the helping professions can quickly revert to short-term compliance-based tactics for a variety of reasons. Motivational trainees have typically provided a number of common ones, including fear of appearing "soft" on offenders, concerns that a warm approach leaves them open to easy manipulation, and pressure to show immediate gains. In some cases, it seems that healthy professionals engage in unhealthy practice because their clients tacitly encourage them to do so.

One motivational interviewing training exercise encourages participants to play the roles of a client entering treatment and the treatment provider. The treatment provider receives explicit instructions

to provide the "client" with reasons and strategies for change and to encourage the client to change. The clients, whose only instruction is to be ambivalent about change, invariably become defensive and resistant. The "clients" often find this role simple to adopt and easy to maintain. In fact, it is easier to play a waiting game of reluctance than to discuss change. Meanwhile, participants role-playing the "therapist" typically find the exercise exhausting and feel that they worked too hard for very little gain. Still, these professionals frequently experience an intense sense of responsibility for the clients' change process.

Practitioners often refer to this sense of responsibility for the clients' change as an example of "the righting reflex"– the all-too-frequent sense human beings experience wherein they must fix things or set something right. However, it can hinder client change, and prompting this reflex is often the client's intent. Its most obvious forms appear as therapists scold, attempt to educate, or generally talk at clients who are unwilling or not ready to listen. Common reactions to the righting reflex include feeling misunderstood, angry, insulted, disrespected, and defiant. As a result, clients deny, minimize, or justify their behavior.

Motivational interviewing does not demand that professionals abandon these concerns. Instead, they can simply put them aside as they awaken clients' incentives or reasons for change. Professionals can be most effective by entering each interaction with an explicit purpose of collaboration. This means abandoning attempts to fix problems or issue directions, asking questions, offering reflections, and providing summaries of what the client says in order to demonstrate that they are listening. From here, the client can make his or her own case for change, as research shows people who perceive themselves as having some degree of choice in an endeavor often become more compliant with it (Bem, 1972; Ryan & Deci, 2000).

Professionals are most effective when they respect clients' autonomy. Clients are often unwilling and unready to change. Using motivational interviewing techniques as a means of manipulating someone to change against their will is unethical and likely ineffective (Miller & Rollnick, 2002). Ultimately, adopting the style and spirit of motivational interviewing involves recognizing and setting aside one's righting reflex, maintaining a position of collaborating with the client, supporting their autonomy as they consider change, evoking and eliciting their thoughts and actions, and – above all – listening.

Good listening

Many professionals believe they are listening when they are not. Truly good listening involves entering each interaction with undivided attention, curiosity, appreciation, and wonder. It means listening with the heart as well as the ears. Most importantly, good listening requires demonstrating to the client that the professional is listening and soliciting feedback as to how well they are listening (Miller, Hubble, & Duncan, 2007). In motivational interviewing, good listening does not include agreeing, advising, persuading with logic, arguing, sympathizing, or consoling. Professionals working with sexual offenders commonly find these clients defensive, reserved, or argumentative. Simply taking extra time at the beginning of each interaction to demonstrate that one is listening can alter the tone of the interview dramatically. The challenge is that good listening often involves reflecting back statements that indicate antisocial attitudes. The professional will doubtless be tempted to provide feedback on these attitudes, but doing so too early disrupts the conversation and demonstrates that the professional is more interested in fixing the client than listening to him or her.

<u>Self-assessment exercise:</u> Ask a friend, colleague, or client if they would be willing to speak with you about any topic of their choice. Have them speak to you for a few minutes while you simply listen with interest. How do you demonstrate interest while saying as little as possible? What non-verbal indicators do you use? If you have a strong reaction to anything they say, how can you put it aside while you continue to listen? When your speaker is finished, offer them a summary of what they have said. Think of their statements as flowers that you will arrange into a bouquet, or gems that you will arrange into a necklace. Finally, ask if you heard it all correctly.

In this exercise there is no penalty for not capturing everything. If you haven't listened, your speaker will let you know, and you may have another chance. The key is asking whether you understood. It is

easy to skip this step in an effort to be efficient. There are numerous times throughout the day when we commonly don't ask people close to us whether we understood what they were saying.

It is tempting to believe that sexual offender treatment providers have an obligation to "lay it on the line" or otherwise scold clients into a more prosocial stance. By doing so, it is easy to create interpersonal conflicts rather than motivate the client to make their own case for change.

Ambivalence

Ambivalence happens in motivational interviewing and sexual offender treatment. Although many clients present themselves as having very little they need to change in their lives, an astute professional can find numerous areas where clients feel ambivalent.

- On one hand, I really want to build a better life for myself and on the other hand, I'm not sure I have it in me to change.
- On one hand, I really want to stop getting in trouble and on the other hand, I don't want to give up my sexual fantasy life.
- On one hand, I want to make connections with my group members and on the other hand, I am concerned whether I can trust my fellow group members.
- On one hand, I want to talk about what I've done, and on the other hand, I don't know if I can handle the feelings it will bring.

One way to gauge a client's ambivalence is to make an educated guess based on the experiences of other clients: "This sounds like a real dilemma. If I'm reading this right, you'd really like to participate more in group on one hand and you're really concerned about trusting people on the other." Notice that the conjunction between the two sides of the ambivalence is "and"" instead of "but". Using "but" risks highlighting this ambivalence as being either one or the other while "and" acknowledges that the client holds these contrary sides simultaneously.

Four Principles

Miller and Rollnick (2002) provide four basic principles in motivational interviewing: developing discrepancy, rolling with resistance, supporting self-efficacy, and expressing empathy. It is often tempting to think that we already work within these principles until we receive direct feedback from others.

Expressing empathy. Empathy has received significant attention in offender treatment (c.f., Fernandez, 2002). It may help professionals to view empathy as their ability to enter and understand a client's world, expressing a clear and deep understanding of the client's perspective, including both what the client says and has not yet said (Moyers, Martin, Manuel, Miller, & Ernst, draft manuscript). Clearly, sexual offenders are responsible for many of the consequences of their actions, but that does not preclude professionals from actively expressing empathy:

- It's hard for you to talk about this.
- You're wondering what this is going to mean for your family.
- You really miss your loved ones.
- You're concerned that discussing your past might get you into more trouble.
- Having to trust others in treatment is really new to you.
- You're wondering if anything is ever REALLY going to change.

Empathy is not the same as sympathy. While it may be tempting to sympathize with clients ("I hear you. Being on the sex offender registry is no fun."), this does little to support their autonomy and is potentially harmful.

Developing discrepancy. Discrepancy is the difference between where someone is at and where he or she wants to be with respect to a given issue. Demonstrating meaningful change in the factors that

contributed to one's offending can be a long and difficult journey. Developing discrepancy can include exploring what a better life would be like ("Tell me about some times when things were going well and you weren't engaged in this behavior"). It may include exploring specific issues ("On one hand you believe it wasn't a big deal, and on the other hand your family has expressed concern about your coming home").

Rolling with resistance. The term "resistance" can be misleading. It is important to consider what the client is resisting and what the motivation for resisting actually is. Are they genuinely uninterested in changing some area of their life? Or are they resisting the professional's attempts to engage them in a change process? Whatever the case, professionals gain nothing by combating resistance. Resistance is an interpersonal phenomenon, which most likely to appear during interactions where the client feels misunderstood or unheard. When all else fails, the most human response can often be the best one. ("So with all the reasons you have for not being here, what would be the most helpful way we can spend our time together?") It is easy to forget that what may appear to be resistance is actually an invitation to understand. ("Since this is obviously a difficult conversation, can I just ask you something? You and I seem to be from different worlds. What's it like in your world?")

Supporting self-efficacy. Autonomy and choice are vital to change. It is easy to assume that people who have sexually abused are unable to make good decisions for themselves. Too often, well-intended professionals attempting to help their clients build safety into their lives end up restricting rather than allowing them to explore and improve their decision-making. Professionals frequently experience a strong righting reflex when they feel responsible for their clients' actions. Although there can be a time and place where direct intervention in an emergent situation can become necessary, professionals will be most effective when they guide clients in making decisions rather than impose them. Many professionals have expressed concern during trainings that this is time-consuming. A helpful phrase to remember at these times is "the slower we go the faster we get where we're going."

Basic Skills

Although proficiency at motivational interviewing can be a life-long endeavor involving many skills, four basic "micro-skills" are vital for practitioners. These are open-ended questions, affirmations, reflections, and summaries. Together, many practitioners refer to them by their acronym, OARS.

Open-ended questions. Closed-ended questions require only yes/no responses or simple information (e.g., what is your name?), Open-ended questions require some thought and can be tricky to formulate. It is tempting to ask at the start of a session, "Is there anything you'd like to discuss today?" However, this question risks an immediate response of "no". Opening this question up can produce more information: "What would you like to discuss today?" Or, "I wonder what concerns you might have today?"" In addition to giving the client options, it introduces a refreshing if slightly directive component to the question:

- What questions might you have for me?
- What concerns you about making a change in this area?
- What would it be like if you made this change?
- Why might others want you to make a change in this area?
- If you did make a change in this, how would you go about it?
- How might others have handled that?

It can be simple enough to open up closed-ended questions. A therapist can simply change "does anyone have any questions" into "I wonder what questions you might have?"" Often, it only takes the open nature of a question to inspire further discussion. Consider the case of suicide assessment. Many students learn to ask, "Have you had any thoughts of hurting or killing yourself," to which experienced clients can easily answer "no". It may be more effective to ask, "Under what circumstances would you think of hurting or killing yourself?" While treatment providers may not think of asking whether their client will engage in future sexual harm (a closed-ended question), "Under what conditions would you do this again?" might contribute to a productive discussion.

One way to practice opening up questions is to listen to interviews on news broadcasts and identify the open-ended and closed-ended questions. How could opening up questions result in a better interview, particularly with image-conscious interviewees? Many newer practitioners believe that close-ended questions are somehow "bad"." They're not. The key is that open-ended questions prompt in the client to speak more than their therapist. This is a hallmark of both motivational interviewing and high-quality sexual offender assessment and treatment.

Affirmations show genuine appreciation for candor, effort, and accomplishment and are most effective when they accompany real understanding of the client's situation and worldview. They are not simply empty compliments or warm and fuzzy praise (e.g., "You're a good guy"). In fact, many sexual offenders – particularly those who have spent a number of years in prison — tend to interpret the latter as unhelpful and manipulative. More effective statements can be:

- I appreciate how difficult this has been for you.
- Your willingness to discuss this today is truly impressive, particularly under your current circumstances.
- It took courage for you address this in front of the others.

As with the other micro-skills, professionals often think they offer more affirmations than they actually do. A warm facial expression, engaged body posture, or friendly smile is not the same thing as a genuine, verbalized affirmation.

Reflections may be most effective means to elicit information and demonstrate active listening. Reflective statements act as mirrors and build upon what the client has said. It can be helpful to think of a mirror when forming them. Which element of the client's statement do you wish to reflect back to them? Do you wish to understate or overstate that element? Because reflections can call attention to different elements of a statement, they can determine the direction of the conversation. Reflections can be powerful, and most effective when they involve few words. Simple reflections feedback what the client has actually said, while complex reflections feedback what they have not yet said.

Reflecting exact words simply repeats back what the client has said. It is difficult to do harm with this kind of reflection, although many newcomers to motivational interviewing express concern that over-reliance on it can undermine attempts to form a therapeutic alliance. *Reflecting closely related words* is self-explanatory and applicable to situations where the practitioner is more comfortable taking a constructive risk:

Rick: Your treatment program is no good.

Practitioner: No good (exact words).

Rick: (emphatically) That's right.

Practitioner: You see nothing worthwhile about it (closely related words).

Rick: I'm only here because my probation officer told me he'd send me to prison.

Practitioner (reflecting slightly deeper meaning): The only reason you're even showing up is to keep him off your back.

Rick: You got it.

Continuing the paragraph is where the clinician is making a guess at the client's deeper meaning. Miller and Rollnick (2002) recommend that clinicians think of this as first taking a question that starts with ""Do you mean…"" Next, rather than asking it as a question (inflecting upwards at the end), take away the "do you mean" and simply utter the question as a statement. Imagine a client says, "I'm only here because my probation officer sent me here." Rather than asking, "Do you mean you have no interest in

treatment?" the clinician can simply say, "You have no interest in treatment.""

Clinicians can also simply *reflect emotion.* For example, when the client says, "I'm only here because my probation officer sent me here," the clinician might simply observe, "And you're pretty frustrated about it.""

These complex reflections, *reflecting emotion* and *continuing the paragraph* can produce powerful results. Where simple reflections using exact and closely related words can be effective with minimally verbal clients, or when clinicians are not exactly sure how best to proceed, complex reflections can be very brief, express interest, elicit more information. Although all people want to be sure that others are listening, people who have sexually abused very often enter treatment with a long history of being discounted and unheard. By preferring reflections to questions, the clinician can demonstrate that he or she is listening.

Clinicians can guide conversation flow with complex reflections. For example, while clinicians may want to use simple reflections in uncertain situations, they can deliberately reflect meaning in order to elicit information, or reflect emotion to guide the client to a deeper place.

Rick: It wasn't my idea to come here to this stupid program.

Clinician: This program seems stupid (simple reflection).

Rick: The only reason I'm even here is because the court sent me.

Clinician: It was part of a plea agreement (continuing the paragraph).

Rick: That's right. Look, I'm sure this is a good program and nothing against you, but it's stupid that I have to be here. I can't be a part of treatment when it involves all these rapists and child molesters. There were a whole lot of problems with my court case and the only reason I pleaded guilty is I didn't want any hassle. This whole thing is stupid. What I really need is some kind of counseling that's going to show the court I'm not the kind of guy they need to worry about.

Clinician: So there's a lot about you that the powers that be don't understand (continuing the paragraph).

Rick: That's right. They were treating me like a common criminal.

Clinician: And it's not making sense to you that you have to be in a program like this with others who you feel are coming from a different place (continuing the paragraph).

Rick: Yeah. Look, no offense to anyone, but I can't be around a bunch of rapists and child molesters.

Clinician: If you were to be in a treatment program, you'd need to be around people you knew you could trust (continuing the paragraph).

Rick: That's exactly right. I've got a lot riding on this, and I need to get back to my family, re-build my career, pay the rent, you know…

Clinician: You love your family (reflecting emotion).

Rick: Well yeah! I have to find some way to get back with them.

Clinician: …And it's been a long time since you've all really been together (continuing the paragraph).

Rick: After everything the court and social services put us through, it's a miracle I still have them in my

life at all (looking down, voice lowers).

Clinician: It's been a long road for you all.

Rick: And now I have to do all this… like talking in some group just to please my probation officer.

Clinician: So this is a dilemma. On one hand, you don't see any value in this for you, and on the other hand, you're thinking that being in treatment might get you to a place with your family and the law where you can get on with your life. Your family and freedom mean everything to you.

Rick: You got it.

In this example, the clinician is deliberately not responding to the comments about other group members, the program, or the client's apparent lack of accountability, any of which would likely prompt further resistance. Instead, the clinician explores the client's ambivalence and develops some discrepancy between where the client is at with his life and where he would like to be.

A general rule in motivational interviewing is to offer two or more reflections for each question. While questions are not forbidden, offering reflections can be more helpful and in line with motivational interviewing's research base. Offering reflections can feel odd at first, and becomes a habit with time.

Recognizing and Reinforcing Change Talk

Research (e.g., Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003) suggests that client statements indicating a willingness to make positive changes are the most important material for clinicians to explore and reinforce. Originally described as self-motivating statements, change talk signals readiness, ability, and willingness to change. It often appears as one small pearl[2] in an ocean of resistance talk. The clinician focusing on the ocean will miss the pearl. In working with sexual abusers, it is easy to imagine the clinician's work as resembling that of a goalie in ice hockey (although it is important to note that treatment is not competitive). In order to be effective, the goalie must focus on the puck while being aware that an entire team of athletes (with skates and sticks) is coming at him rapidly. In the goalie's field of vision, the opposing team is large, fast, and threatening. The puck is small, but the clear object of focus. Just as the goalie needs to attend to the opposing team, the priority —with no disrespect toward the other team— is moving the puck in the right direction.

Change talk typically consists of four types of statements, known by the acronym DARN:

Desire ("I want to")

Ability ("I'm able to"" or "I could")

Reason ("I've got some good reasons to")

Need ("I need to")

These statements deserve special attention, as they may be the first indication that a client is motivated to change. Rather than making a case for change, clinicians can be more effective by rolling with resistance and reinforcing change talk where they find it.

Clinician: So this is a dilemma. On one hand, you don't see any value in this for you, and on the other hand, you're thinking that being in treatment might get you to a place with your family and the law where you can get on with your life. Your family and freedom mean everything to you.

Rick: You got it. I have to find a way to do this.

Clinician: You're thinking it's time to make this happen.

Rick: I really want my life back and my family back. I just don't see how I'm supposed to be in some group with these people.

Clinician: It can be confusing getting going in this kind of program. You have a solid goal for your life and it's not clear how you're going to make it work with the others in this picture.

Rick: It's like you said. I want to make sure that I can work with these other people.

Clinician: Teamwork is going to be a big part of this.

Rick: Yeah.

Clinician (summarizing): So let me see if I have this right. You really want to show the judge, probation officer, and social services that you can and should stay in the community. You really love your family, want your life back, and want to re-build your career and pay your mortgage. It's hard to get past the feeling that you don't belong in a treatment program, and you're really wondering what it's going to be like to be in a group with others who've been convicted of sex crimes. You're not happy about this, but you're determined to make it work somehow. Did I get it about right?

Rick: Yeah.

In this instance, the clinician is responding primarily to those statements indicating that Rick desires, is able, has reasons, or needs to get involved in the treatment program. At this point, Rick has spoken mostly of his desire to keep his family together, get on with his life, and be free of the restraints of the legal system. The clinician is aware that meaningful completion of treatment will require the client to find different motivations (such as a genuine desire to explore his life and make changes) while the clinician needs to reflect back whatever willingness to change that the client has to offer.

Commitment Talk

Statements involving desire, ability, reason, and need to change are vital. Clinicians should reinforce them, reflect, and look for more. It is even more vital to look for signs of commitment to change and statements indicating that a person has taken steps towards change. Continuing the conversation:

Clinician: Did I get it about right?

Rick: Yeah. Given what the court and social services have done to me, if I don't finish this program I might as well throw in the towel. I don't like any of this, but I've been through hard times before. And who knows, maybe I can learn a few things that will help me with my family along the way.

Clinician: You're committed to making this work and hope that you can use it to make your life better.

Below is a list of client resistance and change-talk statements. In responding to them, keep in mind that change talk can appear as a small pearl in an ocean of resistance. The clinician's job is to collect these pearls and feed them back in a summary.

- This program is just the Department of Corrections in sheep's clothing.
- I don't like any of this.
- I have to do something to keep that probation officer off my back.
- How do you know this treatment stuff even works?
- You're trying to provide treatment for something I may do in the future?
- I need to do something to keep my job, not keep a journal.
- I don't think they'll ever let me go home.

- I got some of my treatment assignments done.

Examples of change talk can appear anywhere. Pop singer Amy Winehouse, for example, offers a tragic account in her song, "Rehab." The song contains repeated reasons for not going into drug-abuse treatment ("no, no, no, I won't go, go, go"). After several minutes of protest, she offers some internal motivation to change ("I don't ever want to drink again; I just need a friend"). Media accounts, particularly interviews of public figures can provide rich material for reflecting resistance and change talk in the moment, even in the absence of genuine conversation.

Providing Feedback

In working with people who have sexually abused, clinicians often wonder how best to offer constructive feedback that is consistent with the style and spirit of motivational interviewing. These clients often seem to invite clinicians to get aggressive in providing feedback. Some general tips include:

- *Ask, don't tell*. Asking permission to share feedback sets the stage for a more respectful interaction and ensures that the client has some responsibility in that by giving permission he or she has acknowledged a readiness to listen. Likewise, eliciting the client's response helps ensure that they listen to the feedback.

- *No fixing things*. Clinicians may feel the urge to set the record straight or immediately fix a problem. It helps to view feedback as an offering that the client must decide whether to use.

- *Style is everything*. Providing feedback can be a particularly sensitive time in the course of an interview. Maintaining a spirit of collaboration and respect for autonomy is vital. Given correctly, feedback can be far more helpful than unsolicited advice.

- *Ask - Provide - Ask.* This framework (also known as elicit - provide - elicit) is an excellent approach for clinicians. Essentially it is asking permission to provide feedback, providing the feedback, and asking what thoughts the client might have. For example:

Clinician: Rick, after being in this evening's group, I have some thoughts I'd like to share with you. Would that be OK? (Closed-ended question emphasizes the yes/no nature of the inquiry.)

Rick: Go ahead. You're just going to do it anyway.

Clinician: Actually, I don't believe it would be helpful or respectful to speak with you about this if you're not willing to listen. I'm not just asking to be polite.

Rick: OK, then, go ahead. I'm ready.

Clinician: Rick, the other guys in group have been telling me privately that they feel your behavior is disrespectful. They feel that it's not so obvious as to be openly disruptive or bring the group to a screeching halt. However, they do feel that they can't move forward with their own treatment unless you're an equal, productive member of the group. They've mentioned this privately because they feel you didn't take their concerns seriously when they brought it up in group. What's also important for you to know is that I have had the same concerns myself. You appear to view yourself as very different from and slightly superior to them. My observation is that although you are good at providing supportive and challenging feedback to them, it doesn't seem that you take their feedback seriously or consider it very much. As you know, I have a responsibility for the well being of the entire group. It may be that if things continue along these lines, we may need to consider an alternative treatment situation for you. Just the same, you have my complete confidence that when you are ready to give this group your all, there will be very little that can hold you back. I wonder what thoughts you have about that?

Rick: I'm going to have to think about that. It's like I said when I first started, it's hard to do group with others who have done worse things than I have.

Clinician: And where the others in group are investing themselves, it's hard for you to do the same. This is a real dilemma. You have concerns about them and they have concerns about you.

Rick (after a pause): I hadn't looked at it that way.

Clinician: What do you think you might do?

Rick: I guess I could bring this up in group. I really want to finish that group and get on with my life. I guess I've been unfair to them.

Clinician: As you think about this further, I'm confident you'll do a good job if that's what you choose to do. See you in a few days!

In this instance, the clinician has left no doubt as to where the responsibility for treatment participation lies. The message is very clear and utterly respectful. Using the *ask – provide – ask* format can lessen resistance, and may make the difference between the client's success and failure.

Conclusion

The desire to be heard, understood, and autonomous is universal, while resistance is largely an interpersonal phenomenon. Resistance to change is not the same thing as resistance to others peoples' attempts to change them. At the start of this chapter, a young Milton Erickson recognized that the calf simply wanted to resist at that moment, and he rolled with it. His ability to enter the calf's world fostered a solution. Likewise, Rick's clinician, fearing the consequences should Rick not fully participate in treatment, might easily have resorted to a coercive solution that might have produced short-term compliance. Of course, this could have come at the expense of long-term change through meaningful participation in treatment.

The research on motivational interviewing is impressive (Hettema, Steele, & Miller, 2005; Lundahl, Tollefson, Gambles, Brownell, & Burke, in press). Immersing one's self in its practice is harder than it seems. When the reader is ready, it may be useful to re-visit the questions at the start of this chapter. Now write new responses on the other side of the sheet of paper and see how they differ from earlier thoughts.

Most people who attend motivational interviewing trainings find their answers become shorter and more helpful. They ask fewer questions and are better able to detect clues as to clients' internal motivations to change. By becoming better listeners, we become better agents of change.

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