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Self-Determination Theory and Motivational Interviewing: Complementary Models to Elicit Voluntary Engagement by Partner-Abusive Men

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Abstract

Research examining intimate partner violence (IPV) has lacked a comprehensive theoretical framework for understanding and treating behavior. The authors propose two complementary models, a treatment approach (Motivational Interviewing, MI) informed by a theory (Self-Determination Theory; SDT), as a way of integrating existing knowledge and suggesting new directions in intervening early with IPV perpetrators. MI is a client-centered clinical intervention intended to assist in strengthening motivation to change and has been widely implemented in the substance abuse literature. SDT is a theory that focuses on internal versus external motivation and considers elements that impact optimal functioning and psychological well-being. These elements include psychological needs, integration of behavioral regulations, and contextual influences on motivation. Each of these aspects of SDT is described in detail and in the context of IPV etiology and intervention using motivational interviewing.

Intimate partner violence (IPV) is a serious and continuing problem in our society. Estimates from the National Violence Against Women Survey (NVAWS) that included over 8,000 American women 18 years of age or older indicated that approximately 1.3 million American women are physically assaulted by an intimate partner each year (Tjaden & Thoennes, 2000). The prevalence of intimate partner violence (IPV), the severity of adverse consequences experienced by its victims, an over-reliance on mandated treatment through the criminal justice system to interrupt ongoing IPV, the modest outcomes of treatment programs for partner abusers, and the relatively high attrition rates from these programs all converge to require that high priority be given to intervention research in this field.

The purpose of this article is to consider the potential contributions of two complementary models, a treatment approach (Motivational Interviewing) informed by a theory (Self-Determination Theory), applied to the understanding and treatment of domestic violence perpetration. Parallel treatment approaches in the substance abuse field suggest that an intervention that increases voluntary treatment enrollment by individuals who are motivated to stop the violence may also increase treatment compliance (Carey, Maisto, Kalichman, Forsythe, Wright, & Johnson, 1997), reduce attrition (Lincourt, Kuettel, & Bombardier, 2002), and enhance rates of successful outcomes (Daniels & Murphy, 1997).

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The article begins with a review of risk factors for engaging in intimate partner violence behavior and intervention models constructed to modify one or more risk factors to prevent continuing IPV. This section concludes with a discussion of a set of hypothesized principles derived from the IPV treatment outcome literature (Murphy & Eckhardt, 2005) that suggest the potential usefulness of Self-Determination Theory and Motivational Interviewing as foundational elements for an innovative IPV intervention.

RISK FACTORS AND INTERVENTION MODELS FOR IPV

Elevated risk for engaging in partner abusive behavior is associated with lower socioeconomic status and younger age (Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001), and having experienced childhood in a home where partner abuse occurred (Delsol & Margolin, 2004; Schumacher et al., 2001). Examples of risk factors of a cognitive nature include attitudes and beliefs that support abusive behavior and attributions to the spouse of intentional actions that justify the abusive behavior. Emotional risk factor examples include disturbances in anger, hostility, depression, self-esteem, dependency, and attachment. Among personality disorder risk factors are antisocial, borderline, narcissistic, and aggressive-sadistic disturbances. Other risk factors include substance abuse, relationship distress (e.g., mutuality in abusive interaction initiation), and behavioral skills deficits (e.g., low assertiveness, low competence).

At the core of feminist approaches to interventions with partner abusers is education intended to increase the abuser's knowledge of gender oppression. The emphasis is on changing attitudes and beliefs that support male dominance and privilege and justify abusive behaviors. Social learning approaches, while acknowledging the effects of socialization that supports partner abuse, focus on aggressive and controlling behaviors as learned, systematic distortions in the abuser's processing of information in partner interactions, and behavioral skills deficits. Important elements of treatment include cognitive restructuring, training in behavioral skills, and strengthening the client's emotional regulation capacity.

Approaches based on psychopathology see IPV as resulting from personality dysfunction derived from unresolved trauma. Interventions based on this perspective, with both psychodynamic and behavioral (e.g., dialectical behavior therapy) models having been developed, focus on treating attachment insecurity, borderline personality features, and other psychological problems (e.g., bipolar and other mood disorders, antisocial and narcissistic personality). Finally, treatment of the relationship system is based on a history of coercive interactions. These approaches focus on the dyadic interaction and involve joint treatment in which skills training (e.g., listening, emotional expression, negotiation) and cognitive restructuring are core elements.

As is evident from this brief review, each category of IPV treatment is responsive to one or more empirically identified risk factors. Despite their varying emphases, however, successful outcomes with reference to physical and emotional abuse have not been demonstrated to be more likely with any particular intervention (Babcock, Green, & Robie, 2004; Murphy & Eckhardt, 2005). An over-reliance on coerced treatment is a clear limitation of the current system of services to partner-abusive individuals. However, as is discussed in the following section, the intervention literature points toward promising directions in identifying principles for future intervention trials.

HYPOTHESES FOR ENHANCED IPV TREATMENT EFFECTIVENESS

Based on their review of treatment outcome trials with partner abusers, Murphy and Eckhardt (2005) hypothesize that five principles are likely to underlie effective interventions with this population: (1) a “strengths-based” emphasis on developing enhanced skills and

relationship behaviors; (2) training and practice in problem-solving, negotiation, listening, and non-abusive expression of feelings; (3) avoiding eliciting shame or defensiveness in clients; (4) promoting a collaborative working alliance between client and therapist; and (5) emphasizing a client-directed change process that includes active involvement in goal and agenda setting. As will be noted in what follows, a MI intervention tailored for the partner abuser and based on Self-Determination Theory fits well with these hypotheses.

OVERVIEW OF SELF-DETERMINATION THEORY

Self-Determination Theory (SDT; Deci & Ryan, 1985b, 2000; Ryan & Deci, 2000) is a broad theory of human motivation that has been evaluated extensively in the social, personality, and motivational psychology fields. It has been evaluated less extensively in clinical settings despite its clear implications for treatment and the fact that it was conceived by clinical psychologists. SDT is derived from a humanistic perspective of individuals and assumes that people naturally seek out opportunities for personal growth, expressing competence, participating in meaningful interpersonal relationships, and acting autonomously. The quality of interactions with the environment and important others influence the extent to which individuals are able to progress toward greater self-determination. Formally, SDT consists of several interrelated mini-theories regarding basic psychological needs, internalization of behavioral regulations, and environmental influences on individual differences in self-determination. SDT is complementary to the main elements of Motivational Interviewing treatment approaches (MI; Miller & Rollnick, 2002).

OVERVIEW OF MOTIVATIONAL INTERVIEWING

Motivational Interviewing is a client-centered, directive method of communication that is designed to resolve ambivalence and increase motivation to change. MI (Miller & Rollnick, 2002) can be described as a counseling style that consists of expressing empathy and reflecting on client statements with the goal of helping clients resolve ambivalence about changing their behaviors. Ambivalence is viewed as a natural element of the change process and the therapist's role is to help clients resolve their ambivalence by expressing empathy for the client and exploring discrepancies among the client's values, goals, and behaviors. Resistance is seen as an indicator for the therapist to listen to the client rather than confront him or her. Therapists provide an atmosphere of respect and acceptance with the goal of eliciting statements from the client that express confidence and desire to change. Originally developed in the alcohol field, this treatment approach has been successfully applied to a plethora of problem behaviors. In addition, this approach has been described in function as a clinical application of self-determination theory (Markland, Ryan, Tobin, & Rollnick, 2005; Vansteenkiste & Sheldon, 2006).

INTEGRATING SELF-DETERMINATION THEORY AND MOTIVATIONAL INTERVIEWING

The principles and practices of MI overlap considerably with the premises of SDT and a number of connections between the two are elaborated here. Each of the mini-theories that comprise SDT are considered in the etiology and treatment of IPV perpetrators and the use of MI.

Psychological Needs

One of the mini-theories that makes up SDT is the proposal that all people have three basic and fundamental psychological needs that when fulfilled, provide an impetus for behavior change, optimal functioning, and personal growth. When needs are met, the environment for behavior change is optimal for personal growth. The three basic needs include the need for

competence, autonomy and relatedness (Deci & Ryan, 2000; Ryan & Deci, 2000; Ryan, 1995). Empirical evidence has demonstrated that experiences which support these needs are more consistently associated with life satisfaction across cultures (Deci, Ryan, Gagne, Leone, Usunov, & Kornazheva, 2001). Research has also shown that daily well being is consistently associated with variation in daily satisfaction of these basic needs (Reis, Sheldon, Gable, Roscoe, & Ryan, 2000). SDT's perspective on psychological needs also has direct implications for treatment. Markland et al. (2005) propose that each of the three basic needs are supported by the structure and principles of MI, described in more detail in the following sections.

The need for *competence* asserts that people look for challenges in their environment to increase skill development and assist in personal growth. When people don't feel competent or there are few opportunities to be successful in their surroundings, the result is likely to be low self-efficacy or hopelessness about change. Low competence is also associated with poor treatment outcomes. Aspects of IPV perpetration can be seen as an ineffective means of attempting to satisfy these basic needs. From the perspective of an IPV perpetrator, successful control of one's relationship may demonstrate competence as well as autonomy.

The need for competence is consistent with the MI principle of supporting self-efficacy. Clinicians can assist in fulfilling the need for competence by providing tasks in treatment that are challenging, but achievable. Similarly, clinicians can help patients identify changes that have been made in the past successfully. Some questions that might elicit past successes include “Tell me about a time in the past where you faced a challenge and overcame it”, or “Have you ever tried to change something in your life and succeeded? It could be something like starting an exercise program, eating less, or not swearing?” In addition to supporting self-efficacy, competence can be facilitated by therapists when they help IPV perpetrators develop appropriate goals and provide positive feedback for progress toward behavior change (Markland et al., 2005).

SDT also proposes that people have a need for *autonomy*. People thrive when they feel like their choices and decisions are their own, rather than imposed from an outside force. IPV perpetrators’ insistence on control over one's environment and one's partner more specifically, can be seen as a maladaptive strategy for fulfilling the need for autonomy. The need for autonomy is a key concept when working with IPV perpetrators, the majority of whom are mandated into treatment by the legal system (see Gondolf, 2004) and may feel forced into service programs. There are opportunities to emphasize options and choice even when working with mandated populations or individuals who are “forced” into treatment by ultimatums from loved ones. Again, in thinking about the application of the need for autonomy to treatment of IPV perpetrators, it is helpful to consider the connection between SDT and MI.

Supporting individuals’ autonomy is a main principle in MI. Within MI, counselors avoid telling clients what they “ought to do” or providing a lot of unsolicited advice. Instead, the client is informed that they are the best ones to make personal decisions about their life and that the counselor is there to provide information and support to help them make a decision about whether change is possible and right for them. Supporting autonomy is also achieved by eliciting from the client their own reasons and desires for change. When clients are able to identify ways in which they could personally benefit from the treatment experience, they can experience more choices in their decision and treatment. Autonomy is also supported by a client-centered approach to treatment that avoids confrontation. Clinicians avoid imposing their own views or reasons for changing onto the client. Highly confrontational treatment approaches can lead perpetrators to resist against the counselor and the change process. Even in the absence of apparent choices, as when IPV perpetrators are mandated to receive

treatment, therapists can still support autonomy by emphasizing the choices the client does still have, such as which program facility to attend.

Lastly, SDT proposes a need for *relatedness*. People naturally are drawn to form close social relationships that are caring, supportive and respectful. Relatedness needs are ideally met by forming and maintaining healthy relationships. Among IPV perpetrators, maladaptive strategies for satisfying relatedness needs may manifest themselves in efforts to maintain relationships by force and coercion. Relationships in which their feelings, beliefs, and thoughts are valued can promote optimal behavior. For example, if a man is encouraged to seek domestic violence treatment by a long-time close friend who has demonstrated unconditional acceptance and warmth throughout their friendship, his ability to take in such feedback and act on it will be enhanced. Such close relationships should occur in the natural environment as well as in the therapeutic one.

Assessing social relationships to identify people who can support the client in behavior change is important. Similarly, if the counselor is experienced by the client as caring and accepting of the client as a person, their relationship can strengthen the likelihood that the client can open himself up to change. The MI principle of empathy directly relates to fulfilling SDT's relatedness need (Markland et al., 2005). MI counselors are genuinely interested in understanding the client's perspective and do this through careful reflective listening. Counselors also avoid taking on the “expert” role with the client and subsequently giving the message that the counselor “knows best” what path the client should pursue. Instead, the client is viewed as the expert on himself and his thoughts, feelings, and experiences are respected. When clients feel genuinely respected and heard by a counselor, the abusive behavior may be examined in an honest way and desires for change can be discussed.

Other techniques emphasized in MI that can nurture the client's need for relatedness include exploration of client's concerns, avoidance of blame and judgment, and the use of affirmations (Markland et al., 2005). The counselor actively notices and verbally acknowledges the strengths and inner qualities of the client. Affirmations are provided only when the counselor can do so authentically. The expectation that the counselor will find and affirm positive attributes in the client can set a positive tone for the therapeutic environment. Clients who feel they are genuinely appreciated can feel more comfortable in talking about taboo and shame-ridden topics associated with domestic violence. Effective affirmations are those that are specific and relate to intrinsic qualities of the client. Highlighting a desire to be a good dad or the care in their voice that's expressed when they talk about their children are examples of high level affirmations. Expressing appreciation for sharing sensitive information with the counselor or thanking a client for attending the session are also examples of affirmations.

ORGANISMIC INTEGRATION

A second mini-theory that is part of SDT focuses on the notion that interactions with one's environment go hand in hand with the refinement and internalization of behavioral regulations, explained below (Deci & Ryan, 1985b, 2000). External demands from the environment gradually become internalized, so that behaviors which are initially a direct result of external forces over time become internalized and integrated with one's value system. For example, an individual attempting to reduce his violent behavior may initially do so only to avoid incarceration or divorce. Over time, responding to one's partner in a non-abusive way may become more intrinsically motivated as a part of one's personal growth and values.

Consideration of integration of behavioral regulations has direct implications for how we think about how IPV perpetrators get to treatment and how successful treatment completers integrate changes in their behavior. As stated earlier, the great majority of IPV perpetrators currently enter treatment programs through court referral (Gondolf, 2002, 2004). Few enter treatment without some form of external coercion. Thus, attendance and involvement in treatment for most perpetrators is, at least initially, externally motivated. SDT suggests that better outcomes are likely to result when clients shift their reasons for attending treatment internally. Practical suggestions for facilitating internalization and integration of treatment involvement include acknowledging a client's choice in attending and helping them identify more intrinsic benefits for treatment involvement (e.g., personal growth, alleviating guilt).

The mini-theory of organismic integration also has direct implications for treatment itself. The ultimate goal early in treatment is to strengthen a perpetrator's sense of integrated motivation. A client may enter treatment because it was mandated due to a domestic abuse arrest, but he may become engaged in treatment by actively participating because he values his wife and their relationship and wants to treat her in a loving and respectful way. Early in treatment therapists can work to evoke from clients their own reasons for treatment compliance. The use of open-ended questions can work to stimulate thoughts from the client on this. Some questions designed to develop a sense of integrated motivation include: “How might you personally benefit from treatment?” “How does changing the way you interact with your partner fit in with your value of having a healthy family?” “In what ways might coming to treatment help you meet your future goal of being in a loving and mutually respected relationship?” “How can being here affect your ability as a dad?” All of these questions also highlight a main MI principle of eliciting change talk. MI asserts that assisting a client in clarifying and verbalizing how behavior change can personally benefit them or is consistent with their values or ideals will heighten the desire for change and evoke self-ownership over the process rather than obligation, defensiveness or resistance. Encouraging change talk has also been described as a way of supporting autonomy (Markland et al., 2005).

ENVIRONMENTAL INFLUENCES AND INDIVIDUAL DIFFERENCES

SDT includes two additional mini-theories—cognitive evaluation theory and causality orientations theory (Ryan & Deci, 2002). These theories focus on how aspects of the environment (e.g., coercive versus autonomy supporting) affect attributions of behavior and which in turn become internalized and manifest as individual differences in motivational orientations (i.e., being generally autonomous or controlled). An extensive body of literature supports the general conclusion that environments and contexts that facilitate need fulfillment are associated with better outcomes. The majority of studies in this literature demonstrate adverse consequences of environmental factors and contexts that are experienced as controlling, including reduced competence, persistence, creativity, and intrinsic motivation when emphasizing contingencies through the use of rewards (for meta-analysis see Deci, Koestner, & Ryan, 1999), threats and deadlines (Amabile, DeJong, & Lepper, 1976), surveillance (Plant & Ryan, 1985a) and evaluation (Ryan, 1982).

Anecdotal evidence suggests that homes in which IPV perpetration takes place function as controlling environments. Moreover, control, coercion, force, and lack of choice are in some ways defining characteristics of IPV perpetration. In the SDT literature, repeated and chronic exposure to controlling environments has been proposed to contribute to the development of a motivational orientation that is centered in control (Deci & Ryan, 1985a). In turn, individuals who develop a more controlled orientation are higher on a number of traits associated with aggression (e.g., Type-A coronary prone behavior pattern, external locus of control, hostility, and negativity) (Deci & Ryan, 1985a), emotional reactivity

(Koestner & Losier, 1996), and displaying more aggression when driving (Neighbors, Vietor, & Knee, 2002). Extrapolation of this perspective to IPV perpetration potentially provides a piece of the puzzle in understanding why children of IPV perpetrators often grow up to be perpetrators themselves.

The notion that controlling factors in the environment influence attributions for behavior also has implications for how IPV perpetrators think about treatment. Perpetrators who are forced into treatment are, at least initially, likely to attribute their attendance in treatment to external factors rather than an intrinsic desire to change. In contrast, a fair amount of empirical research has also demonstrated that contexts that facilitate choice and support autonomy are associated with positive outcomes. Autonomy supportive contexts include those which provide more choices, competence promoting information, acknowledgment of one's feelings and options, challenging but achievable goals and meaningful explanations for requested behavior (Gagne, 2003; Williams, Deci, & Ryan, 1998). Positive outcomes associated with autonomy supportive contexts include more positive affect, persistence, perceived competence, performance, intrinsic motivation, and improved outcomes (Deci & Ryan, 1985a, 2000).

SDT would suggest that treatment of IPV be as autonomy supportive a context as is possible. Even in the presence of an extrinsic reason for entering treatment, therapists can provide an autonomy supportive context through the use of MI, which emphasizes autonomy and tends to avoid controlling and authoritarian language.

IMPLICATIONS FOR WORKING WITH IPV PERPETRATORS

In sum, we believe that SDT can provide an integrative theoretical perspective with practical implications for working with IPV perpetrators using Motivational Interviewing skills. SDT's focus on psychological needs provides a novel context for thinking about how and why perpetrators engage in abusive behaviors and why these behaviors often center around issues related to control. SDT also has implications for thinking about the initiation of treatment, which is often mandated and proposes that a primary goal of treatment would be to help clients shift their reasons for treatment engagement from external (e.g., “the court is forcing me to be here”) to attributions that are internalized and integrated (e.g., “I want to improve my relationship and grow as a person”). Furthermore, SDT provides a strong theoretical rationale for using MI as a strategy for treatment and stresses the importance of supporting clients’ competence, autonomy, and relatedness needs by supporting self-efficacy, emphasizing choice, and providing empathy.

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