Talking to Change: An MI Podcast
Glenn Hinds and Sebastian Kaplan

Episode 18: MI with People Who Have Sexually Abused, with David Prescott

Glenn Hinds:

Hello everybody, and welcome back to another edition of Talking To Change. A Motivational Interviewing Podcast. My name is Glenn Hinds. I'm in Derry, in Northern Ireland, and I'm joined, as always, by my good friend Sebastian Kaplan. Hi Seb.

Sebastian Kaplan:

Hey Glenn, how's it going?

Glenn Hinds:

Very best. Very best, man. So, you're very welcome to this episode where we are, again, reaching to the far ends of the globe. We'll be speaking to Kylie McKenzie in Australia, in a few minutes. But, before we do that Seb, do you want to remind people how they contact us using the social media?

Sebastian Kaplan:

Yes, have to do that. On Twitter, you can contact us @ChangeTalking, and on Facebook it is Talking To Change. Any questions or feedbacks or comments that you want to email to us, you can do so at podcast@glennhinds.com. That's G-L-E-N-N H-I-N-D-S.

Glenn Hinds:

Thanks. Thanks, Seb. Like I say, we're joined today by Kylie McKenzie, a clinical psychologist. Living outside a small town called Ballarat. The area is Buninyong. Is that right Kylie?

Kylie McKenzie:

Yeah, that's very good.

Glenn Hinds:

Fantastic. Thank you. So, Kylie is a clinical psychologist, and is a fellow of the Australian Psychological Society; College of Clinical Psychologists. She's a member of the Motivational Interviewing Network of Trainers; MINT, and is a registered psychologist and supervisor, with her Psychology Board of Australia. Kylie is a clinical psychologist with more than 18 years' experience in a regional public hospital setting. Kylie's clinical work focused on mental health and chronic illness led to the discovery of Motivational Interviewing as an engaging way to support and promote health behavior change.

Glenn Hinds:

Since becoming a member of the Motivational Interviewing Network of Trainers in 2008, Kylie has been selected as elite trainer for the international workshops in Krakow 2013, Atlanta 2014, and Melbourne 2015. Kylie is a final-year PhD candidate in the department of general practice at the university of Melbourne, and her research is focused on the potential of Motivational Interviewing in working with people living with mental, physical multimorbidity. Hello Kylie, or g'day Kylie.

Kylie McKenzie:

G'day. That's a very good g'day you've got going there, Glenn.

Glenn Hinds:

Yeah. Thank you. Well, you're very welcome, and it's lovely for you to give us your time today. We're really keen to discover more about supporting people with multimorbidity, but before that we do that, if it's okay, as we do with most of our guests now is, we literally just invite them to introduce themselves and explain to us, and the audience, how you became interested and started to use, and practice Motivational Interviewing.

Kylie McKenzie:

Yeah. I've listened to some of the stories of other people, and there's some things that are the same always, and some things are a little bit different. I started working as a hospital-based psychologist after I'd finished my clinical psychology training, and I think that my training had done a really good job of helping me to understand the importance of empathy and relationships in a clinical context. And, the work that I found myself doing was of course all of the psychological work you would do in a hospital, where people referred with depression, or anxiety, or trauma... and, how that impacted on illness and injury.

Kylie McKenzie:

That work went pretty well, but a lot of the work we also did is about health behavior change in a clinical setting. So, people are referred to psychologists in public hospital settings when the person is not making progress in therapy, or their health behaviors are actually impacting on their health outcomes. And so, I found myself doing work that I wasn't specifically trained for, and trying to apply the clinical psychology training, which is very diagnostic-based and assessment-based, and my training was Cognitive Behavioral Therapy. It didn't quite all fit together, and I guess I couldn't really work out why.

Kylie McKenzie:

And, I found myself at an Australian Psychological Society conference in about 2005, in a session that was about, how do you support people with chronic illnesses, to make changes. And I put my hand straight-up for that workshop, and it was led by the indomitable Helen Mentha who is also a member of the Motivational Interviewing Network of Trainers, and she was starting to talk about the potential for Motivational Interviewing. I had never heard about it before. And, I guess I met her, and it made

sense to me straight away. It was, in some ways, familiar but it also offered me what I'd been looking for.

Kylie McKenzie:

So, I had this experience, clinically, where I understood the importance of empathy, and I understood the importance of engaging in people, which are core parts of Motivational Interviewing. But, I think the missing piece was the thing that connected to supporting behavior change that was outside of Cognitive Behavioral Therapy, context of providing people with advice and skill-development when they were really engaged, or ready. So, I was working with people who maybe didn't meet the criteria for a specific clinical psychology diagnosis, but the support of a psychologist in a healthcare setting was really important.

Kylie McKenzie:

And, I think the missing piece for me was that empathy and advice wasn't enough. People needed that support to make change, and MI gave me a way of understanding that. It gave me a framework, and then I got very excited about it and found myself pursuing additional training. And, in 2008 myself and another Australian, Rochelle Cans, traveled across to Ohio and engaged in the training of new trainers, and it opened a very rich world of understanding MI. Understanding that lovely way of describing MI and the divide between the technical and relational, and how they fit together. So, that relational idea of empathy and engagement, and the technical idea of really listening to people's own reasons for making change and making that a core part of the conversation. So, I've taken it from there and been really quite active and interested in introducing other people to that, and how it might work in a healthcare setting.

Sebastian Kaplan:

Great. So, you mentioned that some of the stories overlap. Or, people's initial exposure to MI and what them brought them to MI, there's a lot of overlap there. So, it seems like, in your situation, there was a lot in your work that you felt solid in and had a pretty firm grounding in, that did have some overlap with MI. Like, the ideas around empathy and engagement. And, in the work that you were doing, you kind of ran into a new challenge, one that you weren't necessarily trained for. You know, the application of CBT for someone who's experienced trauma, or who's depressed was something that you were quite comfortable with, but just a primary care patient, maybe struggling with behavior change, posed that challenge for you, or a new direction in your career that led you to discover new ways of having conversations with people.

Kylie McKenzie:

Yeah. I think that's a really lovely summary of my long-winded history. Sebastian, that's exactly it, and I think it's even a bit more than that. That it opened my eyes to the tendency in healthcare to assess and advice, and I think psychologists in healthcare also have that tendency. It is a skill, it is something that can be really useful, but it's limited. It's helpful some of the time, and it's not helpful when people haven't identified for themselves what it is that they want to change. So, if you tell them to go away and

change something that isn't a priority for them, isn't something that they identify as important, or feel like, even, they can achieve, then I think it's a wasted opportunity for supporting somebody to build a healthier life.

Kylie McKenzie:

I've had conversations since I've become known as somebody engaged in Motivational Interviewing with key physicians and people around my own health service, where they say, "Oh, that's right. You're the woman who's been talking about Motivational Interviewing. That all sounds really nice, but doesn't it take a terribly long time, and isn't it a big investment?" And, I think when you then ask people who have that initial experience, "Well, how many of the patients that you see now go away and do exactly what it is that you ask them to do? And, when they come back and you tell them to do it again, do they go away and do it the second time?" And, that was the missing piece for me. That advising people to do something... they go away. Either it's not important to them or you haven't connected with what they are able to do, is an interaction that's not as helpful as one that's focused on their priorities. One that's achievable for them. One that is something that they want to do.

Kylie McKenzie:

I think that that's the tipping-point for clinicians, as well. When they realize that advising people... people go away, they don't do it, they come back. Then they advise them again, they go away, they come back, and they haven't done it. That that's a really frustrating thing for a clinician, but it's also not helpful for patients. And so, some training that we did with a group of allied health professionals... There were nine disciplines as part of the group. In about 2010 we trained 40 allied health professionals, Rochelle Cans and I. One of the outstanding pieces of qualitative feedback we got was, "I've realized that as the clinician, I don't have to do all the talking," and, that was a real stand out, I think, for us as trainers. That the clinicians understood that that idea of drawing out from the patient was not only helpful for them, as in reduce their own burden as clinicians, it was helpful for the patients as well.

Glenn Hinds:

So it seems that there's a theme of the missing piece, and Motivational Interviewing filling that space, in the sense that your first introductory was that there were patients who were common to different clinicians across the hospital setting, who weren't doing what they were being told to do, and because it was about behavior, and they weren't behaving properly... obviously they had be a psychology issue, so they were sent to psychologists. The psychologists were used to giving them information. It worked for some people, but there was this other cohort of people it wasn't working with, and with your training... that you began to realize, this is where the MI would work. Where we engage people in a process where we help them decide what's best forward. What's best for them, and then help them decide to achieve that for themselves.

Glenn Hinds:

But, also in the sense of supporting practitioners that... Their investment is their training, is their time, but it's also in the desire to be helpful and some of the frustration, it sounds like, they were expressing was, "Here we are, doing all this work for people, and they're not making the changes necessary." But, the relief that came when you introduced them to Motivational Interviewing, which was, "I can help these people change, but I don't have to all the work," and we can actually work in conjunction with them, and it was measured by the length of time that they heard themselves speaking. And, that was a relief for them too.

Kylie McKenzie:

Yeah, and I think that was... in that training we did with Allied Health Professionals, part of the process was to encourage them to listen to an initial audio recording that they did, which was just a role play with a colleague, and listen to the amount that they spoke. And then, at the end of the training, to do the same with the new skills on board. That was the key feedback from clinicians, "Oh, I'm not taking up all the time. I'm not asking as many questions, but I'm getting the answers that I need." So, I think that that's an important change, and I also think that one of the ways that I was introduced to Motivational Interviewing training, and I know has been a core part of the Motivational Interviewing Network of Trainer's approach, is that idea of experiential training, or what people describe as, "Real play." Having the experience is part of what it is that... something that's real for you.

Kylie McKenzie:

So, in training talking about a behavior that's a real behavior for you to change, and then being exposed to what Motivational Interviewing skills feel like, and contrasting that with a more traditional advice-giving approach. I know that I ran a training about weight behaviors and weight-management skills training with GPs in Melbourne about two years ago, and that was the feedback when we ran a practice where people were asked to do a real play with their own behavior, and to take that advice giving stance, and one of the GPs looked up at the end of that practice session and just said, "Oh my goodness. He's just said to me, "Everything verbatim." which I say to other patients in my practice, and I don't like it."

Kylie McKenzie:

So it was that very personal sense of, "Ooh. The advice giving, I give is well meaning, but it's actually not necessarily helpful." I think that that change is an important one when clinicians find that it's almost like something clicks.

Sebastian Kaplan:

Just a quick clarification for people in parts of the world that don't know what a GP is, so a GP is a general practitioner. Is that-

Kylie McKenzie:

Yeah. All right. It's a primary-care physician for your part of the world

Sebastian Kaplan:

Exactly. That's right. So, lots of examples, both... well, I guess your own examples, or your own experience with this, but also some training anecdotes around the realization of... or the limitations of advice giving.

Kylie McKenzie:

Mm-hmm (affirmative).

Sebastian Kaplan:

Well intentioned advice giving. Maybe you could talk a little bit about what... because... and I fell in this trap myself quite a bit, where by the end of a training I think people are getting the message that they're not supposed to say anything. Right? And so, how do you strike the balance there? Or, I suppose maybe a different question is, what does advice giving in your work look like and sound like?

Kylie McKenzie:

Yeah. I think that's a really important point, and I've worked with a whole range of clinicians from general practitioners, or primary-care physicians, through to paediatrics, and prosthetists, and speech pathologists. So, really quite a broad base of clinical practice, and I think that that's a very common question, "But, what happens when I need to give advice?" I've even got a slide in my training set that says, "I get all this MI stuff, and engaging, but what happens if I really need to give somebody advice?" That's literally what the slide says. I think that it's a relief to people to then have that idea, and I've heard other people on your podcasts talk about it. That idea of Elicit-Provide-Elicit with advice giving.

Kylie McKenzie:

So, check in with somebody first about what they already know about the topic, before you start offering advice. I usually try and frame that as, when you ask somebody first what they know, you get a bit of an indication of the kinds of language they use to describe what it is that you're talking about. You get an understanding of what they understand and what they misunderstand. So, you've got an opportunity to reinforce things that are helpful, that you know have an evidence base behind them, and to supplement what they know when you offer information to help address things that they haven't understood, as well. And then, talking about the idea of permission with advice giving as well. That sometimes people will actually ask you directly for advice, and sometimes that's really important for them. That if you know something, that it's about meeting them with what their need is as well.

Kylie McKenzie:

So, if somebody asks you for information, share the information. That's part of that collaborative process. I think it's about framing Motivational Interviewing consultation with the idea that you bring information and knowledge and expertise and training and skill into the room, and the person brings themselves and their knowledge of themselves, and what they know about how their lives work and what they are able to

do. And that's the meeting point for the two of you. So that if you can share something that they can then use, that's a really positive thing. The difference is where you're not checking in with them about what it is that's important to them, what they do already know. And, that seems to make sense to people.

Glenn Hinds:

Certainly, I imagine, that that's reassuring for people in primary care and GP settings, where they have a very brief encounter. That the idea that there is advice that needs to be given to them, and that shifting the way they've normally done that, I imagine could be quite threatening if it's not supported to recognize, look, we're not asking you to take a completely new way about this, it's just take one step to say... just checking what the person knows before you go forward, and in many ways what that'll do is probably save you time, because you will only give them the information they need to know, rather than all the information you have.

Kylie McKenzie:

I've had the privilege of going to Glasgow a couple of years ago, and as a part of my research, looking at routine consultations in primary care. So, at the University of Glasgow there was a database of primary care consultations with general practitioners, and the premise of the database was that the GPs, the General Practitioners, saw permission and then just recorded routine consultations. So, I coded the Motivational Interviewing behaviors. 60 of the consultations, which were for patients who met criteria for depressions and also had other chronic conditions.

Kylie McKenzie:

So, a very complex group of people. I think that the stand out from that, and something that I've talked at Motivational Interviewing Network of Trainers conferences about, was that one of the key findings from that research was that in a 10 minute consultation the General Practitioner's asked, on average, 17 questions, and as somebody who's engaged in MI, that sounds like a lot of questions, particularly when you realize that the coding scheme categorizes questions as a volley of questions. So, you might say to a patient, "How have you been this week Misses Jones? And, tell me about how your cough's been this week, and how did you go on the new medications?" in a volley and, that's one question.

Kylie McKenzie:

So, 17 of those offered in a 10-minute consult with a very complex person, doesn't give a lot of room for that collaborative approach that is probably recommended for people with complex needs. It took me a while to really think about what sense to make of that, because of course interestingly, your own writing reflex kicks in, and it's like, well maybe people shouldn't be asking that many questions. And, I think the more useful point that I finally got to was, actually, question asking is a core skill. So if question asking is a core skill, how can we use that in a way that is more helpful with these complex people where you do need to move beyond assess and advise, and do need to think about engaging them in healthy behavior change.

Kylie McKenzie:

And so, the paper that I wrote with my two academic GP supervisors focused on the idea of asking questions in the direction of change. In Australia, we probably use the term, "Don't ask an open slather question," where you're asking somebody about absolutely everything going on in their life. If you're there as their primary care physician, as them about the things that are really pertinent to their healthcare, or the combination of mental physical healthcare. It's got a sense of some direction to the question so that you're focusing the question on something that is about your expertise on why they're consulting you, because I also think clinicians get really scared when you introduce the concept of open questions because they've got a seven minute consultation, or a 15 minute consultation, and it's very difficult to manage if you open up a conversation that's not about their clinical skillset.

Kylie McKenzie:

The idea of asking an open question, that includes language about preferences, strengths, interests, needs and the behavior that, as a clinician, you think might be helpful for them, or that they've identified would be helpful. So, we put together a structure in the paper in the Australian Journal of General Practice, about with asking. To try and say, "Questions are really helpful. Here's a way that you might be able to use in your practice that might be helpful for the patients and for the way that at the current primary care system practices, in most Western countries anyway.

Sebastian Kaplan:

I imagine this is also part of your own evolution as a practitioner, and in your own skillset. Going back to the story that you were saying, about how you were trained initially and how that evolved as you were working with patients, more with chronic illnesses and multimorbidity, that the kinds of questions that you were asking before were probably different, and perhaps you were asking far fewer questions and focused more on effective listening and establishing empathy, but this seems to be also something that's shifted for you in... I guess, having, really, an open mind to what the world of a busy General Practitioner is like, and that asking questions is really integral to that work.

Sebastian Kaplan:

So, it's not about turning a General Practitioner into a psychologist. It's about helping general practitioners' questions that are more effective and more efficient, given the limited time that they have.

Kylie McKenzie:

Yeah, and I think that that's especially true for people with chronic illnesses, because... well, one of the reasons that I headed towards a PhD looking at Motivational Interviewing with multimorbidity, is this idea that people who have multiple-chronic conditions are actually, sort of, called the new norm in healthcare. This is not an unusual presentation in healthcare. So, General Practitioners, psychologists in healthcare settings, anybody working in a hospital-based program, is likely to meet

people who have multiple-chronic conditions, and I think the way we've got our current evidence base set up, is really helpful if you're somebody who meets criteria for a single condition, because we've got a proliferation of single disease guidelines, and they're enormously helpful to guide clinician practice, where you're a person who has a single disease.

Kylie McKenzie:

Where they're less helpful, is where you're a person who has more than one disease, because the studies around the potential for treatment burden indicate if you followed all of the guidelines for each of your chronic conditions, you wouldn't have much time in your life for living. And, that's a really difficult place for clinicians to be because how do they guide somebody, who could potentially follow many guidelines, to follow something that will actually benefit their health. And for me, Motivational Interviewing has a real role there, because most people who have a chronic condition, and particularly with mental-physical multimorbidity, they're not going to follow every single guideline because it's overwhelming. So, how can you work with them to collaboratively pick the targets that might have the best impact for them?

Glenn Hinds:

I'm going to use terms... maybe a lot of people will recognize it. It's almost like a harm reduction in a sense that because there's a number of issues going on in your life, that there's a crossover if I give you this instruction, it may impact on the other condition that you have. So, the multimorbidity that you have itself, is a single entity, and what we're going to try and do is work with that and see how we can mitigate the circumstances to make your life as manageable as possible. It's almost like living with the illness to the best of your ability and making your life as meaningful and healthy as possible, even though you are sick and potentially going to be sick for a long time.

Kylie McKenzie:

Yeah. Absolutely, and there's been Cochrane review, and a follow up to that review, about interventions for people living with multimorbidity. Broadly, the recommendations from that Cochrane review, and guidelines from the World Health Organization, and there's a National Health Service report from the King's Fund in the UK, as well. The recommendations about multimorbidity intervention are, that it's Patient Centered, focused on Health Behavior Change, can be integrated into routine care and delivered by improved communicational consultation skills. And so, those recommendations really, to me, start highlighting the potential foreign approach, like Motivational Interviewing, because, Motivational Interviewing is, by its definition, patient centered.

Kylie McKenzie:

It can be focused on Health Behavior Change. It can be integrated into routine care, and I think it's an example of communication skills that are enhanced. That do feature that patient centeredness, and the focus on health behavior change. That's what highlighted my interest, is the qualities that researchers in multimorbidity are identifying as, most

likely, to be effective for people living with multimorbidity, really align very well with Motivational Interviewing .

Sebastian Kaplan:

Right. It's almost as if the authors of those guidelines were trying to basically say, "Use Motivational Interviewing ," but they probably wanted to back off on one specific recommendation of a particular method of counseling or conversation.

Kylie McKenzie:

Yeah. That's really interesting. I haven't read by the authors of the review, that specifically talk about Motivational Interviewing . And so, I actually don't think that is the case. I think that's just a connection that has potential.

Sebastian Kaplan:

Yeah. I would imagine it's possible that they weren't going for that specifically, but it just... the way that you listed those key features of the recommendation, it was like checking boxes in the MI world, certainly.

Kylie McKenzie:

Exactly, and that fit makes sense to me as well. Look, I think we talked about what connects you with Motivational Interviewing , and that idea of the missing piece. For me, one of the things that is useful about Motivational Interviewing is that our... it actually articulates what's meant by something, like Patient Centered Care, or Person Centered Care. I'm not sure what it's like in the UK, Northern Ireland, or the US but I know that there are a lot of hospitals, in Australia for example, that have Patient Centered Care as one of their core values. To the point that it's written on walls in hospital foyers and entrance ways.

Kylie McKenzie:

And, I think if you were to scratch the surface, most people would struggle to articulate what's meant by that. For me, Motivational Interviewing provides words, behaviors, descriptions of things that you can do as a clinician that operationalize patient centeredness as an idea, and I think that's really useful because when you say to a clinician that you're doing something in the best interest of the patients. You're working with them collaboratively. You don't have clinicians of any variety say to you, "Oh, I don't want to be doing that." It's the how of doing it that is, I think, sometimes hard to connect with as a clinician.

Sebastian Kaplan:

Yeah. I really appreciate you saying that, Kylie. The image of the patient centeredness plastered on the walls. I think there's a wing or two at the hospital that I work at, that I can think of, that are the same. But also, I don't know of any practitioner that would claim to oppose being patient centered. No one's going to raise their hand and say, "That one's not really for me," or, "I don't really abide by Patient Centered Practice," but

I think you're right. There's just a real limited grasp of how you actually do that. As you said, how to operationalize that.

Kylie McKenzie:

Yeah. So patient centeredness is absolutely something that appeals to clinicians. It makes sense to them, and I think most clinicians who are trying to achieve that in their practice, they're just not quite sure how to go about doing that. And, I think one of the things that I've used in training, and have used in training some of the clinicians in the collaborative care trial I'm a part of, working with patients with multimorbidity, is the video about the writing reflex. It's well articulated by Bill Miller in a video which is available, I think, on Vimeo and on Skype, and it's called The Righting Reflex.

Kylie McKenzie:

What he talks about is something that really makes sense to me. That, clinicians, when they are giving advice and telling, confronting, cajoling, trying to encourage somebody through that directive approach, it's coming from a really good place. It's coming from wanting people to have better health outcomes. To live better lives. And, I think the thing that he highlights in that video is that, in fact what it does is it elicits the other side of the argument for people. So that, if you push for the behaviors that might be helpful, what you get back is the other side of the argument.

Kylie McKenzie:

And, he uses a phrase which I've sort of picked up and run with in my training, and I think it's again going back to that idea of the missing piece. He uses a phrase where he says, "It's important to give the patients the good lines." So, rather than us making the arguments for change, it's about encouraging them to make the arguments for change. And for me, a lot of clinicians really click with that idea of, "Oh, actually, if it's my job to engage people with making a change, I can do that better by getting people to talk about it themselves." So, what do they want to do, what are they able to do, what's important to them, and that idea of moving to trying to push people into change by telling them how to do it, and what to do, and drawing from them what they could do themselves, what's important to them. That idea of the good lines, I think, is a concept that makes sense to people and is a way of articulating how you can be patient centered in your practice.

Glenn Hinds:

It seems to be beginning to explain the point that was being made about the person centeredness being written on the wall, and I think back to a piece we did with David Rosengren, where he described the difference between fluency and mastery, and the idea that there's lots of concepts in helping them, perhaps in all aspects of life, that because they're so familiar, there's a fluency to the... my mind recognizes this work, therefore I don't need to do anymore work on it. But, what you're describing is that that shift needs to take place, and that is maybe about supervision, that is maybe about training, but it's certainly about practice, it’s about how do I put what's written on the wall into practice with my clients, and what you're saying is Bill articulated in one way, which

is to create an environment where you ask the types of questions where you elicit the good lines from the clients. So, I'm just curious to what sort of things could people be thinking about doing, or questions could they be asking? How do we get clients to give us the good line?

Kylie McKenzie:

We ask for them. I think that that's a really... you pose a really good question there because that's exactly what we're talking about. Is how do you put into practice the concepts that you're talking about. And in this case, one way that you can get the patients to give you the good lines, is to ask for them. So, if the good lines are what's important to people, what their preferences are, what they're able to do... that you can actually ask questions that incorporate those idea, and the clinical practice paper that I wrote with my supervisory colleagues, Professor Jane Gunn and Associate Professor David Pierce from General Practice at University of Melbourne, that's one of the things that we put into that paper. A structure that has the open question stems.

Kylie McKenzie:

So, what, why, how, tell me about. And the words that form the basis of the good lines. You know, what do you want, how important is it to you, what are you able to do, tell me about what your preferences are, and then also adding into that the target behavior. So, if you can picture it... and you can see it in the article, but if you can picture it, there's like a structure where you can put together a question using open questions stems, using the good lines or the language of change. Or, for those more familiar with Motivational Interviewing, the words more associated with change talk, and the target behavior.

Kylie McKenzie:

And, if you think about that in just natural language, if you say to somebody, "What do you want to do on Saturday night?" They'll say, "I want to." So, by asking somebody questions that involve the good lines, what they want, what they can do, what they've got reasons to do, what they're willing to do, that's often what people will answer with. Then so, you can really facilitate people offering those good lines, and offering their own preferences, values, strengths, interests, and that's what makes it patient centered.

Sebastian Kaplan:

So, this is really getting at what you were talking about a moment ago, about changing the kinds of questions. Not necessarily asking fewer questions just for the sake of coding or something. It's asking really specific, strategic questions in the short period of time the GPs have to draw out a patient's own desires and plans, and ways they might go about making changes as they're grappling with a pretty complex set of circumstances, often times.

Kylie McKenzie:

Yeah, and it's kind of like what we do in clinical work with people. We start with where people are at and we use their strengths... or, we elicit from them what their strengths

are, and one of the things that I think we identified from the observational study of some routine practice, was that asking questions is a core skill. And so, if you can ask questions that support a Patient Centered Approach, and that are focused on Health Behavior Change, then that's a useful thing to do with somebody who's trying to navigate through multiple single-disease clinical guidelines, to get their best outcomes.

Kylie McKenzie:

So rather than trying to get people to do everything, you get them to do the things that are important to them, that they feel like they can do, and that's more achievable. An achievable goal is an important approach to take.

Glenn Hinds:

For me, it sounds like the invitation for us as practitioners, and certainly for physicians, to have a lighter touch in relation to their support of patients that maybe the patient wants to talk about... or, is willing to make certain changes that don't sit with the priority for the practitioner, or the physician, but some progress is better than no progress. And, for some reason I have an image of a knot made up of multiple threads, and it sounds like part of what we're exploring is, what type of questions can I ask to help this knot begin to be undone, rather than me to say which thread needs to be released first.

Glenn Hinds:

And, that that's the invitation for practitioners, is... look, there's a lot of things being influenced here, let's get some progress somewhere, and that momentum itself is going to be progressive and beneficial for the patient, which is ultimately what you're there to do, is to be helpful for them.

Kylie McKenzie:

You offer a really lovely metaphor there, Glenn, because we all know what happens when you pull on the wrong string on a complicated knot. You tighten the knot, and it makes it harder to disentangle, and so by allowing the patient to choose which part of the tangle that we'll start with, you're much more likely to have some success. And, they're more likely to have some success.

Sebastian Kaplan:

So, Kylie, I wonder if we could hear a bit more about something you said a few moments ago. You used the phrase that you work with, collaboratively picking the targets for change, right? And-

Kylie McKenzie:

Yeah.

Sebastian Kaplan:

... it seemed like another nice example of, not just patient centeredness, but of focusing within Motivational Interviewing . Could you talk about an example of an individual who

had multimorbidity? So, maybe bring up a case example, if you will, of somebody who has two or three health conditions, and how you might go about collaboratively picking the targets with that person.

Kylie McKenzie:

Mm-hmm (affirmative). So, there's a couple things I'm thinking about from your question, and from what we talked about, a little bit earlier too, and one of them is about that the clinician in the room holds expertise about something that the patient, or the client, has come to see them about. So, I think it's useful for the clinician to be a part of the conversation about what they can be helpful with. I'm thinking about an example from one of the pediatrists that I work with at the hospital, who had spent a lot of time working with a patient who had multiple-chronic conditions, and trying to get that patient to change his footwear because of the risk with diabetes, of ulcerated feet and then the potential for amputation, and how very important that is.

Kylie McKenzie:

So, he was trying to come at that any which way he could to try and emphasize the importance of footwear that didn't make the situation worse, and trying to engage the patient to change their foot care and their self-care because of the absolutely high risk of a negative outcome. The thing that he came and talked to me about was, it clicked for him one day because he'd done some Motivational Interviewing training that... instead of telling this patient to change what it was he was wearing, he said to him, "What's important to you in the activities you do every day?" And, the patient talked about the idea of being able to be a little more active with his grandkids, and he said, "So, what do you need to be able to be more active with your grandkids?" And the patient said, "I probably need a better pair of shoes."

Kylie McKenzie:

You know, it's a very simple example, but it's trying to tap into what's important to people. I think that doing that within your own clinical framework is an important thing to do. And the other thing that strikes me about the idea of focus, is that sometimes our hospital, or service, or clinic administration systems actually take a lot of time for people to get through, and they can actually be a barrier in the way of getting to a focus for a patient. We ask a stream of questions and a whole range of background information, some of which is important, and some of which isn't.

Kylie McKenzie:

And, I think that there's room for us to think more seriously about how our administration systems can support trying to come to a focus that's important for a patient. So, one of the things that I'm going to evaluate as part of the care navigation trial for multimorbidity that I'm working on, is, what's the impact been of asking people in a survey-based way about evidence-based potential behavioral targets that are important to them. So, it's a depression in primary care trial, and for people who have complexity and chronic conditions. And they're asked about a range of behaviors that we know from the evidence are related to better, or worse, outcomes with depression. So things like sleep,

and healthy eating, and physical activity, financial management... a whole range of contributors to depressive symptomatology, and people are asked to rate those core areas, those target areas, and then that conversation has some focus to it.

Kylie McKenzie:

When you meet with the person... you know, "When you filled out the screening questionnaires, these couple of behaviors appear to be really strong priorities for you. How important are they to you?" And then you've got a conversation that has a focus that is supported by the administration for the clinic. So, I think that there are some things that we can do that support clinicians to have these conversations as well. I'm not sure if I answered your question there, but there's a whole range of thoughts about focus.

Glenn Hinds:

It sounds like, in some ways, that given the multiplicity and the multimorbidity that you're describing that there's a number of doors we could walk through. Let's find the door that easiest to push open and go through that door first. Or, certainly invite to the patient. It's interesting, what you're describing resonates with another conversation we had with Doctor Damara Gutnick, and she talks about the idea of what matters to you. Not what's wrong with you, but what matters to you, and work from the client's priorities. And start the helping conversation there, and it sounds like even by doing that survey approach... I imagine that that speeds things up because it's got the client to begin to think of the patient, to begin to think about what's important for them before they even walk into the consultation. And time has been saved where the practitioner can immediately go, "All right, I can see from what you're saying," and to start working there. In many ways I can see that that would, in some ways, help the patient or client feel that their point of view has been taken serious because that's been the priority for them.

Kylie McKenzie:

Yeah. Absolutely, Glenn. I think that we could invest a lot more time in thinking about how we get to that point, in a way that honors what's important to the patient. Also, I think sometimes I think the clinician's expertise... Like the question you asked me about earlier, Sebastian, where you said, "But, what about in training when people want to be able to provide advice?" Clinicians do hold information, and they can identify sometimes what would be helpful for patients, and it's about how you get those two things to come together in a helpful way.

Kylie McKenzie:

And again, we've talked about what does patient centered mean, what does collaborative practice mean? And I think that how you bring together clinician expertise with patient priorities is... it's not always that easy to do. So, the more we can find ways that support that collaboration, I think the better we'll be.

Sebastian Kaplan:

Yeah. I mean, it does seem like it's trying to find the right balance between relying solely on telling what the patient should do, from the perspective of the provider of course, but also not the other extreme of it only being about drawing out a patient's desires, and goals, and wants, and aspirations... that there's a place in the middle where there is more a focus, when using MI of course, on what's important and what matters to the patient. But, there's absolutely room for a clinician using the clinician's own expertise, to provide some suggestions or some advice about a person's presentation and what their lab results might mean, or what their physical presentation, or their physical exam might suggest. That in essence is the collaborative part of it, that both sides can influence the direction.

Kylie McKenzie:

Yes. Yes. That bringing together the clinician and patient is... it sounds like such a simple thing, but I don't think it is as simple as it sounds, and I think one of the things, as MI trainers, to be aware of is that potential risk that people leaving MI training without a set of skills for being able to support patients with what they do know, and that's the balance. Which is also very similar to that idea I had, where actually asking questions is a core skill. How do we do that in a way that's more helpful? Owning a device and having advice to give is what people invest a lot of their training time in, but how do we offer it in a way that's more helpful?

Kylie McKenzie:

So, I think there's been some discussions, in amongst Motivational Interviewing trainers, at times, about the idea of, is it important to get all clinicians to be Motivational Interviewing proficient? Or, is it most helpful to just get them on the continuum?

Glenn Hinds:

Okay, hopefully the audience... you're not really noticing just how many technical hitches we've had today, but we've just experienced one, and for the sake of continuity I'm just going to summarize it. My understanding is it... what we were talking about before Kylie, was just the fact that the idea of the continuum of understanding both from a practitioner's perspective, which is helping people to get on to a recovery continuum, at any point, is a good place to start.

Glenn Hinds:

And then from a training and practitioner's perspective that, learning to do something helpful, on the continuum of the helping realm itself, is very useful from an MI perspective... that, as trainers when we're going to practice. Like, getting people to do something different, not necessarily pure MI, itself is useful. And just to elaborate on that, if you could, just on the notion of the continuum and what else you were saying about it. Please.

Kylie McKenzie:

Yeah, absolutely. I think that meeting the full criteria of something like the Motivational Interviewing treatment integrity code can be a little overwhelming for clinicians who

meet MI for the first time, and I think the things we took away from the observational study of routine practice in Scotland, that were helpful, were to think about in what ways can you ask more helpful questions as a clinician? So, questions that are in the direction of change. To be very thoughtful about providing advice and direction, and... so that that advice doesn't have a confrontational quality to it.

Kylie McKenzie:

So, of the consultations we observed in Glasgow, 18% of them had something that had a warning or a threatening component to the advice. So not confronting. Asking more helpful questions. Providing advice that's targeted. So, in a 10-minute session, the clinicians were offering 12 pieces of advice, as well as asking 17 questions, and so that's a lot of information for people who are in complex situations, to take on board. One of the strengths we also saw in those consultations was that 2/3 of them... there was a reflection of some sort in the session, and so we've got a baseline where clinicians offer reflections, they ask questions. And to get them on the continuum, can they ask... find a way to ask more helpful questions that are more helpful for... clinicians, and for the patients.

Kylie McKenzie:

And find a way to target information that they offer, and advice that they give so that it does make those priorities of patients. So that those kinds of ways of getting on the continuum of Motivational Interviewing practice, finding ways to be more patient centered, and finding ways that really elicit from the patient what's important to them. Some of the key ideas to take away, in the direction of having a consultation that has a more Motivational Interviewing flavor to it.

Sebastian Kaplan:

Wonderful. Kylie, we're approaching time to start winding down here, and I wonder if you could share a little bit about the research that you're conducting now? We understand that you are close to completing your PhD, so congratulations about that, ahead of time. What are you looking at now, what are some of the... what's your work focusing on?

Kylie McKenzie:

So, I've moved through some core skills in the research process, and that's been good as a longstanding clinician to step back a little bit from that MI enthusiast role, to being somebody who really looks at research and the concepts of MI, and how they apply, and looking at that for multimorbidity. So, the systematic review of Motivational Interviewing and healthcare across a range of conditions was, sort of, step one. The routine care observations was step two, and from there my work has been looking at the development of an intervention that we're calling Care Navigation for people with mental-physical multimorbidity in primary care.

Kylie McKenzie:

So, an intervention that supports them to make changes aligned with an evidence-base for improving depressive symptomatology, and my job now is to have a really close look at some of those consultations, about 10% of which have been recorded, and the clinician reflections about how the session went. Also, the written material that was shared between the patient and the clinician. And, that that's had a deliberate emphasis on supporting self-efficacy and reinforcing the behaviors for the patient's making, in the direction of change. So I'm at this really exciting part of the research, where I get to have a really good look at how an intervention that's been strongly informed by Motivational Interviewing ... how it went. And also, what the clinician's reflections of that has been. So that's next, and I'm hoping from that, I can share something that is really pertinent and helpful to clinicians working with patients or clients who are living with multimorbidity because increasingly... it's a really core part of the work that all of us will be doing.

Glenn Hinds:

So, in some ways it's a bit more depth high practitioners or physicians learn to do things differently, or to influence the conversations that they're already having with patients, in a way that we now know is most efficient for the patient and their outcomes.

Kylie McKenzie:

Yes. So, that and what are the outcomes for the patient. So, there's a lot of research in multimorbidity about the impact of socio-economic disadvantage, and much earlier onset of multimorbidity. So, one of the things that I'm interested in looking at is the context for the patient, and that the... taking what's called a realist approach, to the evaluation. So, what works? For who? And in what circumstances? So, thinking about the approach that has been put in place for this. The situational context for the patient, and also trying to answer the question of, if MI was used, to what extent? Because a lot of the studies about MI don't always report Motivational Interviewing fidelity, or integrity as part of that. So, I'm really interested to know what a brief training program, and what effect that has on the practice of the clinicians as well.

Sebastian Kaplan:

Well, surely exciting developments to come, both in the clinical practice and training around helping people with multimorbidity. So, Kylie as we wind down today's conversation, one of the things that we ask our guests is if they would be willing to... if there are people in the audience that wanted to reach out with questions or comments, if they could contact you directly. So, would you be okay with that, and if so, how would people contact you?

Kylie McKenzie:

Absolutely, I'm okay with that, and I respond when people contact me, as well. My email is kylie.mkenzieunimelb.edu.au, and that's McKenzie with an M-C-K. And oh, I guess Kylie's not a common name outside of Australia, I think it spread to the UK a little bit. So, K-Y-L-I-E.mckenzie.edu.au. I'm also on Twitter as a very, very poor participant. I

pop in and out of there occasionally, but I can be contacted through there and my Twitter handle is @_KMcK.

Glenn Hinds:

Fantastic, and we'll certainly link people to your Twitter handle when we Tweet out this episode and invite comments. You can contact us on the Twitter handle ChangeTalking, and Facebook Talking To Change, and the email address is podcast@glennhinds.com.

Sebastian Kaplan:

Great. Well Kylie, thank you so much, this has been really, really a fascinating conversation and we appreciate your expertise, your knowledge and of course your patience through our technical glitches today.

Kylie McKenzie:

I appreciate your interest in some of the work that I've been doing, and always the value of the conversation, and benefited so much just from hearing the two of you summarize some of the things that I've been thinking through as well. I really hope that some of those ideas are helpful for clinicians who are listening as well.

Glenn Hinds:

Fantastic Kylie. We really appreciate it, again. Seb, as always, good to talk to you man. Have a great day. Kylie-

Sebastian Kaplan:

Okay.

Glenn Hinds:

... thank you very much, and we will be talking to you all soon. Thanks everybody.

Kylie McKenzie:

Thank you.

Sebastian Kaplan:

Thanks guys. Bye-bye.

Sebastian Kaplan:

Hello everybody, and welcome to another episode of Talking To Change: A Motivational Interviewing podcast hosted by myself, Sebastian Kaplan based in Winston-Salem, North Carolina, USA, and, as always, joined by my good friend Glenn Hinds from Derry, Northern Ireland. Hello, Glenn.

Glenn Hinds:

Hi, Seb. Hi, everybody.

Sebastian Kaplan:

So, Glenn, before we introduce our guest today, get us rolling with the social media contact options that people have.

Glenn Hinds:

Okay, thanks. Facebook is TalkingToChange. Our Twitter handle is @ChangeTalking. And, thank you to Maddy Nicholson, @motivationalmad who responded to a tweet I sent out before we came on air today just asking for questions. So, we have a question from Maddy today, @ChangeTalking. And, for emails, it's podcast@glennhinds.com.

Sebastian Kaplan:

Excellent, and, as always, we welcome any review or questions or feedback that people have about past episodes or this episode or even ideas for future episodes. Okay, so, we'll get started with an introduction of our guest, today. Our guest is David Prescott, who is the clinical services development director for the Beckett family of services. That's a group who practices throughout New England. He also provides consultation to agencies around the world. Mr. Prescott has produced 20 book projects and numerous articles and chapters in the areas of assessing and treating sexual violence and trauma.

Sebastian Kaplan:

His latest projects on feedback-informed treatment and forensic report writing in trauma-informed care were published in 2017-2019. Mr. Prescott is a current fellow and past president of the Association for the Treatment of Sexual Abusers, the largest professional organization of its kind in the world. He is also the 2014 recipient of that organization's distinguished contribution award, one of only a handful of recipients. Previously, he received the Bright Lights Award from the National Adolescent Perpetration Network in 2007. He has since become a member of that organization's board of elders.

Sebastian Kaplan:

Mr. Prescott is a senior associate and certified trainer for the International Center for Clinical Excellence and a member of the Motivational Interviewing Network of Trainers. He's also a consultant, supervisor and invited trainer for the Romanian Association for Brief Therapies and Strength-Based Solution-Focus Consultancy, and on the scientific committee of the Polish Institute for Motivational Interviewing. Mr. Prescott has lectured around the world including, most recently, Australia, Japan, Germany, Iceland, Poland, Romania, Norway, Namibia, Canada and the UK.

Sebastian Kaplan:

He has served on the editorial boards of three scholarly journals: Motivational Interviewing, Training Research, Implementation and Practice, the Journal of Sexual Aggression and Sexual Abuse, a Journal of Research and Treatment. Mr. Prescott is also co-editor of the New England Adolescent Institute News, which is read by

thousands of professionals each month. A very warm welcome to you, David. Thank you for joining us.

David Prescott:

Oh, hi, thanks. It's great to be here.

Sebastian Kaplan:

And, we often get started with our guests, just very interested in hearing your early MI stories. How did you find out about MI and what were some of those first learning experiences that you had?

David Prescott:

Sure, well, I guess I got started in 1984. I needed a job reference so that I could get into social work school, and I took a job at this drug rehab center in Syracuse New York. It was a frightening experience in many ways using hot seat therapy, pretty much all of the low-empathy toxic interventions that many have heard about, but I guess still persist in various corners of the world. But, it was enough to really make me think about, "What is social work?" which has been my area of study. What is social work practice? Where does social control enter into the mix, and where are all of the boundaries in these areas?

David Prescott:

Then, by the time the '80s and the '90s rolled around and I was working in residential treatment with adolescents, I was increasingly asked to work with these kids who had sexually abused, and, there again, it seemed that the common wisdom of the time was that treatment should be harsh and confrontational, brusque and in your face. And, most of the treatment providers that I met at the time seemed to wear these attributes very well. And, I think there was a whole group of professionals like myself that remained very quiet in these days, wondering: was this really the best way to treat kids?

David Prescott:

Over time, I then got asked to go and work in adult program in the upper Midwest of the United States. I was invited to take this position in large part because of my background with adolescents. I hope it doesn't come off too disrespectfully if I say once I was done with 18 years of working professionally with adolescents, I went to a program where, very often, the same adults seemed to be just as impulsive, and, sometimes, as irritable as the ones I'd left behind, or, at least, as the kids I had left behind. Now, I mean this with all due respect, but it was the way things seemed to be.

David Prescott:

Somewhere around in all of this, just at the same time as the second edition of the Motivational Interviewing book by Bill Miller and Steve Rollnick came out. I saw a keynote address given. It referred to it, and the presenter, a wonderful man named David Bergen since retired said, "I really urge you, go out and read the new Motivational Interviewing book. You can go out and read a couple of other books, as well."

David Prescott:

So, I did, and I bought the videos done by Bill and Steve in 1997, I think it was, and I still remember the moment when I asked, "How did this all get started?" They said, "Well, we learned it from our clients," and I thought, "Hey, everything I know, I learned from my clients, as well. I'm starting to like this." It was only then that I realized how difficult many of these most basic skills are to put into practice. As I've heard Bill say, when people get introduced to Motivational Interviewing , it's as though they already knew it in their hearts, and that the real trick to all of this is: how do we put it into our practice on a day-to-day basis?"

David Prescott:

So, it was a natural fit, and it seemed that it relieved me of the duties of having to write down everything that I'd learned from working with some pretty difficult clients because these guys had already done it. From there, it was just a hop, skip and a jump. In my case, there's a wonderful guy in San Francisco named Steve Berg-Smith, to whom I am eternally grateful. Who I attended a training with. He then coached me and listened to recordings of my sessions and gave me feedback. And then, I brought him out to do training for our staff in Wisconsin. So, it's maybe a little bit longer of a story, but I guess the points that I want to highlight are: we really did this.

David Prescott:

In the US in the 1970s, end of the 1980s and the 1990s, treatment could be a really, really harsh place for clients to be. And, at first, I thought I was working with these vulnerable kids, only to find a group of adults that were just as vulnerable, even after 30 or so years of experience of doing the work. I did a couple studies on adults who had sexually abused, and found that they were endorsing rates of adverse childhood experiences that were difficult to imagine even after decades of practice. This is why we do science. We're always astonished by the results.

David Prescott:

But our clients endorsed very high levels of emotional abuse, adult males, adult females who had sexually abused, and it was only then just in the past few years that I developed a deeper, deeper ... I had already known this through clinical experience, but to actually do the statistical work finding out how much the old ways of doing treatment were replicating the very environments that these people had grown up in. That's just not right. So, a long answer to an easy question, but the further I've gone with MI, the more important I realize that is.

Glenn Hinds:

So, #toughlove with kids doesn't seem to have worked that well. It was done with the best intentions, but, after 18 years or experience when you went to work with the adults, if it had been working, you would have expected to see the adults present in a different way. That wasn't the case. When you were introduced to Motivational Interviewing it sounds like that, the challenge for us or challenge for you was the unlearning of the ineffective approaches to get back to what was already in you. And then-

David Prescott:

Absolutely, absolutely.

Glenn Hinds:

And then, the technical side of Motivational Interviewing and the opening strategies, opening equations, affirmations, reflections, summaries were the presentation of the music that was in you, and that took time and practice. But also, quite scarily for me and, I imagine, a lot of people listening to this, recognizing ... one of the things you've identified is that in our efforts to be helpful to these young people, potentially, we are perpetrating the harm that was visited upon them that brought them to our attention in the first place. It's almost like we are creating a parallel experience, and I wonder, can you tease that a little bit further, knowing that, what that has taught you that has helped you to do it differently so that your clients of today are getting a different experience and one, I imagine, you hope to me more of a healing experience?

David Prescott:

You know, the first place I go listening to this question is remembering a quote from Monty Roberts, the Horse Whisperer in a three-minute video that's circulated amongst some MI trainers. He says, "Nobody has the right to say you must, or I'll hurt you." And, unfortunately, from the old days of spare the rod and spoil the child to our flirtation with bootcamps, primarily in the American West, a lot of harm has been done in the name of doing good. You know the old pathway to Hell and good intentions and these kinds of things. The way that I've tried to explain it at a more practical level is: by the time kids or, frankly, anybody ends up in our treatment programs, the whole rest of the world has told them they need to knock it off.

David Prescott:

The whole rest of the world has told them their behaviors are unacceptable, and it didn't work. So, by the time you come to our programs, it's time for something new. I'm very blessed to have worked with a woman in Vermont. I'll even name her. Her name is Leigh Gallagher. She's one of my favorite people, and she might not even remember saying this, but, at one point, she said, "You know, we need to raise our kids in a way that they can someday raise kids of their own." And so, in working with abuse, all too often, it seemed the common wisdom at the time was, "These people abuse out of a need for power and control. And yet, the whole rest of their existences went missing."

David Prescott:

That statement, as far as I can see, is not entirely inaccurate. It's just that there's a lot more to the puzzle as well as the fact that everybody I've ever known wanted some degree of power and control in their life. The things are very tricky. We're dealing with complex human beings, and it took them a while to end up with these kinds of behaviors. It's going to take a while to unpack and undo them, as well. So, yes, and that even goes for me, Glenn, as you rightly observed. Many of us really do have to unlearn a lot of skills in order to really practice MI.

Sebastian Kaplan:

Right, we see this in so many fields. If telling people to change or how to change worked, then we wouldn't have clinics that are filled with people that are needing help with change. And, I suppose, in your field, it's no different. Maybe you could talk a bit about what it's like for a clinician in your world who is faced with a group of people or a person or behaviors that they're trying to change that might pull for a righting. Maybe this speaks directly to Maddy's question, Glenn, who was very curious.

Sebastian Kaplan:

She was curious about a couple things. But, one of the things in particular was about your own righting reflex or the reflex of practitioners in your clinical work. Maybe talk a little bit about the experience of a clinician in that way, and, how do you adjust it so that you can be more helpful to somebody?

David Prescott:

Sure. The answer is complicated. And, by the way, thank you Maddy for the excellent question. Let me take a step back and say, obviously, I believe any amount of abuse is unacceptable. I'll just say at a personal level I'm a husband. I've just in fact celebrated 25 years of marriage. We've raised two kids. Thanks, thank you. We've raised two kids of our own. I am no stranger to the thought process that many of us have gone through that goes something along the lines of, "Please, God, don't let my kids abuse," and both of my kids are boys, so I'm also no stranger to the idea of, "Please, God, don't let my kids grow up to abuse." There are so many different ways the world can be a cruel place for our children, so, all of this, a long-winded way of saying I get it and I've lived it. So, please just understand that as a background to everything that follows.

David Prescott:

From there, then, there's this problem that human beings get, or, a challenge, I guess I should say that we all get, I've heard it sometimes called the flashbulb moment of when we realize that somebody that we might have respected abused somebody else. Here in the United States, we had the famous coach Larry Nassar, or we had the comedian that I grew up with named Bill Cosby. In the UK, it was Jimmy Saville and others where, all of a sudden, we say, "Oh my gosh, he did what?" or President Clinton, or, to be on the other side of the political aisle, Donald Trump with the Access Hollywood tape where, all of a sudden, somebody that we admire and respect, we get clear and convincing evidence that they have caused some kind of harm to others.

David Prescott:

Suddenly, we have this flashbulb moment of one image of the abuse or one facet of the abuse. And, on behalf of all of the people that we read about, the beautiful young woman on the college campus, in that moment, we want to obliterate the abuse, and I think that that's a natural response that we get, or that we even want to obliterate the person who did the abuse. I'm trying to capture the experience for most people. The simple fact is that it is a practiced skill, that once we get to know the person who has abused, very often, we develop a different kind of an outlook.

David Prescott:

People who've defended the folks that I've just named have said, "But, you don't understand. He's a really good guy." Or, even worse, in treatment, "You don't understand. My dad's a really good guy." And, in the past, we might say, "Well, unfortunately, I'm going to have to disabuse you of that notion," or, "Yes, but he hurt you," or whatever else. Our righting reflex comes in because of this flashbulb moment. "How do you move on from abuse? How do you let this go?" etc., etc. And, I guess, the very simple answer is: over time, you get to know the people that have perpetrated abuse, that have caused harm to others as well as those that have been harmed.

David Prescott:

Inevitably, you start to see them as human beings. And then, this leads to a variety of challenges. How do we hold onto the complexity of another human being all at once to say, "Yes, this is a person who's caused immeasurable harm," or, sometimes, in my practice, "This is a person who can probably never be entirely free in the community without being at significant risk. This poor, unfortunate human being is never going to get to know life in the way that many of us have been blessed to know it. This poor human being, this poor soul may very well have to be very carefully supervised at some time. He has really ..." it's mostly he, but certainly women who abuse are out there, as well.

David Prescott:

This is a person who's caused very significant harm, and I would like to be able to help him, and he may never be able to be free in the community, this poor human soul." Or, "This is a person with a genuine, died-in-the-wool, as we say, sexual attraction to children," on one hand. And, on the other hand, they're much more than the sum of their sexual arousal patterns. So, I've come to look at these kinds of things as practice skills. And, very often, frankly, sort of anticipating additional questions, a lot of the skills that we have to develop happen outside, excuse me, outside the therapeutic hour that we might spend with these individuals.

David Prescott:

This, for me, is where MI has come in. "How can I become a more compassionate human being? How do I actually develop and demonstrate compassion in the moment that I'm looking at somebody who looks as though they genuinely don't care about the number of people that they've hurt. How do I get better at steeling myself against the amount of harm that this person has done and its inevitable effect on me?" Because, research does in fact show that working with people who've abused can be a perilous process in terms of vicarious traumatization, secondary traumatization. And, of course, it's not just people in my field. It's people in lots of fields. Although, it seems to be folks who work with those convicted of sex crimes and police officers who seem to be studied the most. Am I answering your question up to this point?

Glenn Hinds:

You certainly are. And, in many ways, you are inviting us to look at the purest presentation of what I think Rogers is talking about, that person-centered approach, which is the acceptance of an individual. We had Stan Steindl from Australia talking to us about compassion, and it sounds like this is the extremities of the capacity of my ability to be compassionate towards someone, that this is someone who has done grave harm to another individual or individuals and, most significantly and I imagine more challengingly for a lot of us, is that some of the individuals you're talking about have done great harm to children and it will trigger something within us.

Glenn Hinds:

It sounds like the journey that you have been on has been about, "How can I, first of all, contain the reality that part of this individual is real, but it's not all of who they are," and your ability to see that part of them, that really dangerous predator in the context of other aspects of their life and to see them in a bigger picture and try and meet them in that place. I suppose one of the questions that I guess a lot of people are asking is: how did you do that, David? What are some of the practical steps? If there are people out there who really want to work on stretching their compassion muscle or really building on their person-centered understanding and practice, what are some of the things that you did or that you could encourage other people to think about doing to help them be able to hold both the darkness and the light of an individual at the same time?

David Prescott:

Sure. Thanks, that was a very kind way to just ask the question, and it actually makes me really and truly feel humble because I don't think I'm necessarily a world leader in this regard. I'm not sure I'm the best example, but I will say that what has worked for me more than anything, obviously, has been cultivating my relationships with other people. If I had one motto, it would be what Ringo Starr sang back in 1967 when he sang the song I Get By With a Little Help From My Friends. And, frankly, to be perfectly open and honest, I spend a lot of time doing meditation.

David Prescott:

I used to be a more on-the-mat yoga person, and I try to walk or jog or run or hike as much as I can. In the old days, we called it getting outside. I heard somebody joke the other day, "We used to call it getting outside. Now, we call it mindfulness or forest bathing or what have you." But, I've increasingly thought that self-care is as important as it gets, and I say this not out of any sort of, "I've transcended all forms of aggressive thinking perspectives," but rather, "I've lot a lot of professionals make some egregious mistakes," so, I have come to believe it's our obligation to take really, really good care of ourselves. So, my thinking is spend as much time meditating as you can. Use red lights and crosswalks when you're waiting to cross the street. These are times you can meditate. It doesn't have to be a 10-day retreat and all of that sort of thing. But, in order to practice MI effectively, I really do see a lot of benefit in contemplative practices, so I hope that this answer is neither boring nor that new.

Sebastian Kaplan:

Well, no, it sounds really critical for you and, I assume, many other people as well, the importance of self-care as a way not just to care for yourself, but also as a way to maintain a high level of clinical skill. These aren't two separate parts of you, so the self-care contributes to you being as effective of a clinician as you can be. It's interesting you brought up meditation because when you were talking about ... you kept saying the phrase, "The poor souls," even when talking about someone who's committed acts so egregious and a pattern of egregious behavior, that they would likely never be fully free. And, you kept coming back to that term poor soul. It almost sounded as if it was a meditation that you perhaps use or draw upon. It made me wonder that, but now I feel the need to ask it since you brought up meditation.

David Prescott:

Sure. It's a great question. I hadn't even considered that, but rather, thought to myself: it goes back to working with kids. We're working with tiny little souls, and that all human beings, and, in my way of thinking, all beings, to some degree, are souls, and we should always remember that. I grew up in the era of the Vietnam war, and, and, like many of my age, remember seeing the body counts in the nightly news. It used to say, "This is how many died in Vietnam. This is how many Vietnamese died. This is how many American soldiers died," and stuff like this.

David Prescott:

And, I would contrast that to when we used to read about shipwrecks. The saying was, "The titanic went down with 1,400 souls," or whatnot, so there's many places where we use language to minimize harm. My clients very often have minimized the harm that they've done through their words by saying, "I was just monkeying around with those kids," for example, and there's times I simply want to tell the truth with language, and, for me, this is one way that I do it, which is, at the end of the day, these are human beings. If you were hurt by one of my clients, I'm so sorry, and I'm so sorry that this happened to you, and I don't expect you to ever feel particularly compassionately about this person. That's where I come in.

David Prescott:

This is my job, and when I read about politicians causing harm to one another, I'm as angry as the next person, and possibly angrier. However, when I'm doing my work and engaging in this practice, I sometimes refer to it as my psychological white lab coat. Doctors put on lab coats so that they remember what their role is. They're a doctor. And, certainly, I don't want a doctor who's empathic with the sense that, "Oh my gosh, my poor patient is bleeding. I feel absolutely sick with disgust and compassion for this poor man." It's not the right demonstration of empathy. I want the physician, the surgeon to go in and do his job.

David Prescott:

On the other hand, he wears a white lab coat to remind him what his role is, and I kind of do the same thing. I go and dress professionally and say, "These are clients in my care." I'm concerned about the community. I'm concerned about their safety. I'm

concerned about my contractual obligations to the criminal justice system. I'm concerned about my ethical considerations with my clients. I'm concerned about my contractual obligations to the various stakeholders with whom I work. I'm concerned with ... I don't really like the word moral because I don't always know what it actually means, but my moral or ethical obligations to the community around me. So, I'm going to operate within the parameters that I experience as a professional. I hope this is making things a little clearer or making sense, or answering the question.

Glenn Hinds:

So, your desire to be helpful is across a multiply-layered dynamic where there's perpetrators; there's victims, the community. There's people, their souls and your endeavor to connect with each at whatever level they're at. So, with a victim, you're acknowledging the pain that the individual is going to be working with has caused them, but that then doesn't mean you deviate from your attempts to be helpful to the perpetrator himself, and it made me think if something that somebody said to me I found very profound, which was, "Why do we interrupt a bully being a bully?" And, it was that it wasn't just to protect the victim because being a bully isn't good for you, and that's why I want to stop it. It's a lovely reframe. In fact, I think it was Didi Stout in the podcast we did with her, a lovely reframe and just about helping me to ... the reason why I want to interrupt your sexual behavior and attraction to children is because it's not good for you, either.

David Prescott:

Exactly, right, yes. If I could go backwards just a step, Glenn, you made such an important point. Yes, when I'm just about anywhere, I'm always aware that we are never more than a stone's throw away from a survivor of sexual abuse. So, there's a lot of it out there in the community, and the world is not divided into perpetrators and victims. Those that have been victimized sometimes have also caused harm to others. And, likewise, those that have caused harm to others very often have a background of victimization. It's not just an intellectual or academic question of, "So where do we draw the line?"

David Prescott:

This is the world that we have, and it's even worse than this, too. There's a marvelous TED Talk. I believe it's called, "We're all criminals," or something to this effect, but it gets to the point that if we go back and remember what we did as teenagers, we find that we too broke the law, and most of us grew out of it. How many of us went to university and drank way too much on perhaps more than one occasion? At the end of the day, I think one of the great realizations and tragedies of the world is ... or, maybe it's a benefit. I'm not sure, but I just know it exists, which is that the difference between people who cause harm and people who don't is, sometimes, the only difference is a six pack of beer and a really bad decision.

David Prescott:

Now, I'm not talking about the people that are bound and determined to do it again. I'm not talking about people who have a very strong element of risk operating in their lives. The simple fact is that the majority of people who are known to sexually abuse others are not known to go on to do it again. This is something that many people aren't aware of. And, in fact, the most recent studies of adolescents who sexually abused have found a known re-offense rate that's under 5%, something that's gotten a lot of us to start to wonder about the nature of science as well as the nature of adolescence and growing up and so on. So, the good news is people change. People change dramatically. The bad news is that, as the saying goes, we're all capable of causing harm. So, I'm sorry. I just had to work all of these things in. But, yes, it's a complicated community out there.

Sebastian Kaplan:

Yeah, one of the things that really comes through in hearing you today and having heard you speak in the past at some of the MI conferences that we've all attended is a real effort to establish, I guess you could say, a common ground or a level playing field for which you view the people that you work with and the people that you try to help. Again, that might be something that's really difficult for people to imagine if they're working with someone who has caused harm to other people in the way that your clients have. It just seems like there's this real concerted effort that you take on to really not necessarily normalize their behavior, but, at some level, normalize part of what they're after, some basic needs that they're trying to meet.

David Prescott:

Sure. This sort of ties into other work that I've done with something called the Good Lives Model that got its start in the late 1990s, early 2000s, first in New Zealand and has kind of spread rapidly, frankly, around the world. And, the Good Lives Model that my colleague and friend, Tony Ward, being one of, really, the primary originator, one of the things that has occurred to us and makes a great deal of sense intuitively is that people abuse others out of a variety of motivations and in a variety of contexts and circumstances.

David Prescott:

And, what I mean is, very often, if you can move upstream from the momentary behavior, that means that we need to move upstream from that flashbulb moment that I talked about as we understand the exact processes that lead somebody to cause harm, which are best, I think, uncovered using Motivational Interviewing . Very often, we find that these individuals have underlying goals that are the same as anybody else in the world. If you move upstream from, for example, molesting children, to use the most graphic and emotionally provocative example out there: if you move upstream, very often you find somebody who, in that moment, was seeking out some degree of emotional connection as well as some degree of autonomous decision making saying, "For once in my life, I want to call the shots or do the something that I want."

David Prescott:

You find the same need for happiness and pleasure that the rest of us have. We just seek it out in different ways ... maybe even the same need for some measure for inner peace. I might be being a little bit unfair because he was not found guilty, but Michael Jackson might provide something of an example, so I'm going to use him rhetorically, or maybe ask people to suspend judgment about Michael Jackson. But, this legendary pop singer who, I have to confess, I like his music now more than I did in the 1980s, he was an immensely talented person whether or not you were a fan of his music. He was a person who actually said that he preferred the company of children to the company of adults.

David Prescott:

Okay, so, what is up with all of that? Most of us only saw the odd and eccentric behavior. He dangled his own child of the balcony of a hotel in Berlin, and most of us have that as kind of a flashbulb memory, or the fact that he was arrested or had a Ferris wheel in his Neverland Ranch, all of these kinds of things. But, if you listen to what he actually had to say, he would say, yeah, I trust children more than adults. He felt that he could be open and, dare I say, intimate with children in a way that he couldn't from adults. His life experiences led him not to be able to trust adults. Anybody that's ever even flirted with being a professional musician knows it's difficult to trust other people in the music business, etc., etc.

David Prescott:

So, he told us himself in his interviews that he wanted some degree of inner peace and almost a sense of sanctuary from the dangers and exploitation of the real world. So, in the moment as we consider what he, I believe, very likely did to kids, we see that he was after some of the same goals as the rest of us. I use meditation to find a sense of inner peace. Unfortunately, he did not. I can have ... well, I guess my ideas of happiness and pleasure are pretty straightforward. I used to enjoy going to see college hockey games for reasons that, I suppose, are strictly MI nonadherent. That's a little joke, there.

David Prescott:

I enjoy listening to music. Unfortunately, Michael Jackson turned to medications, propofol and things like that that ended up being his downfall. So, all human beings seem to be motivated by the same underlying goals, but we all seem to seek them out in dramatically different ways. So, having then suspended judgment, which I think is one of the most important MI skills that there is, suspending judgment, then trying to understand: what were all the goals that were upstream from all of these others? I can't remember her name, but at an MI conference, there was a woman that spoke to this brilliantly by saying, "What is that still small voice within that is sort of underlying all of the other elements that happen in somebody's life?"

David Prescott:

She runs an exercise that goes something like, "Think of anything that you want right now, anything from coffee with some whiskey mixed into it to world peace. And then, ask yourself, if you did have that right now, then, what else in your life would you have?

And, if you had that in your life, then what else would you have?" It's a brilliant, brilliant exercise. I apologize to her for blanking on her name, but she's from the South-Eastern United States. So, the Good Lives Model, I think, taps into this. What are the goals that are upstream? Because, once we know what these goals are and how they've operated in this person's life, then we're better suited to find the humanity. Then, we can enter into partnership and acceptance and compassion.

David Prescott:

And, once we have an idea of what these goals even are in this person's life, we can then go about the business of being evocative and to really be listening for the difference of where they are and where they want to be, in ways big and small that we might be able to evoke and develop skills around. This is why I love the Good Lives Model, because it gives us a kind of repertoire of, "What are these goals?" Now, originally, we tended to think about this in self-determination theory. With Ryan and DC, they talked about competence and connection, that autonomy, which is interesting because, so often, autonomy and connection seem to almost be at odds with one another.

David Prescott:

If you're autonomous, you might not be entirely connected. This means sometimes our goals are in conflict with one another. But, here we had self-determination theory. Sometimes people come to us with extrinsic motivations of criminal justice. But, our job is then to link into the intrinsic motivation that they might have with these three goals. And then, a fellow named Robert Emmons came along with a book, one of my all-time favorite titles, which was The Psychology of Ultimate Concerns. Although it's not a good paraphrase, he basically said, "What's the matter with us that we talk about competence and connection on autonomy, but we haven't talked about meaning and purpose and spirituality? All human beings want to know where they fit into the planet. All human beings have some kind of sense of identity or mission purpose vision that they have. Why aren't we also tapping into that as an intrinsic motivator?"

David Prescott:

And, for some of our clients, some of my clients, anyway, I've found that, very often, they've come to define themself as sexually attracted to children. Sometimes, viewing themselves in shame and in self-hatred, believing that they're nothing more than that, how do we reawaken that drive towards a deeper sense of meaning and purpose? Carl Jung, if I'm remembering correctly, once said, "Before somebody turns 50, their problems are with sex, and, after they turn 50, their problems are with God." Now, that is very reductionistic at best, but you have to admit, he did have something of a point.

David Prescott:

How do we tap into that yearning or what Bill Miller once described; I believe it was at a conference at Fort Wayne, Indiana a few years back where he said, "Sometimes, our goals are like a distant shore that we try to sail towards, never entirely arriving at." Can we reframe some of these issues in the lives of a person who's abused in that way? So,

for me, the motivational… the Good Lives Model and Motivational Interviewing have significant overlap. And, by the way, it's as simple for me as asking this basic scaling questions. On a scale of 0-10, how important is it to you to be independent, to have a real measure of autonomy? On the other hand, under your current circumstances, how confident are you that you can be independent? I understand 3 is not a very high number, but it just amazes me. With everything else that you've got going on, given that you're here with the probation officer that wants to eat your lunch, how come you didn't score yourself as a 0.5 or a 1, etc., to elicit this kind of change talk or meaning and purpose in life and so on and so forth?

David Prescott:

This leads to the inevitable question. I realize I'm not giving you a chance to talk much, but it does lead to the inevitable question of: so, where do you balance serving the various masters of client autonomy and the criminal justice system? I have to say, in real practice, not all of my clients are justice involved at this point, but they are all involved with systems that are beyond all of our control. And, in this moment, I'm trying to be as unattached to the criminal just system as I can be, but I also have to be honest. Let me just say from the outset I do work at the intersection of mental health, if you will, and the criminal justice system. I do, and you should also know that I do stand by the values of: I don't want to see anybody harmed again in the future. So, I do have a value in this regard. But, just as importantly, I'm here to explore where autonomy fits into your future. So, for me, this criticism of MI and criminal justice that I've sometimes heard about is, I think, something that we should think about every single day that we do the work, but really isn't that much of a barrier for me, anyway, long answer to a short question.

Glenn Hinds:

What stands out for me is that idea of suspending your judgment while having an implicit desire to be helpful to someone else almost speaks directly to the spirit of Motivational Interviewing, that everything that you've talked about arises from that place. The upstream understanding of the individual's needs, I think, presents a real opportunity for us whether it is at the extreme level where we're working with a perpetrator of childhood sex abuse or working with someone who maybe drinks too much or maybe somebody who eats too much or somebody who stays out late or somebody who doesn't make their bed. If we go beyond the presentation of the behavior and begin to try to understand; what does doing this give them that they're looking for? And, by trying to understand that, then we can be curious: so, in what other ways could you have those needs met without doing it that way?

David Prescott:

Exactly. And, how do you get these ... number one, how can we help other people get these needs if it's the result of: they have never been able to develop the skills to get them? How do we help them develop their internal capacity to accomplish these goals? How do we help them to manage the external restrictions on achieving these goals? Also, I think, just as importantly is when their goals come into conflict, that sometimes the drive to independence and the drive to connection might come into conflict. Or, it's

as simple with substance use disorders that it might be that the drive towards inner peace and happiness and pleasure come directly into conflict with living and surviving or any other goals that people have.

Glenn Hinds:

Another very important point was that you seemed to describe that no matter what is going on for this individual, it's about recognizing they haven't given up, and it's meeting them in that place. Why is this person's life so bloody dreadful or how dreadful it is for us to look at it and describe it as dreadful? Why haven't they given up? Why are they still here? That opens up a real curiosity as, what's going on in this person's life that makes them want to still be here even under these circumstances? It sounds like that brings us over to strength-based perspective. That can shine a light on what we can be compassionate with and what it is we try to understand from a needs perspective for this individual. And then, how can I help them find that for themselves without necessarily putting themselves or other people in harm's way?

David Prescott:

Yeah, exactly. It always amazes me. I'm just saying this as a human being, not an MI practitioner. Our clients, no matter what our backgrounds, always seem to have survived the most amazing ordeals. It never ceases to amaze me. I keep thinking I would have just waited for the earth to swallow me up, but not my clients. So, yes, the amount of strength that many of our clients present with are amazing.

Sebastian Kaplan:

Before we keep going, Glenn, I just want to make sure: I think we've addressed Maddy's questions, but not explicitly with, "Here are Maddy's questions." Maybe we could touch on that.

Glenn Hinds:

Good point. And, I think you're right. We might have touched on them. But, just to be specific or explicit, again, for Maddy Nicholson, whose Twitter handle is @motivationalmad, which I think is fantastic, the tweet was, "I'm sure you've already got one along these lines, but perhaps something about how David helps balance the needs of the client and the needs of the justice system. I'm interested on his thoughts on how he keeps his righting reflex in check. Looking forward to listening :)" thanks, Maddy.

David Prescott:

Great. Actually, maybe, if I can offer a brief kind of case example: obviously, I sanitize everything that I do when discussing a case, but I keep coming back to the role of community in doing this kind of work. So, I have a contractual obligation to the people that send us their clients, and I always have to remember what is in that person's contract or treatment plan. Or, sometimes, we have something called a behavior development plan, which is developed by a Board Certified behavior analyst. My agencies right now work with a lot of complex systems, and so it points to a certain irony

that, all too often, we talk about strengths-based interventions and Motivational Interviewing and internal motivation to change and all of these kinds of things.

David Prescott:

But, many of us in real life have to work with treatment plans that our clients had absolutely no voice in developing whatsoever. So, as much as we might try to cultivate partnership, acceptance and compassion and evocation and everything that makes the spirit of MI what it is, we then have our contractual obligations. So, what to do, what to do? Then, along comes a client. Now, get ready, here it comes. He says to his clinician who I supervise, "I'm telling you, this three-year-old wanted it. This three-year-old asked for it and she didn't even give me any choice. That's why I did it."

David Prescott:

And, the clinician, in that moment, having been amply trained in Motivational Interviewing by yours truly and being, I think, a very brilliant person, absolutely lost his capacity to speak. The righting reflex is as close to all of us as our jugular veins. So, I forget exactly how he managed the situation, but he said something translated as, "Could we table this discussion for now and come back to it? But, I promise I won't forget." Then, he immediately called me afterwards and said words I will never forget because he's pretty difficult to upset. But, he said in his own way, "David, my client put me in a hole. He really gave me the blues. It was a difficult conversation to have."

David Prescott:

And so, what I ended up doing was going and interviewing this person and realized that he was telling the truth in the only way that he could, that he did not have the skills to say what had actually happened. So, in the old says of working, we might have said he was externalizing blame. In even older times, it might have been, "He was using projection as a defense mechanism." What I was aware of was profound ambivalence that had remained untapped. "On one hand, this is the story that I've been telling. And, on the other hand, I know there's another story and I can't put words to it. On one hand, I really want to tell you. An, on the other hand, I don't know how. On one hand, I want to be honest, and, on the other hand, I'm deadly afraid of how I'm going to experience myself if I do."

David Prescott:

And so, what we came to realize was, in the moment, he perceived himself as unable manage the urges that happened as a three-year-old quite legitimately came over and started playing with him. He was couch surfing. He was staying with her parents. While he was watching TV and they were in another room, she came and jumped on him, and that was more than he could manage at that time. So, we need to slow ourselves down and then listen for the narrative that's there if we're willing to talk with him about it. So, at this point, the way that I'm viewing this was I was the person that came in willing to do Motivational Interviewing, but having read all of the research that I could possibly stand on people who've abused and the processes of abuse. So, I was coming in with all of

this macro knowledge about abuse, and then trying to understand it at the micro level with this client.

David Prescott:

Using MI, the only thing I could do was listen, listen, listen for any window into the ambivalence that this person had, and then be able to use my macro knowledge to influence this micro client, and hopefully use the information that I learned from this particular client to inform the macro knowledge about people who abuse. I hope I'm still speaking English with all of this. The ambivalence is there for the understanding, and I really understood my supervisee feeling overwhelmed in the moment. He interviewed or a respectful stop. I think, at the end of the day, he did exactly the right thing, "We can always reopen this topic." And, frankly, one of the practice skills that I learned the hard way over time is: sometimes when working with people who've seriously caused harm to others, we need to take these conversations slowly lest we open up a great deal of self-hatred and shame and, frankly self-loathing. If we act as though we have all day, the conversations will only take a few minutes. This is another Monty Roberts quote. And, if we act as though we have only a few minutes, it might take all day. Just some thoughts further unpacking a little bit of MI with a difficult case.

Sebastian Kaplan:

I'm just curious about the practicalities of that, I guess. It sounds like one of the things that you're actively doing at the start and throughout these conversations is searching for ambivalence where it may not be readily apparent. So, there's a sense inside you that that's there, that this is a person who is making these statements that seem very clear cut and factual, I guess, from their point of view, but maybe there's an assumption on your part that there is a lack of vocabulary or skill to be able to discuss the other side of the coin. So, what do you actually do, or what are some of the questions that you might ask this person to unpack that or to explore the other side of the ambivalence?

David Prescott:

Sure, well, I might just start with some reflections. Now, in this person's case, it was pretty obvious that he lacked some verbal skills. Sometimes, this kind of presentation is relatively straightforward, but it might just simply look like some kind of reflective listening. "Oh, so, you have, for a long time, viewed yourself as kind of a victim in this process. The system has rolled over you in its search to punish you, okay. And, at the same time, I'm seeing, if I'm understanding the look on your face correctly, I'm seeing some real anguish like maybe there's a little bit more to this. If I'm not mistaken, I'm seeing some pain."

David Prescott:

Okay, a quick pause in this to say you heard me use stems as I'm reflecting this because I did not know what I was doing in that moment with this client. Under other circumstances, I might be a little bit more bold and use the stems and say, "I'm seeing a lot of anguish like there's more to this story. I'm hearing a lot of pain underlying this." And then, I might be able to move into, "On one hand, this behavior existed and you're

not denying it. And, on the other hand, there's a deeper story than most people have been willing to listen to."

David Prescott:

And, on one hand, you feel bad about what you did. And, on the other hand, you don't feel understood. Personally, in my way of doing MI, I use a lot of double-sided reflections, and I even tend to think in terms of double-sided reflections even though I'm in the camp that says there's more than just ambivalence, feeling two ways. My clients are omni valent. As Mary Pipher the author once said, she could feel ambivalent about a paperclip. But, I tend to frame it in a double-sided reflection. "So, there's this greater story. Again, just tell me if I'm wrong, because I most certainly could be, there's a whole story about who you were in all of this and the skills that you did or didn't use within all of this. Again, tell me if I'm wrong, but there's a whole person underneath this, that, in that moment, was trying to be a decent person and ended up doing some things that would haunt you for the rest of your life. And also, that three-year-old, there's a lot of these pieces you're still tossing around and might not fully understand yet."

David Prescott:

I guess it's important to highlight here, and maybe this has something to do with Maddy's question or with the concerns that other people might have, which is there is this question of: at what point does collusion begin to occur or not occur. I've seen some people try to address this with singular reflections, and my way of addressing the collusion is to kind of dance with it a little bit, but always bring it back to, "These ultimately were behaviors that caused harm to somebody else." I'm not going to let that go, but I am going to try to reflect back their own, "I was trying to be innocent at the time," thought.

David Prescott:

So, this is where I think Motivational Interviewing is a skillset that takes a very long time to master. So, I guess I just want to honor that as I use a case example because we should always be thinking in terms of, "We're not going to collude with the abuse process even as we try to understand it." And, to an outsider, it might seem as though, "Wait a minute, in that one reflective statement, weren't you flirting with collusion?" Well, maybe, maybe not, but I'm also going to steer the conversation back into a new direction. I hope that this makes sense or at least that it's being understood in the spirit in which it's intended. And so, this also winds up with, "So, what do you do if you're a probation officer as opposed to a clinician or what have you?" These things are complicated.

Glenn Hinds:

So, in some ways, my willingness to acknowledge what you were thinking or what you were driving towards or what your needs were in itself is not an endorsement on my part. It's an acknowledgement of what it was for you and that the avoidance of the endorsement is where I keep away of the collusive potential of this relationship. So, it's, again, that dance that you describe of being willing to look at, "How can you become the

person that you would like to be while acknowledging how you've been and the harm that that has caused for other people and potentially for yourself, as well, and what do you want to do with that experience in a way that I can be of support to you so that you're less likely to do that to yourself and other people in the future while you strive to become this who-you-could-be?

Glenn Hinds:

And, I image for a lot of people that our conversation today has really stretched their capacity to contain the potential of being helpful. So, it sounds like, in many ways, it's recognizing that the nature of the people you're working with are living and experiencing life on the edge of our society, so it takes a very particular type of practitioner who can go out and meet the individuals at the edge of society and support them out there, and it sounds like that, for me to grow as a practitioner, potentially, I'm trying to grow to the place where I can be helpful to someone out there because it just widens the spectrum of individuals who I can come into contact with and treat them with value and respect and compassion. I imagine that’s mirrored in your own experience with yourself.

David Prescott:

Yeah, yeah, yeah. There's the question about: how does MI affect people? I've found, over time, I've become far more understanding and compassionate, but also much more limited in my confidence that I know that much about the world because there always seems to be so much more. And, in fact, just to add to the case example in your brilliant summary, I have to say the other piece in all of this is that never-ending imposter syndrome that goes along with doing the work, is how do we stand up to our own anxiety that some of us feel?

David Prescott:

And, in the moment when I was interviewing that guy, important to say I was doing this in front of my own supervisee who know I'm a member of the Motivational Interviewing Network of Trainers etc., etc., etc., so there's a part of me that's saying, "Boy, you'd better be getting this right," and I just want to put words to that because I'm not sure that some of that ever entirely goes away. Just the same, if I might offer one little summation of everything that I've read and all of the research, it's that decades of scientific research have shown us that punishing people doesn't get them to change, and that treatment can get them to change. And, with people in criminal justice, very often, they combine good treatment with good supervision.

David Prescott:

Then, that has an additive effect. It helps just a little bit more. But, at the end of the day, with even the most violent people, the safest person who has abused others is stable with their behavior. They're occupied with a job or education. They have supportive people to whom they're accountable, and they have plans for the future, and, therefore, everything to lose by doing it again. I sometimes think of that as the acronym SOAP, stable, occupied, accountable and plan, or, as one person from Australia once said, "How are you going to keep yourself clean? That's right, SOAP."

David Prescott:

I just sort of offer that up as it's one more anchor point or set of anchor points as we go in and we have these difficult conversations with difficult clients. My final response to what you just said, Glenn, is it never ceases to amaze me how difficult the work is that many people using MI actually do. There's a fellow in the Pacific Northwest named Ken who I remember meeting, and I told him what I did for a living, and he then said that he was involved with homeless adolescents trying to get them engaged in safe sex practices. I thought, after that, I will never have much pride about my work again, because there's a guy doing some difficult work, same thing with HIV-infected individuals as we talked about before, etc., etc.

Sebastian Kaplan:

Wow. Well, I feel like we're approaching a need to transition to the end of our talk today. I do also feel the need, though, to go back to this collusion topic. I want to make sure that everyone understands that, and, maybe the word collusion for whom English is a second language or not their primary language, they might not get that or understand what we're getting at, here. But, I also feel like it's one of those concerns that cut across all kinds of clinical populations. So, perhaps just highlight again what you were talking there about collusion and maybe using some other phrases.

David Prescott:

Sure. When I think of collusion, it's a word that's been in the news in the United States a lot. It has different kinds of meanings. I'm using in the sense of, "Am I ending up endorsing views that lead to illegal or harmful behavior? Am I somehow giving permission to believe that abuse is acceptable under some circumstances?" Some extreme versions of that might come from ... well, I've heard it said in group therapy, for example, "Oh, no, I understand exactly what you mean. I've drunk the equivalent of the Atlantic Ocean, and, let me tell you, having sex during alcoholic blackout is a very real thing." Or, "As a matter of fact, I've also met children who can consent to sex," or what have you. Obviously, that's an extreme form of collusion, but it could look like, "Oh, sure, I know exactly what college life can be all about."

David Prescott:

If I'm indicating to this person that there's something about abuse that is acceptable, that could be viewed as endorsing them. American slang word is to cosign as if I was cosigning a loan with them. And, of course, the word that I've always heard clinically is to collude. Or, its noun form is collusion. That's probably the best that I can do, is, "Am I somehow endorsing or siding with them in a way that's losing sight of the fact that abuse is abuse?"

Sebastian Kaplan:

Right, so, rather than, I guess, ignore parts of somebody's story that seem to indicate some rationale for their behavior, you use double-sided reflections a great deal. And, as you described it, dancing with those statements not to ignore them, but to acknowledge that that's part of what this person's thinking is about, or that's part of how they're trying

to make sense of the world. And, you're also reflecting back some of the parts of them either emotionally, nonverbally, or parts of their verbal story that are at odds, perhaps, with some of their behavioral choices.

David Prescott:

Yes.

Sebastian Kaplan:

Right, thank you. So, Glenn, should we start transitioning to the end, here?

Glenn Hinds:

Sure.

Sebastian Kaplan:

As always, we could go on and on and on.

Glenn Hinds:

Yeah, absolutely fantastic.

Sebastian Kaplan:

This is so fascinating.

Glenn Hinds:

Yeah, absolutely, and, what we normally do, David, is offer our guests an opportunity just to take a moment before we finish just to reflect on anything that is of particular interest to them, their curiosity in the world. It doesn't necessarily have to be Motivational Interviewing oriented, but something that you're pondering, something that you're interested in, something you're exploring at the moment that you'd be happy to share with us and we could spend a few minutes talking to you with?

David Prescott:

Sure, I guess it never ceases to amaze me how compassion seems to be in short supply. Perhaps this is a byproduct of reading headlines. I know that the world is filled with wonderful and compassionate people, but I constantly look for more evidence of compassion within the actions of our various governments. Maybe that goes without saying, but sometimes I think we should still say it nonetheless. And, within that, then, within the context of that, I guess the point that I didn't get to make earlier is how often people who have been criminally justice involved or who have struggled terribly with substance use disorders or what have you, my MI practice has been limited in some ways in that I wind up having to be very careful with affirmations.

David Prescott:

How I affirm people, I tend to work it in almost on the sly or a semi-sneaky fashion into my reflective statements and my summaries. I don't get to provide affirmations as much

because when I use affirmations in the way that some people do, I might actually go too far with some of my clients for whom a world-class affirmation as you would see in an MI video would end up coming off as too much or an overdose of affirmation to people who have been taught and who have come to hate their lives and hate their futures and hate themselves in many respects. All too often, my clients have been taught to hate themselves because of the behaviors that they've engaged in. And, as a result, if somebody were to come and score me or to observe my MI practice at work, they might say, "David, why didn't you use more affirmations?" I would have to say, "Well, I used affirmations as far as I could, but I have to use them in very, very, very low doses, because, very often, my clients will simply object or disagree with me," so I have to work them in very slowly.

Glenn Hinds:

So, you're very sensitive to the needs of the people you're working with, and it sounds like that you strive hard to do MI in those situations, but MI in those situations sounds very different from MI in other situations because of the needs of the people you're talking to, and that's what's most important to you, being helpful?

David Prescott:

Yeah, yeah, yeah, exactly, thank you. And, I will get the affirmations in and I will say timing, I think, is everything. "Despite everything else, despite the response that you've gotten from the entire world, you're still willing to talk with me today about having sex with children. That takes a lot of courage, a lot of strength, and really speaks to your commitment to be able to," etc., etc., etc. So, this is something in MI practice that I've thought about a great deal over the years is, "Why don't I get to use affirmations like that other person?"

Glenn Hinds:

It doesn't seem fair, does it?

David Prescott:

Right, exactly.

Sebastian Kaplan:

I imagine it's one of the things you're most careful about just in hearing the affirmation you just offered that the affirmation highlights, I guess, for lack of a better term, the pro social behavior or the non-harming behavior, making sure that that affirmation links with that.

David Prescott:

Yeah, exactly, exactly. Certainly, an affirmation for criminal diversity, for example, would speak for itself.

Sebastian Kaplan:

You were talking about thinking maybe more geopolitical terms as where your thinking is going at this point?

David Prescott:

Well, it's just something that I notice, that human beings can be such wonderful and helpful creatures, and we can come to one another's assistance in the most wonderful amazing ways on one hand. And, on the other hand, when I read the headlines, perhaps it's that compassion doesn't sell. I don't know, but I often think to myself our world leaders don't always use their conversational skills to the best of their abilities. Perhaps they do behind the scenes and I'm not aware of it, but I would love to see a great deal more of MI skills in world discussion. I realize I'm on a touchy subject because there's a real reaction to "How do we use MI on the world stage?", whether the ethics of MI and everything else that others will speak to more articulately than I can. But I guess 35 years of professional practice, 13 years of being a MINTie has influenced me in the direction of: I want to see more compassion in the world around me. And, hopefully as I approach the end stages of my career, I can be helpful in that regard, but I don't know what it looks like, yet.

Glenn Hinds:

What struck me, I was just curious. I wonder what the upstream understanding would show us if we were to listen to world leaders and try and hear what they're really asking for, if they are who we think they are.

David Prescott:

Yes, exactly.

Glenn Hinds:

Behind their public presentation.

David Prescott:

There you go, balancing competence and connection and autonomy.

Glenn Hinds:

Yeah, definitely a conversation for another podcast, perhaps not necessarily for a Motivational Interviewing , but certainly one I would imagine a lot of people would be interested to be part of and have an opinion on. But, as Seb was saying, we do need to close, so, Seb, you just remind people how they can contact us before we finish.

Sebastian Kaplan:

I will. But actually, before that, David, we always ask our guests if audience is ... this stirs up some questions or some ideas that audience members would like to contact our guests directly for, would you be open to that? If so, how do people contact you?

David Prescott:

Please do. My current email address, although I've had it since the mid-1990s, is VT as in Vermont, prescott@earthlink.net. And then, if you don't mind a little bit of very, very inappropriate humor, if you simply Google search my name David Prescott plus the term sex offender, I will probably be your first 100 hits. I also have a website, which is www.davidprescott.net. I would never name a website after myself, but I'm married to the web designer, and she thought it was a thing to do.

Sebastian Kaplan:

Good choice. Good choice, David.

Glenn Hinds:

It's important to say that the Prescott has two Ts?

David Prescott:

Prescott has two Ts at the end, yes.

Glenn Hinds:

Okay, great.

Sebastian Kaplan:

Excellent.

David Prescott:

Very good.

Sebastian Kaplan:

Okay, well, right, so, again, reminders about ways to contact us ... and, again, we welcome reviews, ratings, questions, comments. TalkingToChange is the Facebook page, @ChangeTalking is the Twitter handle, and you can contact us directly via email with podcast@glennhinds.com. Well, David, thank you so much for this really, really interesting conversation. We really enjoy it, and we hope our listeners do, as well, so thank you so much.

David Prescott:

Thank you very much and keep up the great work with an excellent podcast. It was great to listen to it.

Glenn Hinds:

Thanks, David.

David Prescott:

All right.

Glenn Hinds:
Take care, Seb.

Sebastian Kaplan:
Okay, Glenn, until next time.

Glenn Hinds:
Cheers, man. Bye, everybody.

Sebastian Kaplan:
Bye.