

## **Rehabilitating high-risk offenders: Pre-treatment motivation, therapeutic responsivity, and change**

**Devon L. L. Polaschek**

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Client motivation to undertake the treatments we offer, and relatedly, motivation to change, are concepts on which clinicians place considerable emphasis. I have noticed that when we get to talking about client motivation with each other, several common points arise; whether the clients are offenders or not. First, motivation is often spoken of as if it is the responsibility of the client, rather than an issue of interest to both client and therapist. Second, clinicians make judgements about the presence or absence of this desired client characteristic using a number of criteria with little or no established empirical basis (e.g., acceptance of personal responsibility, disclosure of personal information: Barrett, Wilson, & Long, 2003; and “expressions of regret for their offences, a desire to change, and sounding enthusiastic about the treatments on offer”: Ward, Day, Howells, and Birgden, 2004, p. 646). Miller and Rollnick (1991) observed that actual client behaviour has demonstrated a stronger relationship to treatment outcome than what people say about their intentions. Yet we often find more compelling evidence in what our clients say. Third, it follows that we clinicians may believe that our judgements about initial client motivation predict treatment outcome. And they may, but not necessarily because of our ability to discern poor prognosis; it is possible that our clients’ progress is also influenced by our perceptions of them.

The research evidence is, at best, mixed on whether pre-treatment ratings of client motivation predict treatment outcome, both with offenders and in other samples. With obsessive-compulsive disorder, Pinto, Pinto, Neziroglu, and Yaryura-Tobias (2007) found that being pre-contemplative predicted poorer outcomes, but Vogel, Hanson, Stiles,

and Götestam (2006) found stage of change was not predictive. Pre-treatment motivation also was not predictive of outcome in panic disorder (Kampman, Keijsers, Hoogduin, & Hendriks, 2008). Motivation at treatment entry has predicted alcohol cessation following treatment (Adamson, Sellman, & Frampton, 2009), though Anderson, Ramo, Schulte, Cummins, and Brown (2008) found it was not predictive in a youth sample. With sex offenders, Terry and Mitchell (2001) found that rapists’ changes in cognitive distortions—a treatment outcome variable—were not predicted by pre-treatment motivation, but were in child-sex offenders. Barrett, Wilson, and Long (2003) found that motivation to change increased over the course of sex offender treatment, but that only two of their five motivational variables predicted treatment outcome.

One potential source of disparate findings about motivation’s relationship to treatment outcomes lies in how motivation is measured. Some studies measure it using structured instruments, but in clinical practice we often make global, unanchored judgements about the client in front of us. Suppose we hold negative views about low motivation, and we judge it to be lacking in a client. Is it possible that the expectations we develop as a result comprise a more active ingredient in determining outcome than the client’s actual motivation at that initial point in time?

We cannot rule out this competing explanation because there is surprisingly little research on the effects of therapists’ expectations on a client’s capacity for change. However, in a related field—education—there is ample evidence that teacher expectations have a direct effect on student achievement (Rubie-Davies, Hattie,

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& Hamilton, 2006).

We recently conducted a study with violent offenders that may also address this issue of whether it is initial client motivation, or our “take” on it, that has the most influence on outcome. Ross (2008) conducted a longitudinal study of the intensive group treatment for high-risk violent prisoners conducted at Rimutaka Prison’s Te Whare Manaakitanga Unit. She found that therapists’ self-rated perceptions of client motivation to change—a single item in a questionnaire on clients’ attributes—predicted both the strength of their therapeutic alliance with the client later in treatment, and ultimately, the amount of change the client made. Independent raters assessed both the therapeutic alliance and change. Actual initial stage of change on the Violence Risk Scale—averaged for 20 treatment targets—was not significantly correlated with therapists’ ratings in the first two weeks. Nor did it predict the amount of change made at the end of the 8-month programme (Ross, 2008). In other words, therapists’ perceptions of motivation influenced outcome, but were unrelated to more objective, anchored measures of motivation to change. Therapists’ perceptions of the client, not actual readiness to change, predicted how much change clients made.

More generally, the sensitivity of client motivation to contextual factors also can be seen in these two recent examples from mental health. First, Huppert, Barlow, Gorman, Sheer, and Woods (2006) found low motivation predicted poorer outcomes only if the therapist adhered very closely to the stipulated cognitive-behavioural protocol in treating panic disorder. This finding raises the issue of whether we can be more effective agents of change when we match what we offer to our clients’ needs; a point to which I will return later. Second, Meyer and Garcia-Roberts (2007) found that clients’ initial motivation for depression treatment interacted with the match between their theories of the causes of their

depression and the type of intervention. If clients thought the therapy was based on the wrong ideas, they were not so motivated to undertake it.

In criminal justice settings, as in many other settings where services are funded by tax dollars, we are required to target interventions where they will have the most impact. In Corrections, impact on community safety—via reductions in risk potential—is the first consideration in deciding who should gain access to our most intensive interventions. Those with the highest estimated future risk—“high-risk offenders”—are therefore our most important treatment clients. Most of them are men. In this population low motivation to change at the point of initial assessment is the norm; understanding and intervening to enhance motivation are essential to good clinical practice.

Before moving on to consider the specific issues in working with under-motivated offender-clients, I will outline some definitions of motivation, and consider whether there are important distinctions to be made between types of motivation.

#### *Definitions and types of motivation: Implications for practice*

Motivation is the “why” of action. It is defined in the Dictionary of Psychology (Chaplin, 1985, pp. 287-288) as “an intervening variable used to account for factors within the organism that arouse, maintain, and channel behaviour towards a goal.” Others have defined it as a combination of “energy, direction, persistence, and equifinality (Ryan & Deci, 2000), and as “selection, activation, and sustained direction of behavior toward certain goals” (Bandura, 1997, p. 228). Miller and Rollnick (1991, p. 19) defined motivation in the context of behaviour change as “the probability that a person will enter into, continue, and adhere to a specific change strategy”. Given that they proposed the most popular and effective motivational intervention in recent times, their definition is particularly interesting for its lack of

emphasis on types of motivation and on the role of internal factors.

We often are concerned about whether a client is “really”, or “genuinely”, motivated, and this concern comes through to in the clinical writing on this topic with offenders (e.g., Harkins & Beech, 2007; Ward et al., 2004). When talking to other clinicians and clinical students about what these terms mean to them, they often refer to “intrinsic” motivation. Ryan and Deci (2000), proponents of the clinically-important Self-Determination Theory, make similar implicit judgements about the quality of different types of motivation by referring to intrinsic motivation as “authentic” (p. 69). They review research that strongly suggests that intrinsic motivation is associated with the most sustained changes on clinically relevant problems (see also Markland et al., 2005; Ryan & Deci, 2008). When we refer to intrinsic motivation in our clients, we may instead be talking about self-determination, or autonomy: how much a person feels committed to what they are doing (Markland et al., 2005). Based on Deci and Ryan’s work (e.g., Ryan & Deci, 2000, 2008), I will argue that our clients are almost never intrinsically motivated at the start of treatment no matter where we work, but that other forms of motivation can also be powerful drivers of change, and that we need look no further than our own lives to see these forces at work. Lastly, I will suggest that we may well be able to move any client who turns up for treatment from entirely external motivation toward self-determination as a function of our interventions and how we deliver them. First, a review of some more definitions of motivation.

According to both Bandura (1997) and Ryan and Deci (2000), tasks or activities that we enjoy doing for their own sake, that are inherently satisfying, are intrinsically motivating. Ryan and Deci also view intrinsic motivation as a tendency towards spontaneous interest, exploration, learning and creativity: some of the most positive

characteristics of being human. If this is the definition, how often do mental health or criminal justice clients enter therapy with significant intrinsic motivation? I suspect very rarely. It is surely the case that at best, people enter treatment to alleviate personal suffering, dissatisfaction, or dysfunction. At worst they do so solely at the behest of other people, or to otherwise avoid external sanctions of various kinds.

These are all extrinsic motivations, but the first group of reasons may—according to Deci and Ryan (2000)—result in significant changes in behaviour, if the extrinsically motivated person perceives their involvement in treatment to be one of personal choice (i.e., autonomy). None of us would have qualified as clinicians if we had only ever acted from intrinsic motivation: because the assignment or task was inherently enjoyable to us. Successful people learn to regulate their behaviour: to do tasks that are unpleasant or boring if their completion is necessary to achieve some valued goal, such as qualifying professionally. So we know how compelling of behaviour extrinsic motivation can be when completing the task is important to us, and, when we feel like it is ultimately our choice whether we complete it or not. If Deci and Ryan are right, then rather than focusing on intrinsic motivation, we should instead be concerned with helping clients—even those who come to treatment initially entirely under the control of external contingencies—to develop a sense of autonomy in regard to changing the target behaviour. Although motivation may not be predictive of therapy outcome, therapists’ support of client autonomy is predictive of outcome, and may be one of the key mechanisms underlying the effectiveness of Motivational Interviewing (Britton et al., 2008; Markland et al., 2005; Ryan & Deci, 2008). After all, as Bandura put it: “Children are not born innately interested in... playing contrabassoons” (1997, p. 218). We have learned to experience as self-reinforcing many of the tasks we now find intrinsically motivating. Perhaps we can help our clients learn similarly.

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### *High-risk criminal justice clients and poor motivation*

As suggested earlier, low treatment motivation is often regarded as the norm in criminal justice settings, as is portrayed by Inciardi (1994, p. 18):

“Among clients mandated to treatment from the criminal justice system, it is unusual for a client to be genuinely enthusiastic about entering treatment. Most clients are not ready, do not want to be in treatment, and do not like it”.

Although, strictly, clients are not often mandated to treatment in New Zealand, there is no doubt that external contingencies—most notably avoiding imprisonment, or gaining parole—are influential in propelling many high-risk offenders into pre-treatment assessments. However, as McMurrin (2002, p. 6) noted, if offenders appear unmotivated, or motivated only by external coercion, they may be denied treatment. This stance is embedded in requirements in some accredited UK programmes: to select “adequately motivated offenders” (McMurrin & Ward, 2004, p. 296).

Given how commonly offenders appear poorly motivated (e.g., by denying responsibility for the offending, or stating that they do not need intervention), such an approach may leave a significant proportion of them untouched by the benefits of rehabilitation. In New Zealand most prisoners will eventually be paroled. Without a concerted effort at making positive changes, they may pose the same level of risk to others as before. An additional—often overlooked—policy cost is the potential for inflated rehabilitation effect sizes, because harder to treat clients are excluded from outcome research (Humphreys, Harris, & Weingardt, 2008), or (possibly) in the comparison group, in quasi-experimental designs.

Of course we should not be surprised that high-risk clients often do arrive at assessment with little or no commitment to

self-improvements that could also make them less of a risk to others. Both theory and data confirm the view that low motivation to change—of any type—is the norm for high-risk offenders. According to Ryan and Deci (2000), a developmental lack of support for the fundamental human needs for autonomy, relatedness, and competence will inhibit, or even crush intrinsic motivation. Many have developed along Moffitt’s (2003) life-course persistent pathway, growing up in circumstances that could only have suppressed the natural development of the processes of self-motivation (Ryan & Deci, 2000). On top of those early developmental influences, New Zealand prisoners often now are not referred for psychological treatment until they are near the end of their sentence. A prolonged period residing in an institution with almost no autonomy, and seriously limited options for relatedness and competence is unlikely to improve this state of affairs.

In adulthood, several prominent characteristics of high risk offenders—negative attitudes to authority, externalisation of responsibility for behaviour, a lack of persistence and work ethic, social support for a criminal lifestyle, and hostility to others—are both dynamic risk factors (i.e., targets for change in treatment) and actively undermine any interest in crime-free self-development. Data have consistently shown (Polaschek, 2008) that more than half of the high risk violent offenders arriving at Te Whare Manaakitanga (Rimutaka Prison) report they are, at best, somewhere between Precontemplation (denying that dynamic risk factors are relevant to them, or if relevant regarding them as unproblematic) and Contemplation (acknowledging that they may be worthy of attention) on almost all of the 20 dynamic risk factors that are measured pre-treatment (using the Violence Risk Scale; Wong & Gordon, 2000). Similarly, using 260 volunteer prisoners from Rimutaka, Polaschek, Anstiss, and Wilson (in press) demonstrated, using two

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other measures of motivation to change—the University of Rhode Island Change Assessment Scale (URICA), and a variable derived from a New Zealand Corrections criminogenic assessment tool (The Criminogenic Needs Inventory: Readiness to Change)—that on average, prisoners' scores placed them between Precontemplation and Contemplation on Prochaska and DiClemente's stages of change model (see Prochaska, DiClemente, & Norcross, 1992). Low motivation to change is indeed the norm.

#### *Working with clients with low motivation*

How much does it really matter if our clients inevitably arrive in our offices and group-rooms with little commitment to making the changes we think are important? Sometimes therapists and clinicians express pejorative, and even hostile views of clients we judge as unmotivated. We sometimes speak of client motivation as a construct that stands unconnected to other elements of therapy, particularly our own cognitions and behaviour (e.g., expectations of readiness) and the nature of the treatment being offered (e.g., match to current client needs). Are we comfortable recognising that a client's apparent motivation may be related to their perceptions of what we have to offer? Sometimes we talk as if we see what we are offering to clients as intrinsically good and helpful, and in turn, view clients who are reluctant to imbibe without reservation as misguided, even ungrateful. These kinds of attributions may explain why clinicians sometimes express hostility in their discussions of clients who are reluctant or resistant to taking part in intervention (Howells & Day, 2003), rather than viewing such initial presentations as an interesting clinical challenge.

The belief systems that underpin our conduct in therapy are a fascinating but rarely-examined research topic. In one exception, Haarhoff (2006) studied groups of post-graduate trainees in a cognitive-behavioural therapy course. She found these therapists held three schemata commonly:

“demanding standards”, “special superior person”, and “excessive self-sacrifice”. Predictions can be made about how each of these schemata interacts with client behaviour to trigger negative thoughts about the clients, including that they are “not motivated”. For example, “demanding standards” was endorsed by at least three-quarters of those surveyed. Haarhoff described this schema as “signalling a somewhat obsessive, perfectionist, and controlling approach to therapy” (p. 128). When such therapists perceive that therapy is not going well, they blame the client, including, Haarhoff suggests, perceiving them as unmotivated. That's food for thought, isn't it?

So, initial perceptions of good client motivation matter a lot if we insist that clients should fit in with what we want to offer them, that we know “what's right” and they should just comply. In thinking this way, we may even make it less likely that we can give clients the room in therapy to develop the autonomy they really need to succeed.

In the criminal justice domain, we often refer to the importance of the “responsivity principle” (Andrews & Bonta, 2006). Although not well understood, broadly defined, the responsivity principle embodies the need for a match between those programme and offender characteristics that enhance or inhibit the client's ability to use the programme to reduce their recidivism risk. For example, programmes should be pitched at the right level for offenders, be taught in active, compelling, and comprehensible ways, and so on. On the other side, offenders should be sufficiently intelligent, literate, psychologically stable, motivated, and capable of learning.

Since we are the service providers, it seems obvious that we should bring our programmes to meet our most sought-after clients where they are. With high-risk offenders that means we need to be equipped to start our work with clients who may be not excited about working with us.

However, that also may mean we need more room to adjust programme content to offenders, something our highly structured and manualised programmes often do not allow at present. When we seek to understand clients' preparedness—or lack of it—to engage with therapists and make desirable changes, therapist factors and the responsiveness of the treatment to the client are seldom discussed in comparison to the client's "deficiencies" (McMurrin & Ward, 2004; Ward, Day, Howells, & Birgden, 2004). One reason for therapists' negativity toward apparently unmotivated clients may have arisen from the dominance of "action-ready" intervention packages, leading to a lack of confidence about our ability to offer interventions that will work with clients who are not currently ready for change. However, motivational interviewing interventions—based on Miller and Rollnick's (2002) approach—go some way to reducing such perceptions, and are frequently mentioned as important for use with a wide variety of clients (Britton, Williams, & Conner, 2008; Markland, Ryan, Tobin, & Rollnick, 2005), including offenders (Chambers, Eccleston, Day, Ward, & Howells, 2008; McMurrin, 2009).

Does motivational interviewing work? At Rimutaka prison, Anstiss, Polaschek, and Wilson (in press) found that compared to untreated prisoners, prisoners who attended four hours of individual motivational interviewing intervention focusing on their offending were significantly less likely to be reconvicted, and less likely to be reimprisoned. Those who undertook the intervention increased their readiness to change by a full stage while those who did not were unchanged. Neither group undertook any further effective interventions prior to release. This result speaks to a pathway to change that is most likely to be associated with increased autonomy and agency, rather than the deficit-remediation that dominates most offender rehabilitation approaches (Ward, Melsner, & Yates, 2007). A review of motivational interventions with offenders

also showed generally positive results, though the number of studies remains small (McMurrin, 2009).

Although it appears to work, the theoretical underpinnings of the effectiveness of motivational interviewing have been unclear. Recently it has been suggested that its action may be explained by Deci and Ryan's self-determination theory (for more detail see Britton et al., 2008; Markland et al., 2005). If so, we now have a well developed theoretical framework with the potential to direct assessment of changes in motivation through treatment, and to engender confidence that we can help clients move toward intrinsically motivated change through developing their autonomy, competence, and relatedness.

Directly meeting clients' relatedness needs requires that we develop strong therapeutic alliances. According to Bordin's (1979) model, the alliance is composed of three factors: a bond, agreement on the goals, and agreement on the tasks of therapy. Once again, Rimutaka prison research—again at Te Whare Manaakitanga—has demonstrated that strong alliances can develop between high risk offenders and therapists, if therapists accept that these clients arrive in treatment at best thinking about changing some risk factors, rather than being ready to engage in change (Ross, 2008). Ross's data showed that observer-rated alliance strength predicted therapists' later ratings of client motivation. Conversely, therapists' early appraisals of client motivation predicted later alliance strength; showing how interactive these processes may be, and further reinforcing the importance of therapists' perceptions and expectations in contributing to client progress.

Currently, the most commonly prescribed solution for clients who arrive treatment-unready is to place them in "preparatory programmes" that precede the treatment proper (Hiller, Knight, Leukefeld, & Simpson, 2002; Ward et al., 2004). Although data are scarce, this approach may be

effective if what follows is a highly prescriptive, manualised programme that requires the client to be somewhat autonomously motivated if they are to benefit at all. However, offering clients “pre-treatment” implies that the next stage of treatment need not concern itself with responding dynamically to clients’ self-determination or motivation. In fact, rigidly structured programmes, particularly didactic psychoeducational approaches—may damage both the development of a sense of relatedness between therapist and client, and inhibit the development of client autonomy, since they leave clients with little choice about how they engage with the programme, or with change.

### *Conclusions*

Motivation to change is a dynamic characteristic that can be developed during treatment programmes, if clients arrive in treatment without enough of the motivation types most associated with positive outcomes. Although clinicians highly value the idea that their clients start treatment intrinsically motivated, in most treatment settings they will not be. In prison rehabilitation programmes with high-risk offenders, early developmental conditions and current circumstances function to suppress or destroy intrinsic motivation, and self-determination in general. However, both intrinsic and self-determined extrinsic motivation can be developed with carefully chosen therapy approaches, and the resulting increases in motivation to change have been associated with reductions in recidivism risk without any further interventions being provided.

At the same time, we may not sufficiently recognise the potential importance not of client motivation, but of our expectations in contributing to successful outcomes for the client. Examining our assumptions about how we judge which clients will do well is important. Though there is surprisingly little research in the psychotherapy literature on the effects of therapist expectations and schemas on client outcomes, other sources

of empirical findings suggest that they may be crucial and warrant significantly more research attention.

Strong therapeutic alliances are necessary to help clients to become self-determining, and self determination, or at least a sense of agency, is likely to be vital to succeeding in crime desistance. It is therefore essential that we meet clients where they are, rather than where we think they should be, and that we shape our programmes around them, rather than insisting they come back when they better fit the programme we have chosen to provide. If we accept that most high-risk offender-clients will enter treatment environments with little or no autonomous commitment to change, we may need to rethink the balance between offender responsiveness and therapy responsiveness. Rather than suggesting we prepare clients before putting them into treatments that may then damage the ongoing development of more integrated and internalised forms of motivation, should we instead adjust our visions of the “right” programme so that we can facilitate the development of self-determination throughout and beyond the programme?

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