Issues in Domestic Violence: Motivational Interviewing and Stages of Change

Introduction

Case Vignette

Kelly Sykes, LSW, is working with Lauren, an adolescent client. Lauren has been dating Nick for 6 months, and thinks that he is “the one.” Lauren’s mother is concerned about Nick’s severe verbal abuse towards her daughter, and Kelly has been working hard to educate Lauren about healthy relationships. They have worked together on assertiveness skills, and Kelly has enlisted Lauren’s mom as a positive, supportive influence.

Kelly is relieved when Lauren tearfully tells her that she and Nick are “over.” In their next session, Lauren joyfully tells Kelly that she and Nick are together again, and that Nick has promised not to yell at her or call her names. Two weeks later, Nick shoves Lauren against a wall. Kelly is extremely disappointed, feeling that she has somehow failed Lauren.

This case vignette may sound familiar to many working with intimate partner violence. While there are numerous therapeutic issues in working with men and women who are in abusive partnerships, many of the challenges in domestic violence counseling can be summed up by a single word: change.

As evidenced in Kelly’s interventions, traditional behavior change interventions have focused on increasing skills and reducing barriers. While both of these things are important, they are not always enough. Telling people what to do, or how to do it, is rarely effective in supporting change. This is especially true in working with domestic violence, where change may be synonymous with endings.

In partnerships touched by domestic violence, what does genuine change look like? Is it even possible? How can clinicians motivate someone to make changes? How can you determine if someone is embarking on this process?

One of the main contributions of the Transtheoretical Model (Prochaska & DeClemente, 1984) is its utility in helping clients to make changes. Motivational Interviewing is an empathic, gentle, and skillful style of counseling that allows clinicians to have productive conversations with clients. While widely used with clients with addictive and co-occurring disorders, this approach is applicable to a wide range of behaviors and is well-suited to working with domestic violence issues (Prochaska & DeClemente, 1984; Prochaska, DeClemente & Norcross, 1992).

Much of the evidence base for the transtheoretical model comes from addictions treatment and practice. Alcohol and drug-dependent clients are often resistant to
making changes, and traditional methods of treatment that were appropriate for self-motivated clients did not always work. In the mid 1990s, researchers first began looking at the potential applicability of the TTM in understanding the change process for both perpetrators (Daniels & Murphy, 1997) and victims (Brown, 1997) of domestic abuse. With regard to perpetrators, resistance to change is often apparent. There may be a tendency to deny or minimize problems or to blame others for their actions. They also often fail to attend even court-mandated treatment and are noncompliant with interventions intended to change behavior (Murphy & Maiuro, 2009). Victims often need to change existing values, thinking processes, and relationship skills and may not be ready to do so.

It is important to review the definition of domestic violence. The National Coalition Against Domestic Violence defines domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior perpetrated by an intimate partner against another.” Domestic violence is displayed across a broad spectrum of cultural, economic, religious and racial groups. The terms “domestic violence” and “intimate partner violence” will be used interchangeably in this training material.

This course will provide an overview of the transtheoretical model of behavior change. It will also include motivational interviewing skills and techniques and their applicability to working with domestic violence.

Upon completion of this course participants will:

Objectives

1. Discuss the overall goals of the transtheoretical model of behavior change, including the stages of change
2. Discuss the research base regarding the applicability of the transtheoretical model to domestic violence
3. List the components and strategies of motivational interviewing and describe how these are used to promote change
4. Discuss the applicability of motivational interviewing in work with perpetrators and victims of domestic violence

Goals of the Transtheoretical Model

Case Vignette 1

Tom and Mary are presenting for couples counseling. The two describe periods of intense conflict that often escalates to physical violence. Tom is clearly angry to be attending the session, and states “if she wouldn’t provoke me all the time, things would be fine.” Mary becomes enraged, stating, “I provoke him? Let me tell you what he says to me.” Tom angrily stalks out of the room, slamming the door in his wake.
Case Vignette 2
Kevin and Louise are also in couples counseling. They have frequent, physical altercations. When asked what he sees as the reason that their fights, Kevin states “I know it gets bad at times.” Louise angrily retorts, “that’s what you always say, but we can never get past this. Last time you only came with me to counseling for two sessions. I’ve had it with this.” Kevin states “I’m here aren’t I?”

The transtheoretical model of behavior change is aptly named. It is a treatment model centered on the premise that clients can change otherwise dysfunctional behaviors. Although this idea is at the heart of the transtheoretical model, the model does not assume that maladaptive behaviors are immediately amenable to change. As with many clients, a degree of ambivalence may be apparent. As Kevin says “I’m here, aren’t I?” Being “here” is not necessarily equivalent to being ready to dive into treatment and make changes.

In contrasting the two cases presented above, it’s apparent that each of these couples is in a very different place in terms of readiness to make changes. But significant changes do need to be made. Some of these changes include the couple communicating more effectively, the abusive partners using anger management strategies, and both parties recognizing that abuse in any form is not allowable. How, then, does the therapist collaborate with the client to move them forward?

Assessment of Readiness

Case Vignette
Carla is a 45-year-old woman in a relationship with Bob. Carla works for a pharmaceutical company is a fast-paced position. In her first session with Dr. David, Carla reveals a history of long-term emotional abuse. Dr. Davis states that in order to heal, Carla will need to end the relationship with Bob, and points out that in her work life she often has to make difficult decisions. Carla angrily responds that she does not need anyone else “browbeating me” and does not return for a subsequent session.

A central tenet of the transtheoretical model is the assessment of an individual's readiness to act on a new healthier behavior. According to Wahab (2005), the intention behind assessing motivation, readiness and confidence levels for change is to tailor the intervention accurately to the client’s stage of change at any given moment. As the case above illustrates, there are times that therapists do not take into consideration a client’s readiness for change.

The transtheoretical model conceptualizes behavior change as a process with various stages. The stages represent distinct categories along a continuum of motivational readiness. The stages include precontemplation, contemplation, preparation, action, maintenance and relapse.
According to Prochaska and DiClemente (1982) precontemplation is the state in which an individual is not yet considering the possibility of change. People who are in this stage may classically be labeled as “resistant” or “unmotivated.” In the case study, for example, Tom’s verbalizations and actions are suggestive of a person at the precontemplation stage of change.

The next stage in the continuum is contemplation. People in the contemplation stage have the intention or express the desire to change and existing behavior or to initiate a new behavior. While people in this stage are contemplating change, there is no clear plan of how or when to initiate changes. Kevin fits the profile of someone in the contemplation stage. He recognizes that changes need to be made, but his “plan” of simply being there in the sessions is not indicative of immediate action.

Preparation is a state characterized by an intention to change in the immediate future, usually within the next month. There is a clear plan in place that includes steps that will facilitate change. This generally leads to action, the stage where the person takes action in order to achieve a behavior change. In the examples at the beginning of this section, an example of action would be actively practicing anger management strategies, such as identifying triggers or taking a time-out.

Maintenance is the stage where the individual strives to maintain and integrate a behavior that has been successfully started or changed. This stage is one in which fosters the consistency of newly developed behaviors. People at this stage report greater self-efficacy and resistance to relapse.

At any point in the change process, a person may exhibit signs of relapse. Relapse is not exactly synonymous with the definition from the additions field. A person is considered to be in the stage of relapse when he or she re-engages the undesired behavior and/or stops the desired behavior. For example, a goal of change may be for a client to communicate feelings to his or her partner rather than using alcohol to self-medicate. If a client has mastered this skill, but then begins to isolate and not communicate feelings, this would be considered indicative of relapse, whether or not substance use is involved.

The transtheoretical model employs a specific set of techniques, known as motivational interviewing, to move people from one stage of change to the next. These techniques are supportive in nature, but also focus on pointing out the dissonance between what a person desires or knows to be productive and the current behaviors he or she is exhibiting. A discussion of motivational interviewing is contained in the next section of this training material.
Motivational interviewing is a therapeutic approach based on the recognition that clients who need to make changes are at different levels of readiness to change. Motivational interviewing strategies engage clients in the therapeutic process, mobilizing intrinsic motivation by developing cognitive and behavioral discrepancies and by exploring and resolving sources of ambivalence that inhibit change.

While the idea of therapeutic alliance is important with all clients, with men and women affected by domestic violence it is key. Clients may seek therapy unwillingly, or with little real hope for change. They may also have been in domestic violence systems that have contributed to the already disempowered way that they feel. Motivational interviewing uses empathic listening, affirming client’s autonomy and choice and matching interventions to the clients own level of readiness to change. As such it is nonjudgmental. Clients therefore feel “accepted” despite “unacceptable behavior.”

According to Murphy and Maiuro (2009), Motivational interviewing involves four therapeutic principles:

1. Assessment of client’s stage of change, which allows the therapist to better communicate understanding, empathy and congruence.
2. Development of cognitive/attitudinal discrepancies. How does the client want to live their life? What is their life currently like? What are the potential benefits of change?
4. Support of self-efficacy by allowing the client his or her autonomy

Some of the characteristics of Motivational interviewing include:

- Expressing empathy through reflective listening
- Noting discrepancies between current and desired behavior
- Evocation; drawing out rather than imposing ideas
- Avoiding argumentation
- Collaboration to build rapport and facilitate trust
- Encouraging belief in the ability to change
- Communicating respect for and acceptance of people and their feelings
- Establishing a nonjudgmental relationship
- Developing and action plan to which the client can commit
- Using affirmations and language that affirms clients’ strengths
- Providing summaries that highlight important aspects of the discussion, shift the direction of conversations that become "stuck"
- Communicating interest and understanding of an individual's perspective
Motivational Interviewing, 6

- Belief in the autonomy of the client rather than the authority of the therapist

Specific techniques include:

- Use of open-ended questions
- Asking permission to explore topics
- Affirmation of client strengths
- Expressing appreciation of client difficulties
- Reflections to express empathy and facilitate change
- Summaries

Sample client conversation and use of techniques

Therapist: Hello Maria, it is nice to meet you. I imagine based on what we discussed in our phone call that you may have some mixed feelings about being here. Could we spend some time exploring your situation (ask permission)?

Maria: Yes, it’s very hard to be here.

Therapist: I’m sure it is. Could you tell me about the specific incident that brought you here (open-ended question)?

Maria: Well, my husband hit me. He was angry. He likes for me to have the kids in bed before her comes home and to have dinner on the table waiting. The kids were so crazy, and time got away from me. I could tell as soon as he walked in that he was mad.

Therapist: He came home and was angry that the kids were up and dinner wasn’t ready? What happened next?

Maria (crying): I hate for my kids to see that. It was right in front of them. He promised to stop (crying harder). He pushed me down and was screaming and hitting. I would hear them crying in the background. I was begging him to stop. I was scared the neighbors would hear, and that they would call the police again.

Therapist: You were concerned about the kids because you hate for them to see that? And also that the police may come (reflecting emotion)?

Maria: Yes. I love him. I didn’t want him to get into trouble, I didn’t want the kids to be scared.
Therapist: It sounds like even though your husband has hit you, you love him (reflection).

There are a number of differences apparent in this conversation. First, although the therapist may be concerned about the information she is learning about Maria’s situation, she is non-reactive, and takes time to explore Maria’s situation. The therapist does not use words like “abuse,” or jump immediately to safety planning. The therapist is also respectful of the fact that Maria loves her husband, even though her husband is violent. While conducting this conversation, he therapist would be aware of some of the targets for change and where the client is in terms of readiness for change.

Sample assessment of readiness for change:

Therapist: It sounds like even though your husband has hit you, you love him (reflection/summary).

Maria: Yes. We’ve been together since we were both 16 (laughs). Things were so different then. Then the kids came along. He’s a good provider and loves the children. He has never laid a hand on them. My friend tells me I should leave him, but I could never do that.

Therapist: You have a long, complicated history together. He has many qualities that are important to you. Tell me a little more about why you would never leave him. What are the benefits of staying (assess pros/cons of present behavior)?

Maria: When this happened before, he didn’t hit me for a long time. He was so sweet to the kids. If I stay I don’t need to worry about money, or getting a job. I can stay home and be a good mom to my children.

Therapist: So now that he’s hit you, things will be better. It’s also more financially secure for you and for the children. Is there anything else?

Maria: Nothing that comes to mind.

Therapist: Are there any disadvantages to staying with your husband?

Maria: Next time may be worse. He could even kill me. I know it probably sounds crazy to you, but I still think that staying is better than leaving.
Therapist: On the positive side the finances are taken care of if you stay. You wouldn’t have to worry about looking for work or not being home for the kids. On the other hand, your husband may kill you someday. It’s a risk you are willing to take (summarize, create discrepancy.)

Therapist: Where does this leave you now (support self-efficacy.)

Maria: I’m not sure. I know all the reasons I should leave, just pack up the kids and leave. I often want to leave. But I stay. Crazy, right?

Change Talk

An important aspect of motivational interviewing is the clinician’s reinforcement of change talk. Change Talk refers to the client’s mention and discussion of his or her Desire, Ability, Reason, and Need to change behavior and Commitment to changing. Clearly Maria is aware of the need to change. She may even desire to leave. It is not fully clear from the session, however, how much of the focus on change is self-motivated, versus coming from her well-meaning friend or a response to what Maria thinks her new therapist would like to hear. It makes sense that when people talk about change themselves; they are more likely to change than if someone else talks about it.

Listening for and appreciating the client’s ambivalence about change is a significant aspect of motivational interviewing. While many of us may be ambivalent when confronted with the need for life changes, for clients affected by domestic violence not making changes is often dangerous.

Change talk is divided in five categories: Desire, Ability, Reason, Need, and Commitment:

Desire: Why would you want to make this change?

Ability: How would you do it if you decided?

Reason: What are the three best reasons?

Need: How important is it? And why?

Commitment: What do you think you’ll do?

Central to motivational interviewing is the consistent emphasis on client autonomy and self-determination. This is helpful for victims of domestic violence, who often feel as if systems, including the mental health system, are autocratic and reinforce dependency. Perpetrators of domestic violence also benefit from feeling as if changes are those they want to make, rather than are forced to make. With motivational interviewing, the client has the freedom and responsibility to contemplate and engage in change.
Working with Perpetrators of Domestic Violence

While the case example provided above dealt with a victim of domestic violence, Motivational Interviewing is also an effective technique for working with perpetrators of domestic abuse.

Researchers have looked at the utility of using Motivational interviewing with this group. Kistenmacher & Weiss (2008) conducted a small-scale study of the potential effectiveness of motivational interviewing in changing the way perpetrators think about their violent behavior. They studied thirty-three men who were court-mandated to treatment for domestic violence. The motivational interviewing group demonstrated generally more improvement on stages of change as well as a significantly greater decrease in the extent to which they blamed their violence on external factors. Similarly Musser et al. (2008) studied motivational interviewing as a pre-group intervention with perpetrators. They found that the motivational intake led to more constructive in-session behavior during the early phase of group CBT, greater compliance with group CBT homework assignments, higher late session therapist ratings of the working alliance, and more help seeking outside of the domestic violence program. Alexander et al. (2010) also looked at motivational interviewing and compared it with standard CBT approaches when working with perpetrators. They found that motivational interviewing led to significant reductions in female partners' reports of physical aggression at follow-up.

These studies demonstrate that motivational interviewing is an effective technique. While some of the challenges of with this group are apparent from the literature, it is helpful to review these prior to looking at a case example. According to Worden (2000), some of the challenges and areas of intervention with perpetrators of domestic violence include:

1) System Blaming: Many perpetrators of domestic violence believe that the systems (such as the criminal justice system, child services, etc) treat men unfairly in domestic violence cases and that women abuse the laws.

2) Problems with Partner/Partner Blaming: Perpetrators of domestic violence and blame the partner for the violence.

3) Problems with Alliance: Use of direct confrontation in therapy results in and inability to help the clients who have been abusive to feel understood, safe, and supported.

4) Social Justification: Perpetrators of domestic violence often believe that change would be difficult—or impossible—in one's
environment, given social and religious norms and expectations.

5) Hopelessness: Perpetrators of domestic violence often feel hopeless, overwhelmed, depressed or anxious about making changes.

6) Isolation: Perpetrators of domestic violence often lack support from family and friends because of social isolation, distrust, or discomfort seeking help.

7) Psychological Reactance: Perpetrators of domestic violence often respond to pressure to change with an angry stance.

8) Passive Reactance: Perpetrators of domestic violence may respond with pressure to change by participating only superficially, without meeting expectations or responding appropriately.

Motivational interviewing can help to support change by addressing many of these issues. The following example demonstrates its utility in working with this population. Note that the therapist does not confront or challenge Tom, but instead allows his story to unfold. While doing so the therapist assess Tom’s readiness to change his behavior.

```
Therapist: Hello Tom, it is nice to meet you. Could you tell me a little bit about why you’re here (ask permission)?

Tom: My wife thinks I need anger management.

Therapist: You’re here at the request of your wife? Is there a reason that she thinks you need anger management (open-ended question)?

Tom: I know that I get really angry sometimes. All the men in my family have tempers.

Therapist: You’re aware of your tendency to get angry. Could you tell me more about what happens when you get angry (restatement, open-ended question)?

Tom: She can be a bitch too you know.

Therapist: You feel like your wife can also be angry?

Tom: You got that right. One time she was angry because I stayed out late. She raised her voice right in front of my son, disrespecting me.
```
Therapist: What happened then?

Tom: Well, I had to be a role model for my son. I popped her one. She shut up real fast. Didn’t want to do that, you know, but all that disrespecting.

Therapist: You want to be a role model for your son, and to feel like your wife respects you (reflection).

Tom: You got that right.

Therapist: So when you hit your wife, you feel more respected. Are there any negatives about taking that action?

Tom: She gets really upsets and cries and says she’ll leave me. This time she packed the kids up. She’s at her mom’s now. I haven’t seen her or my boys in a week. I miss them.

Therapist: So, even though putting her in her place felt good, your wife leaving has been a negative. You miss your wife and kids (summarize, create discrepancy).

Tom: That’s why I’m here. I want them back. Maybe I do need to work on my anger.

Working with Victims of Domestic Violence

Domestic violence victims can also benefit from motivational interviewing strategies. While victims of domestic violence often need to make a number of changes in behavior, a continuing theme is that they do not recognize the dangers of remaining with an abusive partner.

Several researchers have looked at the use of motivational interviewing in working with victims of domestic violence. These have included Simmons et al. (2008), Burke et al (2001) and Burkitt & Larkin (2008). These studies have been small in scale but have demonstrated promising effects on victims’ use of community resources, cessation of ongoing abuse, and utilization of mental health and social supports.

Burke et al. (2001) conducted research into the transtheoretical model as a conceptual framework for understanding how women end abuse in their intimate relationships. In-depth interviews were conducted with 78 women who were either currently in or had recently left abusive relationships. Women talked about the following five stages of behavior change:
Precontemplation | The woman does not recognize abuse as a problem and is not interested in change
Contemplation | The woman recognizes abuse as a problem and has an increasing awareness of the pros and cons of change
Preparation | The woman recognizes abuse as a problem, intends to change, and has developed a plan
Action | The woman is actively involved in making changes related to ending the abuse
Maintenance | The abuse has ended and the woman is taking steps to prevent relapse

In the example we viewed earlier involving Maria, Maria was in the contemplation stage. While Maria may not yet be ready to develop a plan or take action

| Maria: I’m not sure. I know all the reasons I should leave, just pack up the kids and leave. I often want to leave. But I stay. Crazy, right? |
| Therapist: This is a hard time for you. There are advantages and disadvantages to leaving. Whatever you decide to do is your choice. I’m confident that you will make the best choice for yourself (support self-determination). |

While Maria does not yet appear to be ready to leave her husband, there may be other avenues to explore, such as why she may want to make this change, or how she could do it if she decided to do so:

| Therapist: I’m confident that you will make the best choice for yourself (support self-determination). If you did decide that leaving was the best choice, what steps would you need to take? |
| Maria: Remember, my friend I told you about? She told me I could stay with her. My husband would never try to interfere if I went there. He’d be too embarrassed. I’d feel bad about asking her for help, but I know she would help me. |

Summary

This training material reviewed some of the strategies of motivational interviewing in supporting change in victims and perpetrators of domestic violence. While the complexity of target behavior in this group is readily apparent, research indicates that many of these behaviors are amenable to these supportive strategies, which affirming client autonomy and empower them to make changes in their lives.
References


