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Motivational Interviewing: An Update for Professionals Working with People who have Sexually Abused

David S. Prescott, LICSW
Director of Professional Development and Quality Improvement
Becket Family of Services

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Introduction

A client, complaining about the treatment he was receiving, once filed a complaint in writing:

> Client: *When am I going to be done with treatment? I can't get a straight answer. Everyone keeps lying to me.*
>
> Response: *Mr. X, we've spoken about this. You need to be more appropriate with your concerns. This communication is indicative of your ongoing criminal attitudes.*

There is little doubt that mandated clients who don't like their circumstances become frustrated with the often slow pace of meaningful change. How a professional chooses to respond to these harsh statements, however, can mean the difference between a resident who feels engaged and invested versus one who will become angry, drop out of treatment, and spend his spare time filing formal complaints and – possibly – legal challenges. It is not clear that any resident would engage in a meaningful dialog under these circumstances. One could view this situation as simply an ornery client deliberately challenging authority, or as an opportunity to demonstrate empathic understanding to a client who – as far as he is concerned – is speaking truth to power.

How is it that professionals so often resort to harsh tactics when empathic responding has shown itself to be a better overall strategy? One possible answer is that empathic responses require a specific skill set (e.g., open questions, affirmations, several types of reflective statements and summaries, described later in this article) that can take years to develop. Another possibility is that the challenge in treating and supervising people who have sexually abused brings with it a powerful urge, known in motivational interviewing as the "righting reflex". All human beings have the instinct to recognize that something isn't right and requires our attention and action. In much of human experience, this instinct can be vitally important and helpful(e.g., "Something is wrong with my health; I should call the doctor"). In the provision treatment for people who have sexually abused, it can include the inclination to respond harshly to clients in the name of providing feedback or other messages, which they may be unready, unwilling, or unable to accept. This article examines motivational interviewing and provides an update on its foundational spirit, processes, and skills, in tandem with the recent, revised publication of the third edition of *Motivational Interviewing,* by Bill

Miller and Steve Rollnick (2013). It is intended to benefit those who treat – and supervise the treatment of – people who sexually abuse.

Of course, this scenario is a very small example of how interactions in sexual offender treatment programs can become unhelpful, even as they illustrate the fact that every conversation can be helpful and, under the right conditions, lead to increasingly substantive dialog. Readers can consider whether the residents in the examples above are more likely to remain rude or defiant in the initial example as opposed to the following:

> Client: *When am I going to be done with treatment? I can't get a straight answer. Everyone keeps lying to me.*
>
> Therapist: *You're really fed up with being here and it feels like no one is giving you straight answers.*
>
> Client: *Yeah. I'm never going to be done with this and we both know it.*
>
> Therapist: *If I understand you correctly, it's as if you've been feeling hopeless on one hand, and on the other hand, you still want to find some way to make things better, or else you wouldn't be talking to me. You're speaking your truth to me and want the same in return. What part of this can you and I discuss in the time we have today?*

In this instance, it would be easy to revert to setting limits or reminding the residents about the need to interact respectfully. In this case, there is a reduced risk that the conversation will escalate into a problematic situation, one that could involve formal complaints against the therapist or treatment program.

Motivational interviewing

Definitions of motivational interviewing have seen a dramatic evolution in recent years. Miller and Rollnick (2002) defined motivational interviewing as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (p. 25). Central to this definition is the idea that motivation should be intrinsic. In reality, many people can and do make changes in their lives based on extrinsic factors. Ryan & Deci (2000) have observed that people may begin a change process because of extrinsic factors (e.g., being mandated to treatment) and find their own intrinsic motivations for change through therapeutic experience. In other words, a person's own reasons for change may be intrinsic or extrinsic. Likewise, the authors came to realize that client expression of ambivalence towards change is not a necessary condition for motivational interviewing, although it is a frequent situation where people become stuck and have difficulty changing Miller & Rollnick, 2013).

More recently, several definitions of motivational interviewing have emerged, along with key points for consideration (Miller & Rollnick, 2013):

1. Layperson's definition: motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change

   Key points include:

   - The overall style of motivational interviewing (MI) is one of guiding, which lies between and incorporates elements of directing and following styles.
   - Ambivalence is a normal part of preparing for change and a place where a person can remain stuck for some time.
   - When a helper uses a directing style and argues for change with a person who is ambivalent, it naturally brings out the person's opposite arguments.
   - People are more likely to be persuaded by what they here themselves say (p. 13).

2. Practitioner's definition: motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.

   Key points include:

   - MI is done *for* or *with* someone, not *on* or *to* them.
   - Four key aspects of the underlying spirit of MI are partnership, acceptance, compassion, and evocation.
   - Acceptance includes four aspects *of absolute worth, accurate empathy, autonomy support,* and *affirmation*.
   - MI is about evoking that which is already present, not installing what is missing (p. 24).

3. Technical definition: motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (p. 29).

   Key points include:

   - Four key processes in MI are *engaging, focusing, evoking*, and *planning*.
   - *Engaging* is the process of establishing a helpful connection and working relationship.
   - *Focusing* is the process by which you develop and maintain 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.
   - Five key communication skills used throughout MI are asking open questions, affirming, reflecting, summarizing, and providing information and advice with permission (p. 36).

Also of importance is that where Miller & Rollnick (2002) provided four key principles, these have essentially been replaced by the four key processes in MI of *engaging, focusing, evoking*, and *planning*. The four principles, now replaced, were:

- Express empathy (now considered a part of acceptance)
- Develop discrepancy (now largely subsumed in the four processes describe above, including *focusing*)
- Roll with resistance
- Support self-efficacy (subsumed largely under acceptance, above)

Conspicuous in its absence from the most recent definitions is the idea of rolling with resistance, which many professionals once considered the quintessential heart and soul of MI. The authors have long been vocal about their discomfort with the concept of resistance, despite having no substitute term. Many professionals have regarded the term resistance with skepticism, particularly because it seems to label the client rather than processes within the client. In recent years, the authors have deconstructed resistance into two components:

- *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 on the same wavelength as your client (e.g., this program sucks"; "I want the Clinical Director to get the spray bottle for me"; 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 bear 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.

If sustain talk is language favoring the status quo, change talk is any statement reflecting a *desire*, *ability*, *reason*, or *need* to make a positive change. Prescott and Porter (2011) have described it as:

> *Research (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003) suggests that when client statements indicate a willingness or commitment to make positive changes, it is particularly important for clinicians to explore and reinforce them. These have variously been described as self-motivating statements, change talk signals readiness, ability, and willingness to change. All too often, this appears as one small pearl*[1] *in an ocean of resistance and sustaining the status quo talk. The clinician who focuses on the ocean will overlook the pearl. Likewise, in working with sexual abusers, it is not hard to liken the clinician's work to that of a goalie in ice hockey (although it is important to note that treatment is not competitive). In order to be effective, the dispassionate goalie must realize that an entire team of athletes is approaching rapidly (with skates no less) and focus on the puck. 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. While the goalie needs to be aware of the opposing team, his focus is to get the puck and send it in the right direction. There is no disrespect toward the other team – far from it – just a desire to focus on the puck and send it in the right direction.* (p. 387)

To summarize up to this point: There are different ways to define motivational interviewing depending on one's circumstances. The common thread is that they are all counseling approaches for exploring why and how a person might change, and grounded in the use of a guiding style (as opposed to a directive or following style). The four-part foundation or "spirit" of MI involves an intentional mindset of partnership, acceptance, compassion, and evocation. It involves four processes: engaging, focusing, evoking, and planning. Professionals accomplish this with four key skills: open questions, affirmations, reflective statements, and summaries. A critical component to motivational interviewing is the elicitation, exploration, and reinforcement of change talk.

Advantages for treatment programs of using motivational interviewing include that it has a very good evidence base (e.g., Hettema, Steele, & Miller, 2005; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Adherence of treatment sessions to motivational interviewing is measurable to a reasonable extent (Moyers, Martin, Manuel, Miller, & Ernst, 2007). Its collaborative approach can contribute to reduced client-driven grievances and complaints against treatment providers as well as reduced dropouts. Also important to clinicians and administrators is that it can provide a framework for responding to challenging clients under difficult circumstances. While many empirically supported treatment curricula provide specific treatment activities, motivational interviewing can build consistency of language and action among therapists and reduce the variability between them. It can do this through its foundational spirit, core processes, and key skills even as it provides a common way to understand discussing therapeutic interactions in supervision or with peers.

Getting started

Four foundational elements, four processes, and four key skills can appear at first to require proficiency in juggling as well as counseling. The author has found that the following tips helpful for professionals as they begin practicing MI, or at least incorporating what they can into their practice on a day-by-day basis:

Get into the mindset of creating new mindsets. Sexual offenders can have serious deficits in cognitive flexibility. In a meta-analysis of 39 studies with 4,589 participants in all, Morgan and Lilienfeld (2000) found that antisocial groups performed 0.62 standard deviations worse on tests of executive functioning than comparison groups. This was a moderate to large effect size. Schlank (2006) reported similar findings among a group of civil commitment center residents in Minnesota. Even taking into account other factors such as

distrust of authority, people who have sexually abused often have a difficult time shifting their mindsets even when they want to. Likewise, van der Kolk (2012) has observed that people who have experienced trauma (which is over-represented in all criminal populations) and other serious adverse childhood events tend to display lower levels of curiosity. In large measure, this is because of the heightened state of physiological arousal (also known as a flight-fight-or-freeze response) that is common among traumatized people (van der Kolk, 1994). Taken together, these findings suggest that professionals using MI can first:

1. Become genuinely curious about the individual they are speaking to, even if they do not appear curious about themselves.
2. Take several moments to slow down, take a deep breath, orient to their surroundings, set aside whatever obligations are clamoring for their attention, and focus on the client in front of them. Clients cannot engage in helpful discussions if the professional is not fully present and self-regulated. Matching one's breathing to that of the client can be an enormously helpful skill, although it is also very easily forgotten.
3. Although it can seem strange at first, develop a motto of "keep that focused sparkle in your eye!" (Prescott, 2011).

Practice reflections and other listening skills. Sooner or later, every human being has the experience that the person they are talking to is not listening with interest, curiosity, and delight – that they are in fact mentally rehearsing what they are about to say. Beginning one's practice with MI involves considerable self-observation and self-consciousness. While measures of MI adherence require at least two reflections to each question – a daunting task at first – professionals can still practice the key skills of open questions, affirmations, reflections, and summaries while listening to the news or interview shows on the radio while driving to and from work.

Seek feedback when expressing empathy. Many professionals have had the experience of considering an interaction to be a brilliant only to find out that they had badly misunderstood their client. Some are obvious:

> Client: *I hate my father. He left our family when I was six, came back when I was ten, and left us again when I was twelve. If I ever see that guy again, I just might kill him!*
>
> Therapist: *So you never felt you measured up in your father's eyes.*

While others are not:

> Client: *I'm so sick of everyone breathing down my neck and watching my every move.*
>
> Therapist: *You wish people would just leave you alone.*
>
> Client: *No, it's not that. I just can't figure out why people can't trust me even a little bit. It's like nothing I've done in treatment even matters.*

Simply asking, "Am I getting it right?" can advance a dialog and cut through discord. While there is nothing fundamentally wrong in this second example, small misunderstandings between clients and therapists can add up to breaches in the therapeutic alliance over time.

Keeping the spirit alive

Treatment programs for people who have sexually abused are challenging environments for using motivational interviewing. In fact, there can be times when professionals should not use it, such as with concerns regarding the immediate safety or wellbeing of clients. Many of these circumstances (e.g., imminent fighting, serious threats made towards staff) will be obvious and require no further discussion here. More challenging can be subtle circumstances where staff members experience the righting reflex. Consider the following situation:

Rob, a clinician, has been using motivational interviewing with a client who has progressed slowly in recent months. There have been concerns about his influence on others and that his interactive style may be holding others back. In fact, there are questions about whether the client needs to return to an earlier phase of the program. Meanwhile, Rob is aware that Anne takes a more no-nonsense towards the clients in her treatment groups. Rob feels Anne's interpersonal style is more brusque and confrontational and not within the spirit of motivational interviewing. However, it also seems that she is an influential clinician within the department, often seen smiling and laughing with the supervisory staff in a number of departments, and seems to have enormous influence across the institution. Meanwhile, Rob and his supervisor don't seem to enjoy the kind of camaraderie he sees elsewhere, particularly since a misunderstanding about a request for vacation time some months ago. Privately, Rob begins to wonder whether he doesn't need to take a harsher approach towards his clients. Although this would mean compromising key components of motivational interviewing, he would also like to have the level of influence that Anne does. Without explicitly saying it, Rob feels he is getting the message "why can't you be more like Anne" in his supervision sessions, but is reluctant to say anything because of their past misunderstandings.

In this situation, client care will become compromised in the absence of a clear mandate to use motivational interviewing, and in the presence of diffuse boundaries and complicated interpersonal relationships that can arise in even the best programs. To be clear, this is an implementation problem and not one stemming from motivational interviewing itself. The unfortunate reality in programs treating people who have sexually abused is that the many demands that staff experience can take away from the sterling efforts required to ensure fidelity to the style and spirit of motivational interviewing. Across many areas of clinical endeavor, it can be easy for supervision to focus less on the long-term success of cases and more on the short-term "administrivia" of daily life in the program. The following areas can also threaten the integrity of motivational interviewing:

Abandoning the guiding style. Guiding clients towards change necessarily involves having specific goals in mind. As in other areas of clinical endeavor, setting goals that are personally meaningful and relevant for clients can itself be a challenging balance of art and science. It can frequently be the case that newcomers to motivational interviewing adopt an overly directive style, *assigning* goals to clients rather than working collaboratively to establish them in a shared fashion. Likewise, others attempting to use motivational interviewing can become confused or misunderstand the foundational spirit and allow the client to lead the discussion, although in the author's experience this tends to be much less frequent. In some extreme cases, this can also appear as abandoning motivational interviewing altogether, as in one instance where a clinician said, "we tried MI with him on Monday and Wednesday, and it didn't work, so we really gave him hell about his treatment participation this morning."

The expert trap. There can be tremendous pressure on therapists, both from outside the treatment room and within, to provide answers and be in control. This can come from clients themselves who can sometimes appear more interested in getting a certificate of treatment completion than in actually changing. Many therapists have had the experience of a client saying, "Just tell me what to do." Miller and Rollnick (2013) have noted that simply asking too many questions gives the message that "I'm in control" and that, given enough information, "I will have answers to problems." They observe that this does not work well when the goal is meaningful personal change for the client.

Losing hope. Snyder, Michael, and Cheavens (1999)noted that therapists who are burned out or otherwise fail to model hopefulness do not inspire hope in their clients. This is a critical consideration among those who do not know when – or if – they will return to the community. Extending this into the treatment of sexual offenders, Moulden and Marshall (2009) have emphasized the importance of building *agentic thinking* (awareness that a goal is possible) and *pathways thinking* (having ideas about how to accomplish these goals). The key word here is thinking. In other words, it is one thing to put goals and strategies into a treatment plan, and it is another to have them clearly in one's mind.

Losing curiosity. As noted earlier, clients in treatment for sexual aggression frequently appear less curious about their lives than other people who enter traditional outpatient settings. Many can seem openly uninterested in making any significant changes to their lives. For these reasons, it is vital that clinicians actively maintain their interest in their clients. A helpful reminder to therapists might be that by the time a

client lands in treatment for sexual aggression, virtually everyone in their lives has lost interest in them. If the therapist isn't curious about them, who will be?

Implementing motivational interviewing in programs

Evidence-based treatments are one matter; implementing them is another. Emerging literature on implementation science can be helpful to program administrators and supervisors(e.g., Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This research, as well as the experience of numerous trainers and clinical staff, suggests that traditional attempts train clinicians (e.g., sending therapists to a one-day training) will be effective only infrequently. Programs that are serious about implementing motivational interviewing more typically start with a two- or three-day training of all therapists, followed by several months of coaching(which involves an outside professional viewing or listening to recordings of sessions), followed by an advanced training. The element of coaching and/or fidelity monitoring (in which the outside observer uses a measure to code the therapists actions in sessions), with their attendant feedback to clinicians, appears to make the greatest difference in bringing therapists up to competence. While the "spray and pray" approach of providing a single training and trusting that clinicians will implement and maintain this practice is economical, research and practice have indicated it is not enough (Fixsen et al, 2005). The following tips may help administrators. They are based on research and experience in implementing a range of evidence-based treatment practices:

- Ensure that the administration clearly supports, and is committed to implementation. Those who have studied leadership and management know that without ongoing, genuine support from the top, implementation efforts are in jeopardy.
- With senior administration support ensured, involve the supervisory staff as early as possible. Training supervisors at the same time as front-line clinicians weakens their ability to support supervisees' learning, and can even serve to undermine their credibility under the wrong circumstances.
- Expect that about 15% of staff will be very strongly interested from the start and that their enthusiasm can be infectious. Likewise, a small number will not be interested, and may demonstrate very low levels of empathy, compassion, autonomy support, etc.
- Fixsen (2010) observes that an introductory training will result in only about 10% of clinicians becoming confident, although with coaching over an extended time, this figure can rise dramatically, as high as 90%. In the business world, similar results are 20% with introductory training, but only 80% with coaching.
- Anticipate that the beginning stages of implementation will be awkward and that the bulk of competency for an agency is only apparent after about two years.
- Employ other efforts to keep the spirit alive. For example, one agency assigned staff to send out a "motivational interviewing tip of the day", and structured it according to the game "tag, you're it". Whoever offered the tip one day would end their email with "tag! Rob, you're it", and Rob would offer a tip the next day.
- Use a structured measure for fidelity monitoring. The Motivational Interviewing Treatment Integrity (MITI) scale can be very helpful for understanding sessions and structuring feedback (Moyers et al., 2007). It consists of spirit items and skill items.
- Expect that where therapists make mistakes will follow a pattern of "sins of omission" followed by "sins of commission". In other words, therapists new to motivational interviewing will forget or leave out key elements (e.g., not enough reflections) rather than try to implement aspects of it and fail. Supervisors can be helpful by making sure that the spirit and process elements are included as well as the key skills.
- Routine, specific feedback to therapists is essential, as is following up on that feedback to ensure that therapists are actively self-monitoring and improving. There is some indication that in the absence of a deliberate plan for practice improvement, inherent self-starters will improve more than others. Supportive supervisors can counter this kind of "the-rich-get-richer" phenomenon in supervision in many of the same ways therapists do with clients, by building agreement on the nature of their relationships with clients and on the goals and tasks of treatment provision.

Conclusion

Professionals treating people who have sexually abused often come upon motivational interviewing because they have tired of the more directly confrontational approaches that recent research suggests don't work. While motivational interviewing has intuitive appeal and a strong evidence base, it offers additional advantages to those working with this population. It can reduce tension between staff and clients, reduce variability between therapists under the right conditions, and reduce the number of client-driven grievances in institutions. However, implementing motivational interviewing can be as much of a challenge as practicing it. Therapists and administrators alike may wish to forgo asking "can we do this?" in favor of asking, "what is the likelihood we can achieve full compliance within two years, and what barriers would prevent this?"

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[1]The author is grateful to Steve Berg-Smith for this analogy.