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WHEN CONFRONTATION WAS CHALLENGED

Cast your mind back to the '80s and before when confrontation was not just a widely accepted way to treat addictions but *de rigueur* in many services, battering down the defences of patients until they admitted they were hopeless junkies or alcoholics with no option but to submit to whatever treatment was prescribed including humiliation and denigration. In the words quoted by Bill Miller in 1993, "A good counselor needed a loud voice and an arsenal of four-letter words".

His study (study 1) published in 1993 more than any other challenged these assumptions and paved the way for modern more empathic approaches. It was one of the first trials of motivational interviewing, developed by Bill Miller and Stephen Rollnick as a counselling style which would avoid resistance-provoking confrontation and instead 'non-directively' stimulate and take advantage of the client's own ambivalence in order to bolster motivation to change. These first trials were all conducted by Miller's research team based at Albuquerque in New Mexico, where they had the unique benefits of his expert tuition and oversight.

Initial trial

Before this study the approach had had been tested (study 2) as a standalone brief intervention combined with the Drinker's Check-up, a two-hour battery of tests of alcohol use and related physical and social problems. Heavy drinkers responded to ads offering the check-up, followed a week later by a single session feeding back the results in a motivational interviewing style. Two-thirds had their check-ups without delay while a randomly selected third had to wait six weeks. Over this period there seemed no change in their drinking, while in the six weeks following feedback alcohol consumption fell by 27%, a reduction sustained for at least 18 months. However, about two-thirds were still drinking heavily and experiencing alcohol-related problems. During this time a third of the sample had sought further help when few had done so before.

These outcomes suggested that motivational feedback was often insufficient in itself, but could serve as a useful motivator of change and treatment entry in this type of population – drinkers a long way from seeing themselves as alcoholics (most saw themselves as 'social drinkers') but concerned enough to respond to the offer of a check-up. After years of alcohol problems, it seemed the offer of a 'check-up' had enabled them to take a first step towards seeking help without violating their self-image as non-alcoholics.

Empathy beats confrontation

The next study (study 1) was similar, except that feedback was provided in one of two styles. One was the empathic motivational interviewing style, the other the supposedly counterproductive style this aimed to improve on: explicitly directive, confronting client resistance, arguing when they minimised their problems, and (when the cap fitted) telling them they were alcoholics. Again, feedback was followed by substantial reductions in drinking not seen in those who had to wait six weeks.

As expected, giving feedback in the empathic style did result in greater reductions in drinking, but the effects were small and failed to reach conventional levels of statistical significance. One reason may have been that, though they did differ in the intended ways, analysis of audiotaped sessions revealed considerable overlap between the two styles, which were delivered by the same therapists. For example, confrontation was practically absent in the motivational style and noticeable in the directive, yet even there it was rare. Conversely, though there was more 'restructuring' in the motivational sessions, this core technique was rarely deployed compared to simple listening or 'teaching', responses not characteristic of motivational interviewing.

Only when the researchers focused on how therapists and clients had *actually* behaved did significant findings emerge. The more the therapist had confronted (arguing, showing disbelief, being negative about the client), the more the client drank a year later. The same was true of 'resistant' client behaviours like interrupting the therapist, arguing, avoiding therapeutic interactions, or being negative about their need to change or prospects for changing. These relationships *were* very strong and highly statistically significant.

During sessions these behaviours seemed to feed off each other resulting in them being highly correlated. In general, client resistance behaviours were strongly correlated with therapist confrontational responses, while positive, self-motivational client responses were related to therapist listening and restructuring.

Impact and implications

Despite their strength, what the relationships between actual client and therapist behaviour and later drinking meant was unclear, because there was no way to pin down what was cause and what effect. For motivational interviewing, the favoured interpretation is that when therapists confronted, clients were provoked in to hitting back or withdrawing, rare but powerfully counterproductive interactions. In this scenario, by adopting motivational interviewing's non-confrontational style, therapists would avoid provocation and improve outcomes.

But the causal chain *could* have been the other way round: perhaps clients who were always going to resist change argued and interrupted more, provoking therapists to argue back. We know this can happen from a British study (study 3) which used actors to mimic either highly resistant smokers angry about being referred for counselling, or more contrite ones keen to reverse a relapse. The former provoked counsellors into non-motivational-style responses including unilateral agenda-setting, confrontation, and closed-end questions, all related to poorer outcomes with this kind of resistant patient.

Whether the Albuquerque therapists were also provoked by resistant clients is unclear. Arguing against is the fact that therapist and client behaviours *were* changed by the assigned therapist style – they were not simply determined by whether the client was difficult to begin with. From the client, the motivational style elicited twice as many statements acknowledging their problems and fewer resistant behaviour such as arguing, interrupting and introducing irrelevant topics. And though not possible in this study, some key studies of the impact of therapist behaviours have been able to eliminate the possibility that they were simply reacting to the clients (1 2 3 4).

Conceivably, a combination of both processes – therapist influencing client and the reverse – explained the results in Albuquerque. Whatever the truth, probably more than any other, this study heightened the profile of the therapist's interpersonal style in substance misuse research, seeming to confirm that the style mandated by motivational interviewing was preferable to confrontation.

Not a silver bullet

This account was adapted from a Findings review (study 4) which also established that the way motivational interviewing was done in these early days – without a manual to constrain therapist discretion – remains the best way to do it, and that the approach is not always the safe, 'At least it can't hurt' option it once seemed, at least not in too inflexible a format or done without due sensitivity; sometimes for some people, the old-style straightforwardly directive approach does work better.

We also know (study 5) that while therapies based on motivational interviewing are better than doing nothing, across the most rigorous studies they seem no more effective than usual/other treatments for problem drinkers and drugtakers. However, they have

two great advantages: first they can be relatively brief, saving time and money; secondly, as a standalone approach or a treatment style/component, they are broadly acceptable and applicable to people seeking or not seeking treatment and across the severity range, the reason why they have been the mainstay of attempts to broaden intervention to non-dependent problem drinkers and drugtakers.

MAJOR SOURCE STUDIES **Click blue titles to download the Findings analysis or access original documents**

1 Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*: 1993, 61, p. 455–461.

2 Motivational interviewing with problem drinkers: II. The Drinker's Check-up as a preventive intervention. *Behavioural Psychotherapy*: 1988, 16, p. 251–268.

3 When smokers are resistant to change: experimental analysis of the effect of patient resistance on practitioner behaviour. *Addiction*: 2005, 100(8), p. 1175–1182.

4 The motivational hello. *Drug and Alcohol Findings*: 2005, 13, p. 23–30.

5 Motivational interviewing for substance abuse. Strang J., Manning V., Mayet S. *et al*. *Cochrane Database of Systematic Reviews*: 20011, 103(10), 5, Art.No.:CD008063.