My way or yours?

How directive the therapist is in the face of client resistance is emerging as one of the strongest and most consistent influences on the outcomes of therapy. There is no one right answer – it all depends on the client, in particular on how much they perceive and react against threats to their autonomy.

by Mike Ashton *of* FINDINGS

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HOW DO YOU FEEL when a companion takes the lead, leaving you no option but to tag along or object? Maybe not bothered, perhaps even relieved that someone else is taking the decisions when you lack confidence, energy or impetus. If they are the guide on this excursion, you might simply expect it. Or maybe you react against it – this is your trip too, and even if they are the guide, their role is to lead to where *you* want to go. You might be annoyed enough to subvert their plans, insist on another direction, or just decide against continuing the journey in tandem.

What if instead your companion answers every question about where you should be going with, 'What do you think?' – a welcome acknowledgement of your autonomy, or maddening buckpassing? It may help ensure things stay on track, or be a recipe for stagnation if you really don't have much idea where to go or how to get there.

Common and difficult enough in everyday life, during therapy such relationship issues are writ large, leading to correspondingly substantial consequences. This happens partly because *as a matter of design*, some therapeutic philosophies consistently demand conformity to a set world view and a way of tackling addiction, while others just as doggedly insist that the therapist takes a back seat and stays there. Both attitudes preclude the adjustments which could avoid counter-productive interactions.

As in life outside the consulting room, neither back seat nor driving seat is invariably the preferred position – it all depends. Any given mixture of taking versus ceding the lead will be right for some companions at some times, wrong for others. Get it right, and the client wants to stay (retention) and joins with you in progressing to a mutually desired destination (outcomes); get it wrong, and they find more amenable companions, abandon the journey, or even go in the opposite direction.

Generally termed 'directiveness', across a variety of psychological complaints and psychotherapeutic approaches, this dimension of the therapist's interpersonal style is an important determinant of how clients react. One recent review found that in 16 out of 20 studies where this was investigated, outcomes improved when therapist directiveness matched the degree to which clients tended to 'resist orders'.[1] Highly resistant clients benefited more from self-control methods which left them in charge and from minimal therapist directiveness, while clients with low resistance benefited more from therapist directiveness and explicit guidance.

The exceptions to this rule were the few studies in which the tendency of highly 'reactive' clients to ricochet against direction was exploited not by being *non*-directive, but by directing them in the *wrong* direction, encouraging a continuation of their problems.[i] Setting these studies to one side (none concerned substance misuse treatment), the resistance–directiveness match is unusually consistent – if one is high, the other should be low.

The same pattern is now clearly emerging in addiction therapy. FINDINGS readers will already have come across it in the context of our review of motivational interviewing, but the principles extend to other major therapeutic approaches. This review pulls together the relevant data and asks how far it can guide therapists about when to set the agenda, and when to leave this to the client.

Inescapably, this is a complex issue because human interactions are themselves complex. Simplification is bound to lead to errors, and has demonstrably done so in studies where one-size-fits-all interventions have failed clients who actually do *not* fit. To help get a grip on the data, it is essential first to clarify the concepts involved, for which readers are referred to the panel *Directiveness and resistance* on page 25.

Pre-structured motivational induction; helps the unsure, confuses the committed

Readers who've followed the *Manners Matter* series will already appreciate the risks of over-directive therapy, one theme in our analysis of an initial motivational interview as an induction intended to promote engagement with treatment or aftercare ▸ *The motivational hallo*, issue 13.[2]

The relevant findings came from four studies during which motivational therapists, mandated by a manual and held to it by supervision, directed their clients to address certain issues in a predetermined sequence and at more or less predetermined stages of therapy.[3 4 5 6 7] Paradoxically, this tightly controlled structure was intended to ensure that therapists remained *non*-directive about what the client should think and do about their substance use. Indeed, clients were led to reconsider decisions and judge-

ments they may already have made, even if these promoted recovery.

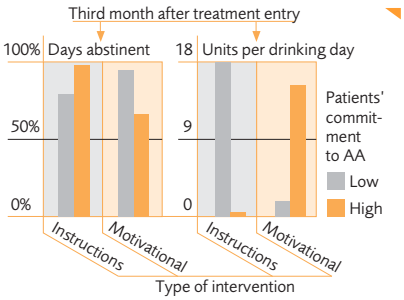
All the studies assessed (though in different ways) how ready clients were to tackle their drug problems and found that this influenced how they reacted. Across all four, if we can read the 'unready' clients as being 'resistant', what we have is resistant clients reacting well when this type of intervention non-directively accepts and explores their ambivalence about their drug use, badly when interventions directively constrict how this should be seen and tackled. Conversely, the more ready, presumably non-resistant clients, reacted badly to opening up the options and did better when left to more directive normal or alternative procedures.

'JUST DO IT' OR 'LET'S THINK AGAIN'?

One of the studies was particularly instructive, because it directly contrasted motivational interviewing with an intervention not only highly directive in structure, but also in content.[5]

The alcohol-dependent patients were undergoing inpatient detoxification in a unit whose programme featured daily AA meetings. Additionally, they were randomly allocated to one of two interventions aimed at encouraging engagement in aftercare and continued sobriety. The first was simple – explicit, abrupt instructions to abstain and join AA – the second, a motivational interview which invited patients to weigh the pros and cons of drinking and of AA or other approaches. Abstinence and AA engagement remained the aim, but the interview opened up other options and left the conclusions to be drawn by the client.

To judge by their later drinking, those eager and ready for AA found that the more abrupt intervention matched and maybe reinforced their commitment, while the 'Let's think again about this' approach was an undermining step backward. But for others – in the context of the unit's programme, the 'resistant' clients less committed to AA – instructions to abstain and join AA seem to have pushed them down a route they were not ready to take, prematurely closing off other options. In any event, they drank far more after this short intervention than after the motivational approach. The effects were visible both in terms of days abstinent and the amount drunk on each drinking day *chart*.



Instructed to join AA, patients already committed to that course were virtually abstinent after detoxification. Ambivalent patients benefited more from a less directive, motivational intervention.

Within this nutshell of a study, an approach which comprehensively contravened motivational interviewing's core principles nevertheless worked better for some clients, whilst its more modern, science-based tactics backfired. They key was how resistant/committed the clients were to the 12-step-based detoxification and aftercare

CONTRAVENING MOTIVATIONAL INTERVIEWING'S CORE PRINCIPLES WORKED BETTER FOR SOME CLIENTS regime on which the interventions were superimposed. If they were at least somewhat unsure or resistant, a motivational interview which acknowledged and explored their ambivalence helped sustain their sobriety. If they were pretty well fully committed, a more directive approach consonant with this commitment worked best.

CORNERED CLIENTS STRIKE BACK

Another of the studies, this time of drug users entering treatment, illustrated that while directively addressing set topics may be fine, there can still be resistance when the client is implicitly directed to reach predetermined conclusions on those topics.[6,7]

The therapists' agenda included getting the client to weigh the pros and cons of their substance use based on feedback from a prior assessment, then to formulate a plan to change this, and finally to anticipate and prepare for potentially derailing influences.

For the more 'ready' clients, it worked fine. The problem was with 'resistant' clients who did not see their former drug use as all bad. It cropped up first when they were landed with what in the event was almost uniformly negative assessment feedback. Linguistic analysis revealed the classic counter-reaction *against* curbing their substance use. Counter-productive reactions also occurred when later they were prematurely asked to commit to change and then to defend their change plan, seemingly before its motivational underpinnings had been secured. In each case, the effect was to weaken their commitment to curtailing drug use, followed by the predictable outcomes in terms of actual drug use.

Inside Project MATCH: anger, reaction and confrontation

Despite the interventions being merely brief preludes to more extended treatment, in the four studies reviewed so far, the impact of (mis)matching directiveness to resistance emerged strongly. What of studies in which the entire treatment adopted a more or less directive stance?

Because it involved a version of motivational interviewing, closest to the studies reviewed so far is the multi-million dollar US Project MATCH study of alcohol dependent patients. It compared motivational enhancement therapy to two therapies which more explicitly imposed a set programme and a set view of addiction.[8] One was 12-step facilitation, an approach based on the disease model of alcoholism and on AA tenets; the other was cognitive-behavioural therapy, which sees addiction as a learnt behaviour and aims to develop new learning in the form of skills and strategies to maintain sobriety.

One of the clearest findings was that patients prone to react angrily did best in motivational therapy, at least in the 'outpatient' arm of the study where the MATCH therapies were the primary treatments.[9,10] They drank on fewer days and less on each of those days than after the other therapies, an effect which remained strongly significant even three years later. This much was expected; deflecting anger and resentment is supposed to be motivational interviewing's

GOLDEN BULLETS Key points and practice implications

- Non-directive styles generally suit clients characterised by anger or resistance; directive approaches profit clients who welcome a lead.
- The ability to assess which style is likely to work best, and to adjust accordingly, could be one way in which empathy and social skills improve outcomes.
- Key therapist behaviours are how often and how forcefully they offer interpretations, confront resistance, and initiate topics rather than allowing clients to set the agenda.
- Which 'brand' of psychosocial therapy is offered does matter, but largely because it influences the style of the therapist.
- Ideally, initial assessments of the client and/or their reactions early in therapy which indicate how far they resist direction would be integrated with other considerations to decide which therapists or therapies were most likely to get the best results.
- Before changing therapeutic style, consider first whether it is the direction the client is being led in which needs to be changed rather than the degree of directiveness.

Directiveness can work. Lord Kitchener's famous injunction, underlined by handlebar moustache, steely gaze and pointing finger, helped recruit over three million volunteers in the first two years of World War I.

strength. But unexpectedly, the reverse was also the case – the least angry patients did *worse* when allocated to motivational therapy.

How this happened has been investigated across the five outpatient clinics.[10] Compared to the more directive alternatives, motivational therapy excelled at handling high client resistance to treatment, preventing this from expressing itself in continued drinking, presumably a benefit of the motivational therapists' drilling in 'rolling with resistance' and avoiding provocation. Conversely, it seemed that clients ready and willing to be directed were somewhat let down by the hands-off, 'It's up to you' stance of the motivational therapists.

This picture was pieced together from paper and pencil tests which only indirectly measured client resistance and without any measures of how directive therapists had actually been. Work done at one of the MATCH clinics in Providence enables us to probe deeper. There, videos of counselling sessions afforded a direct, observational measure of how clients and therapists responded to each other.

BEST NOT PROVOKE THE PROVOKABLE

Though in the other arm of the MATCH study,[ii] at this clinic too, motivational therapy was generally most effective for patients prone to react with anger, least effective for the less fiery.[11] The videos revealed the underlying reason. Motivational therapists had been significantly less directive than those implementing cognitive-behavioural therapy, and it was this which accounted for the differences in how patients reacted. True, motivational therapy promoted a less directive style, cognitive-behavioural a more directive, but still, style rather than therapeutic 'brand' was decisive.

The upshot was that, whatever the therapy, clients with a medium to high tendency to react angrily remained virtually abstinent after seeing therapists who had avoided being directive. For calmer clients, it was the opposite; they remained virtually abstinent when the therapist had given a lead. Reverse this matching, and both types of patients were more likely to drink.

But there was a remaining puzzle. As expected, for angry patients motivational therapy had worked better than cognitive-behavioural, but the same was not true of 12-step therapy. Yet on the face of it, this programme based on an approach which insists on a fixed notion of addiction and how to recover from it, should have counter-productively lit their fuses. The explanation was simple: confounding expectations, 12-step therapists had actually been no more directive than the motivational therapists. Presumably as a result, these therapies had similar impacts on angry patients.

The question then becomes, why weren't the 12-step therapists more directive? Possibly for two reasons. First, in the US context,

THE MORE DIRECTIVE THERAPISTS HAD BEEN, THE MORE HIGHLY REACTIVE PATIENTS DRANK

12-step approaches are accepted wisdom and familiar to patients – 'second nature'. There would be little need to direct and teach, even more so in the arm of the MATCH study which Providence hosted. Here, nearly all the patients had just emerged from detoxification and they were heavier drinkers, more treatment-aware, and more involved with AA, than patients in the other arm of the study.[12 13]

Second, the 12-step therapy manual was far less prescriptive and detailed than the cognitive-behavioural version. Both influences would have promoted a more directive style for cognitive-behavioural than for 12-step therapy, sharpening the contrast with the non-directive motivational style.

The (tentative) lesson is that whilst some therapies seem to lend themselves to a directive style, whether this is actually the case will depend partly on the patients and on the cultural context.

RISKY TO CONFRONT THOSE WHO HIT BACK

Digging yet deeper in to what was happening in Providence, another report drew on observations not just of the therapists, but of the clients.

From videos of the first therapy session, raters assessed the degree to which clients seemed reluctant to relinquish control and reacted against direction.[14] Though based on actual responses in therapy, the raters' mission was to assess the client's *predisposition* to behave in these ways rather than to record responses to the particular situation. In this it appears they largely succeeded *Directiveness and resistance* page 25.

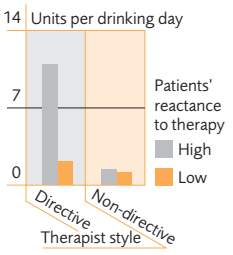
Importantly, their assessments of the patients 'reactance' were unrelated to how directive the therapist had been during that and subsequent sessions. It seemed that patients who started treatment in reactive mode were not responding to the therapist; it was simply how they were. Therapists too were more or less directive, regardless of how the patients behaved. Had each been echoing the other, it would have muddied the causal waters, making it difficult to know what was cause and what effect.

In the event, the waters seemed remarkably clear. Whether the outcome was the number of drinking days or the amount drunk on each of those days, the more directive therapists had been, the more the highly reactive patients drank in the year after therapy ended *chart below*.

Paired with a directive therapist, on average they drank on around a quarter of days and then fairly heavily, about 11 UK units. Paired with a non-directive therapist, the same type of patients went on to drink rarely and on average just one or two units. Given a non-directive style, despite their tendency to obstruct and resist, these patients did just as well as the more cooperative patients. It seemed that their potential to ricochet in the wrong direction had been defused by the absence of a hard therapeutic direction to ricochet against.

A more detailed analysis explored whether the effect of directiveness–reactance matching applied in each of the three therapies. With respect to drinking days, it did, but the effect was much more apparent after motivational interviewing, perhaps because tactics such as confrontation or

Clients who react against therapist direction do better when the therapist gives them little to react against.



interpreting the client's resistance rather than 'rolling with it' violate its essence in a way they do not for the other therapies.

Overall, in this clinic and with these patients, it was safer to be non-directive. On average, no type of client suffered as a result, and it avoided poorer outcomes among reactive patients. In other MATCH clinics and in other studies, this hasn't always been the case – sometimes the calmer and less resistant patients do lose out if therapists take too much of a back seat.

IS ANGER THE SAME AS REACTANCE?

With outcomes related both to how anger-prone patients were and how reactive they were, the next step was to check whether these were simply the same characteristics measured differently. This new analysis first

DIRECTIVENESS AND RESISTANCE

To make sense of the data we need first to clarify what directiveness is and what it is not, and similarly for resistance. These seemingly simple concepts are in fact complex, partly because it is perfectly possible at one level to be directive or resistant, yet simultaneously, at another to be the opposite.

Directiveness – content and style

Therapists can be *directive* in the sense of directing the client to do or talk about certain things, or limiting their freedom of action, yet still be *flexible* about which things, when, and with whom, and *sensitive* enough to deploy that flexibility in ways which adapt to the client.

In theory then, mistakes can arise in several ways. First, a directive style *as such* may be the problem: no matter how sensitive or flexible the therapist, some clients may react badly to being led. Alternatively, the style may not be the problem, but the *content*: the client may be ready and willing to be directed, but is led along a counterproductive trajectory due to insufficient flexibility or sensitivity.

Important as they are, these distinctions are not as sharp as they seem. At a deeper level, sticking to an explicitly directive style when that is just going to provoke, is itself to be insufficiently flexible or sensitive. And a directive style provides more opportunities to be inflexible or insensitive by directing the client in ways which clash with their own priorities or motivational state.

So in practice, these dimensions are often conflated. The therapist is at the same time directive in style, relatively inflexible in content, and limited in the extent to which they sensitively adapt content and style to the client. In research settings, this often happens because they have themselves been directed to follow a set procedure, often in manual form. Commonly this prescribes both the style and the content of the interaction.

The content imposed by a directive therapist can itself occupy at least three different levels. First is being directive about the *structure* of the session – mandating that certain topics are addressed, when they are addressed, and/or in what sequence. Second is being directive about the *conclusions* of those discussions – for example, the implicit or explicit indication that drug use must allways be bad, that only certain goals are acceptable, or that addiction always has similar roots and manifestations.

At a further level up, neither structure nor conclusions may be imposed, but still the therapist is directive in the sense of knowing where they want the interaction to go, and seeking to subtly nudge the client in to adopting that direction too – the classic motivational strategy.

Resistant by nature, or just a raw nerve?

On the client's side, the key distinction is between being generally *predisposed* to resist direction from other people, versus in a given situation, reacting as anyone might to uncomfortable topics or unpalatable threats to one's autonomy. These are hard to disentangle and measures intended to reflect one may be contaminated by the other,[29] but in clinical terms, the distinction is crucial.

Awareness of the client's predisposition should influence the overall therapeutic style, typically contraindicating explicitly directive approaches for resistant clients. On the other hand, 'normal' signs of resistance evoked during therapy can be handled by micro-managing the encounter rather than a wholesale change in style.[1]

AT THE CORE OF THESE REACTIONS IS A RESISTANCE TO BEING DENIED CHOICE OR HAVING ONE'S AUTONOMY UNDERMINED

So if the task is to match therapeutic style to the patient, gauging predispositions is the important issue. In the MATCH Providence studies, observers were asked to infer these predispositions from how patients *actually* behaved early in therapy ◤ *Risky to confront those who hit back* page 24.[14] On the face of it, there was a risk that raters would mistakenly see uncooperative behaviour as characteristic of a stubbornly resistant streak, rather than as a normal reaction to what was happening then and there.

In fact, their assessments of the patients' predispositions were only weakly related to whether the patient actually exhibited resistant behaviour.[30] And on the key issue of how patients responded to directive versus non-directive therapy, resistant behaviour was unrelated, whilst the measure intended to reflect enduring predispositions did affect outcomes. The raters seem to have successfully divined the patients' predispositions and it was these rather than in-session resistance which interacted with therapeutic style.

There is also a distinction between more passive forms of resistance, such as diversion and dragging one's feet, and outright opposition. This latter manifestation is closely associated with traits such as anger, defensiveness, dominance and need for autonomy[29] – important, because often these are what is measured rather than resistance as such.

At the core of these reactions is a resistance to being denied choice or having one's autonomy undermined in other ways. Some philosophies see this as part of the pathology being treated, an avoidance of painful insights or repressed feelings and impulses. Others say it's simply human nature to counter threats to what you see as your legitimate freedom to act. Sometimes called 'reactance', different people express this to different degrees and in different ways, partly in response to the seriousness and nature of the threat, but partly also in accordance with their own predisposition to perceive such threats.[1]

Mirroring the levels of therapist directiveness, clients may resist structure as such, resist a particular structure, or accept the order and timing of topics yet resist being led to reach certain conclusions about those topics. An example is the study in which it was thought some clients reacted not against being led to consider the pros and cons of their drug use, but against the conclusion being imposed on them that it was unremittingly negative ◤ *Cornered clients strike back* page 23.

established that in fact, the two dimensions were only loosely related; someone could score high on anger yet not react against direction, and vice versa.[15]

So while 'angry' and 'reactive' patients overlapped somewhat, they were distinct groups. Still, it was possible that these two groups would respond similarly to directive therapists. To test this, the researchers decomposed directiveness into what turned out to be two quite different components.

First was the prototypical confrontational style, characterised not just by confrontation, but also by interpreting the meaning of the patient's own behaviour or experiences. No matter how diffidently, such interventions impose on the client the therapist's view of who they are and why they behave as they do. Second were activities less to do with imposing content than with imposing structure – initiating a focus on certain topics, providing information, and asking closed-end questions. These sub-styles too were only loosely related: therapists might be directive in one way but not the other. At issue was whether the consequences for the patient might also differ.

LACKING A SPARK OF THEIR OWN, CALMER PATIENTS NEEDED SOME INCENDIARY FROM THE THERAPIST TO MAXIMISE CHANGE

In the event, whether the measure was drinking as such or heavy drinking, highly reactive patients reacted badly to both forms of direction, yet with non-directive therapy, they did about as well as other patients. The exception was simply providing information, a relatively neutral form of directiveness which did not provoke much of a backlash, even among reactive patients.[14]

Less consistently relevant was whether clients were prone to anger. Here, only the confrontation sub-style mattered, and then only with respect to abstinence. In the year after treatment, anger-prone patients drank on fewer days if therapists had avoided confrontation, on more if the therapist had confronted.[iii]

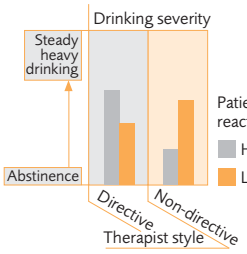
This much was the predictable result of provoking the provokable. Less expected was the finding that after seeing a non-

confrontational therapist, calmer patients drank on *more* days than they did after being confronted. In fact, they ended up drinking more than their angry peers – as if lacking a spark of their own, they needed some incendiary from the therapist to maximise change.

Persuasive as these findings are, it is important to remember the context – the MATCH study, in which therapists were highly selected, trained and supervised.[16] In this context, such 'confrontation' as there was is unlikely to have been extreme, persistent or abusive. A further caution – that not too much should be made of results from a single set of clients at a single clinic participating in a tightly controlled study – would be worth emphasising more if these were isolated findings. In fact, they exemplify a pattern seen elsewhere in very different circumstances.

Similar view beyond motivational interviewing

By now a fairly clear picture is emerging. Across several common types of therapies, if the therapist is directive they risk a backlash from patients with a short fuse or who resist other people's attempts to lead the interaction. Conversely, calmer patients or those who welcome direction thrive when given more of a lead.



Patients prone to react against attempts to influence them drank least when therapists had been non-directive. For patients willing to embrace influence and direction, the reverse was the case.

From studies of motivational interviewing, we also know that when direction is pre-structured and inflexibly applied, there is a risk of fouling things up both with those most and those least committed to tackling their drug use, when the programme's mandate fails to match their state of mind.

So far this picture has emerged from studies which have included adaptations of motivational interviewing. We'll see now that the landscape remains familiar when widened to studies which have not explicitly involved a motivational approach.

SOME WANT TO LEAD, OTHERS TO BE LED

First is an analysis of alcohol patients engaged in two sorts of outpatient couples therapy, one cognitive-behavioural, the other family-focused.[17] Both were intended to span five or six months, of which the last three or four were a 'maintenance' phase designed to sustain the gains made earlier. The outcome was how far drinking severity (assessed by clinician-observers using all the available data) during this phase had changed compared to pre-treatment drinking levels.

The degree to which outcomes were affected by the therapist was assessed through ratings made from sessions videoed in the first phase of treatment. Directiveness was measured using the scale used in the Providence MATCH studies, except that the raters assessed not just how directive therapists had been (eg, asking closed-ended questions), but also how far they had actively been the opposite – for example, asking open-ended questions and allowing patients to select the topics to be discussed.

Regardless of which type of therapy they'd been in, patients prone to defensively resist attempts to influence them[iv] drank least when their therapists had been non-directive, most when therapists had tried to take the lead. For patients willing to embrace influence and direction, the reverse was the case. They drank least when the therapist took the lead, most when they avoided being directive and/or were actively non-directive *chart left*.

As in the MATCH clinic in Providence, how the therapists behaved was largely independent of their patients' predispositions, strengthening the implication that the therapist's style truly was an active ingredient in producing the drinking outcomes.

THE CLASH BETWEEN DIRECTIVE THERAPISTS AND REACTIVE PATIENTS LED TO POORER OUTCOMES AMONG RETAINED PATIENTS; OTHERS JUST LEFT

These findings are compromised somewhat by an inability to re-assess 27 of the 75 patients who started the study. But had these been followed up, the results might have been even more clear cut, because they tended to be the patients prone to react defensively and those who had seen the most directive therapists. If (as it probably did) retention in the study reflects retention in therapy, it seems that the clash between directive therapists and reactive patients might not only have led to poorer outcomes among retained patients, but also led others to leave early.

STRUCTURE SUITS THE 'HELPLESS'

A similar picture emerges from a study of a very different set of patients, not mainly white, employed drinkers, but poor, black, single unemployed men seeking outpatient treatment at an inner-city clinic in Philadelphia, where cocaine was the dominant drug problem.

How far they resisted direction was not directly assessed, but a similar variable was. People characterised by 'learned helplessness' feel unable to control their lives, in particular that it is futile for them to try to initiate positive changes. They seem like the people who in other studies would welcome direction from others. At the other end of learned helplessness are people confident in their abilities to initiate positive change, the ones who seem most likely to react against the therapist doing the initiating.

Patients were randomly allocated to 12 weekly sessions of two kinds of therapies, designed in some ways to be at opposite poles. In one the counsellor structured the therapy, leaving little room for the client to take the lead. They directed the client to

OFFCUT 1

Steep recent increases in liver cirrhosis deaths appear to expose the failure of British alcohol policy to curb consumption and related medical harm. The analysis by researchers from the London School of Hygiene and Tropical Medicine and the National Addiction Centre found that Scotland led the way with a doubling between 1987–1991 and 1997–2001 in deaths in men and a 63% increase among women. ❶ In England and Wales, the corresponding increases were 67% and 35%. These rises were the steepest in western Europe. Across the rest of the region, on average mortality rates fell over the same period. From in the late '50s being at or near the bottom of the European cirrhosis mortality league, rates in Scotland are now among the highest in western Europe and in England and Wales have climbed to match the average.

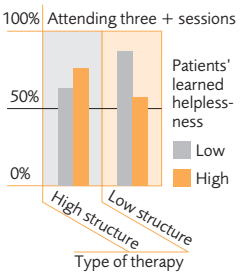
Declines elsewhere have the researchers argued been driven mainly by falling alcohol consumption in the wine-drinking countries of southern Europe, while in the UK consumption per head has doubled over the past 40 years. "There is no doubt", said a linked editorial, that this played "a primary role" in the trend in deaths, yet UK policy has not targeted across-the-board drinking reductions and avoided measures capable of achieving such reductions. ❷ Those with the greatest research backing include the politically unpalatable options of increasing the price of alcohol through taxation and restricting its availability. ❸ ❹ Instead the British health service has focused on research on tackling "alcohol misuse" rather than drinking as such. ❺

❶ Leon D.A. *et al*. "Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data." *Lancet*: 2006, 367, p. 52–56, and corrections in *Lancet*: 2006, 367, p. 645.
❷ Room R. "British livers and British alcohol policy." *Lancet*: 2006, 367, p. 10–11.
❸ Babor T. *et al*. *Alcohol: no ordinary commodity*. Oxford University Press, 2003.
❹ Chisholm D. *et al*. "Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis." *Journal of Studies on Alcohol*: 2004, 65(6), p. 782–793.
❺ Mulvihill C. *et al*. *Prevention and reduction of alcohol misuse*. Health Development Agency, 2005.

identify concrete behavioural goals, taught cognitive-behavioural strategies for reaching those goals, and reviewed progress. In the less structured therapy, counsellors instead provided a sounding board for exploration of feelings and the development of the client's awareness and understanding. Though the same counsellors delivered both versions, video-based ratings by observers and feedback from clients confirmed that the therapies differed in the intended ways.

At the time of an earlier report,[18] 80 patients had been randomised; later, 120 and post-treatment follow-up data was available.[19] Both reports found neither therapy preferable overall, but that this masked different impacts on different types of clients. Those characterised by learned helplessness did better when the therapy required the counsellor to take the lead, while clients who felt more in control of their lives did better when the less structured therapy allowed them to set the agenda.

Given directive, structured therapy, patients who like to feel in control (low learned helplessness) tended to leave early while their less confident peers stayed longer.



During treatment, the effect was seen in patient and therapist ratings of benefit, retention (*chart*), and numbers of drug-free urines. In the six months after treatment, it was apparent in measures of drug, family, social and (to an extent) psychiatric problems, though none of these reached conventional levels of statistical significance.

More depressed clients also did best in the more structured therapy and worst when required to take the initiative, again, potentially related to their tolerance for direction: depressed clients seem unlikely to be prone to angry defensiveness. However, depression did not account for the earlier findings: when it was statistically 'evened out', learned helplessness remained just as or even more significant.

By the time of a third report,[20] 143 clients had been recruited to the study but the results seen earlier held up.[21] The main reservation over this study is a low follow-up rate, just 85 of the 120 patients in the most relevant of the reports,[19] a shortfall attributed to the indigent caseload.

Principles and probabilities but no universal recipes

What might all this mean for practice? At best it identifies some general patterns in how people who differ on one particular dimension of personality respond to therapeutic styles also narrowly characterised as differing on one particular dimension.

Partly because there is much more to people and much more to therapy, such research cannot be used to determine which therapeutic style should be adopted for any particular individual. The reasons for this caution are not just easily dismissed nitpicking, but integral to the nature of research and to the nature of the human interactions which constitute psychosocial therapies.

BEWARE GENERALISATIONS

First is the fact that many more dimensions are involved than directiveness, and they interact. For example, in one of the studies reviewed above, the biggest influence on drinking outcomes was not directiveness, but whether therapists addressed the emotional states of highly distressed patients.[17] Had they failed to do so for fear of being over-directive, they might have done more harm than good.

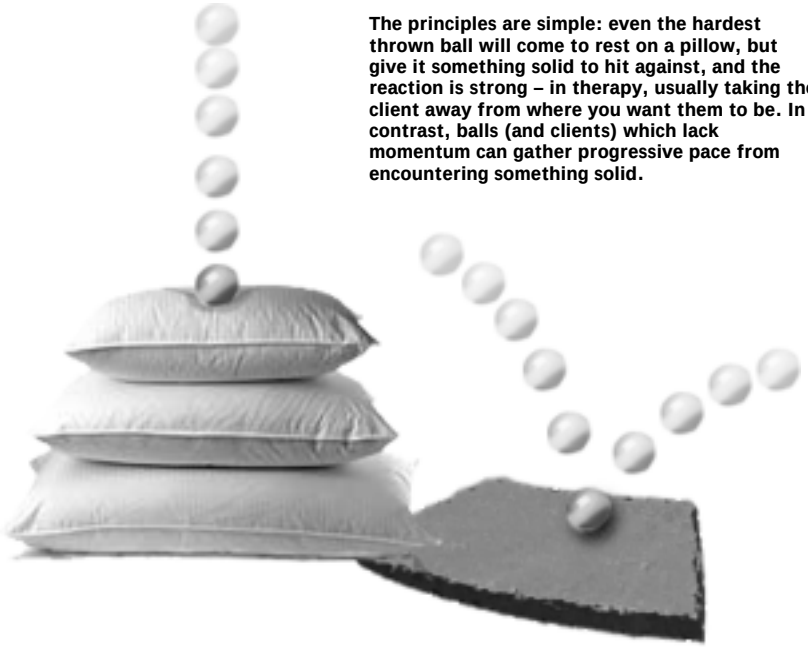
Complicating things further is the possibility that adopting one style or the other, when it does not come naturally or fit the circumstances, will violate another tenet of effective therapy – being and seeming genuinely caring. An 'It's up to you' stance from a probation officer to an offender can seem less than genuine, even to the officer,[22] as can biting one's tongue when it would have been natural and caring to be direct about the risks the client faces.[23]

There is also the concern that what in short-term evaluations seems an effective approach with some patients, may in the longer term prove less so, or vice versa.[v] This phenomenon of shifting outcomes has been seen with skills-based therapies[24 25] and with motivational interviewing,[26] generally seen as at opposite ends of the directiveness dimension. In Project MATCH, the most substantial client-therapy match seen in the study did not become apparent until three years after the therapies had ended.[27]

The results for directiveness and resistance, and all the other dimensions on which therapists and patients may differ, are averages over many clients and several therapists. Typically, the extent to which knowing these variables helps predict individual outcomes is quite limited. Even with a comprehensive score sheet from both sides of the table, for any given therapist-client pairing, it is impossible to categorically recommend one approach above another.

SUBSTANCE USE IS NOT THE ONLY OUTCOME

While this is the outcome focused on in the research, substance use as such is rarely why patients seek treatment, rather, it is the problems to which their use gives rise in the context of that individual's life circumstances and social reactions. It is entirely conceivable that some angry patients who get confronted by therapists, and end up drinking slightly more than they might have, nevertheless benefit psychologically from being challenged, whilst the calmer types driven to abstinence by a directive therapist may suffer in other ways, perhaps by having their subservience confirmed.



The principles are simple: even the hardest thrown ball will come to rest on a pillow, but give it something solid to hit against, and the reaction is strong – in therapy, usually taking the client away from where you want them to be. In contrast, balls (and clients) which lack momentum can gather progressive pace from encountering something solid.

So even if we knew for certain (which we cannot) that a certain approach would maximally reduce substance use for this particular individual, whether that is what matters most to them, and whether globally they end up functioning and feeling better, are separate issues and arguably a more appropriate focus for person-centred therapy.

Even assuming, once again, an implausibly well stocked set of measures characterising both patient and therapist, how these will relate to outcomes does not necessarily stay invariant across different cultures or different settings. We got a hint of this in the surprising fact that in one of the US studies,[11] 12-step therapists were no more directive than motivational therapists, possibly a function of the way in that culture, and especially for these treatment-hardened patients, 12-step approaches are second nature.

Last and most fundamentally, the most the research can show is that *generally* certain types of clients respond best to certain therapeutic styles, but it also shows that doing *anything* 'generally' risks counter-productive reactions among some clients.

'YOUR WAY OR MINE' – IT DOES MATTER

What we can say is that the research offers some useful and unusually robust findings for therapists to incorporate in their thinking as an aid to clinical expertise and individualised treatment, not as a substitute.[28]

Part of this grist to the mill is that non-directive styles generally (in terms of substance use) work best for clients characterised by anger, defensiveness, or resistance, or who like to take control, while more structured and directive approaches may profit calmer clients, those who welcome a lead, and those already committed to the course of action being directed.

But before making a wholesale change in style or therapist, first the possibility should be considered that it is not directiveness (or its opposite) as such which is rubbing the client up the wrong way, but being directed along an unsuitable trajectory. This can include leading clients to commit to certain courses of action before they are ready, but can also take the form of leading clients to reconsider commitments and judgements already decided on.

DOING ANYTHING 'GENERALLY' RISKS COUNTER-PRODUCTIVE REACTIONS AMONG SOME CLIENTS

When therapists encounter this choppy water, experience from general psychotherapy suggests negotiating a different direction, acknowledging and exploring the nature of the resistance, or explicitly focusing on the therapeutic relationship, the aim in all cases being to defuse the situation by returning a sense of control to the client.[1]

CLUES TO SUITABLE STYLES

The ability to assess (either explicitly or 'instinctively') whether a change of style is needed, and which style is likely to work best, could be one way in which therapist empathy and social skills improve outcomes. Some therapists can (or can be trained) to deploy approaches at opposite poles of the directiveness dimension. In other cases, it may be best to match the therapist's style to that of the client.

More formally, initial assessments of the client could probe how far they resist or welcome direction and allocate them to the therapists or therapies likely to get the best outcomes. Standard psychological tests can be used and/or such tendencies may be evident from the patient's history, especially how they have typically responded to authority figures.[1]

Patient behaviour early in therapy is also a powerful clue, and one immediately available to the observant therapist. Remember that at the Providence MATCH clinic, a tendency to resist direction, assessed from behaviour in the first therapy session, was a better indicator than a pre-treatment measure of anger.[15] If the observers could gauge this tendency from session videos, then in theory, so too could the therapists, paving the way for adjustments to be made to ease up on confrontation or agenda-setting or to inject a little directional impetus if the patient lacks momentum.

Feedback from early counselling sessions through recordings assessed by supervisors or peers, or through short 'de-briefing' surveys given to the clients, could also be used to assess whether there is a mismatch between therapist and client interactional styles. If there is, clinical supervision can be used to encourage a more suitable therapeutic style or to revise client allocation.

Among the therapist behaviours particularly to look out for are how often and how forcefully they offer interpretations, confront resistance, and initiate topics rather than allowing clients to raise the issues most important to them. These seem particularly potent ways to prompt counter-productive reactions from predisposed clients. However, they are neither 'good' nor 'bad' in themselves, but good or bad for different kinds of clients.

Finally, which brand of psychosocial therapy is offered does matter, but within the limited range studied so far, this is largely because the therapy influences the style of the therapist. To a degree, style can be changed even while the therapy remains cognitive-behavioural, motivational, or of some other ilk, but it might be more effective and easier to choose therapies which promote the required style. For example, the teaching stance of cognitive-behavioural therapy lends itself to directiveness in content as well as structure, while true-to-type, non-standardised motivational interviewing lends itself to the opposite.

But how far therapists *need* to direct clients in any particular therapy will depend partly on how familiar and comfortable the client is with it. At this level too, there are no hard and fast recipes for success, rather multiple influences whose complex interactions change with the context.

OFFCUT 2

Gaps in Britain's harm reduction defences of the kind previously highlighted in FINDINGS ❶ are permitting a minor resurgence in HIV infection. The most compelling findings were reported by researchers from the Health Protection Agency and the Centre for Research on Drugs and Health Behaviour.❷ To model HIV spread from 1990 to 2003 they combined the results of HIV tests on injectors attending drug services in England and Wales with tests on injectors recruited on the street and in non-treatment locations. The proportion infected with HIV bottomed out at 0.5% in 1999 but then more than doubled in the first years of the new millennium, reaching over 1.5%. In each year of the 2000s injectors were two to three times more likely to be infected than in the mid '90s. Though numbers were very small, there was an increase in the proportion of new (under three years) injectors who had become infected. The rate at which injectors became seropositive was greatest among new injectors in London, where it had increased since the late '90s to around 3% in the first year of injecting. In UK terms (modest compared to other nations), the figures were consistent with an upsurge in new infections since 1999 focused on London. Other reports indicate that most of the newly diagnosed infections in the capital involved injectors from mainland Europe.

Though this report was reassuring about trends outside London, later tests on injectors attending drug services revealed that outside the capital there had been a six-fold increase in HIV prevalence from 0.2% in 2002 to 1.2% in 2005.❸ Though the numbers were small, nationally over the same period the proportion of new (last three years) injectors infected had increased from 0.3% to 1.3%, consistent with a recently increased rate of spread.

❶ Ashton M. "Hepatitis C and needle exchange: part 3 • the British record." *Drug and Alcohol Findings*: 2004, 10, p. 22–29.

❷ Hope V.D. *et al*. "HIV prevalence among injecting drug users in England and Wales 1990 to 2003: evidence for increased transmission in recent years." *AIDS*: 2005, 19(11), p. 1207–1214.

❸ Health Protection Agency. "Evidence of a continuing increase in the HIV prevalence among injecting drug users in England and Wales." *CDR Weekly*: 16 March 2006, 16(11).

NOTES

i I am grateful to Larry Beutler for for pointing this out.

ii In which patients had all just left intensive treatment, usually inpatient detoxification.

iii This was the case relative to less angry patients and also within the group of more angry patients.

iv Assessed before treatment using questionnaires intended to measure this concept.

v I am grateful to Petra Meier for pointing this out.

OFFCUT 3

Rapid change on entry to treatment is well documented and with respect to cocaine addiction, cutting back in the run up to treatment is the best predictor of longer term success. The rapidity and timing of such changes precludes treatment as a major factor, at least in their initiation. The US alcohol treatment trial Project MATCH provides an example. Patients who did not return for therapy did almost as well as those who went through all 12 sessions of the two most extensive therapies. Across the study, nearly all the improvement there was going to be in drinking had occurred by week one.❶ In another US study of heavy drinkers who responded to ads offering help to cut back, most of the drinking reductions occurred after they had responded to the ads, but before receipt of any of the project's assessment or self-help materials.❷ In both cases, change was on average well sustained after treatment.

Such findings focus attention on the processes associated with deciding to cut back or stop using. When these processes are intentional – weighing up the pros and cons and taking an explicit decision – Prochaska and DiClemente's 'stages of change' model offers a detailed description. But this is not the only nor it seems the most robust way people change. In a national UK survey, half of all attempts to stop smoking were unplanned – often smokers did not even finish the pack.❸ These resolutions were twice as likely to 'stick' as planned attempts. Similarly in California, a survey of problem drinkers found that weighing the pros and cons as a reason for cutting down was much less likely to lead to lasting remission than 'conversion' experiences like hitting rock bottom, a traumatic event, or experiencing a spiritual awakening. ❹ In these situations too, half finished bottles can be poured down the sink.

The authors of the UK paper relate their findings to "an alternative model to the stages of change … based on 'catastrophe theory' [which] deals with the way in which tensions develop in systems so that even small triggers can lead to sudden 'catastrophic' changes." They argue that the build up to such events creates a state of "motivational tension" in which "even quite small 'triggers' can lead to a renunciation of smoking." A catastrophe model has also been developed in the USA for the opposite process – relapse to dependent drinking.❺

❶ Cutler R.B. *et al*. "Are alcoholism treatments effective? The Project MATCH data." *BMC Public Health*: 2005, 5:75.

❷ Sobell L. *et al*. "Responding to an advertisement. A critical event in promoting self-change of drinking behavior." Presented at the Association for the Advancement of Behavior Therapy, 2003.

❸ West R. *et al*. "'Catastrophic' pathways to smoking cessation: findings from national survey." *British Medical Journal*: 2006, doi:10.1136/bmj.38723.573866.AE. For more see www.primetheory.com.

❹ Matzger H. "Reasons for drinking less and their relationship to sustained remission from problem drinking." *Addiction*: 2005, 100, p. 1637–1646.

❺ Witkiewitz K. *et al*. "Modeling the complexity of post-treatment drinking: it's a rocky road to relapse." *Clinical Psychology Review*: in press.

REFERENCES

1 Beutler L.B. *et al*. "Resistance." In: Norcross J.C., *ed*. *Psychotherapy relationships that work*. Oxford University Press, 2002.

2 Ashton M. "The motivational hallo." *Drug and Alcohol Findings*: 2005, 13, p. 23–30.

3 Stotts A.L. *et al*. "Motivational interviewing with cocaine-dependent patients: a pilot study." *Journal of Consulting and Clinical Psychology*: 2001, 69(5), p. 858–862.

4 Rohsenow D.J. *et al*. "Motivational enhancement and coping skills training for cocaine abusers: effects on substance use outcomes." *Addiction*: 2004, 99, p. 862–874.

5 Kahler C.W. *et al*. "Motivational enhancement for 12-step involvement among patients undergoing alcohol detoxification." *Journal of Consulting and Clinical Psychology*: 2004, 72(4), p. 736–741.

6 Amrhein P.C. *et al*. "Client commitment language during motivational interviewing predicts drug use outcomes." *J. Consulting and Clinical Psychology*: 2003, 71(5), p. 862–878.

7 Amrhein P.C. "How does motivational interviewing work? What client talk reveals." *Journal of Cognitive Psychotherapy*: 2004, 18(4).

8 Ashton M. "Project MATCH: unseen colossus." *Drug and Alcohol Findings*: 1999, 1, p. 15–21.

9 Project MATCH Research Group. "Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes." *Alcoholism: Clinical and Experimental Research*: 1998, 22 (6), p. 1300–1311.

10 Waldron H.B. *et al*. "Client anger as a predictor of differential response to treatment." In: Longabaugh R. *et al, eds. Project MATCH hypotheses: results and causal chain analyses*. US Dept. of Health and Human Services, 2001, p. 134–148.

11 Karno M.P. *et al*. "What do we know? Process analysis and the search for a better understanding of Project MATCH's anger-by-treatment matching effect." *Journal of Studies on Alcohol*: 2004, 65(4), p. 501–512.

12 Connors G.J. *et al*. "A longitudinal model of intake symptomatology, AA participation and outcome: retrospective study of the Project MATCH outpatient and aftercare samples." J. *Studies on Alcohol*: 2001, 62(6), p. 817–825.

13 Project MATCH Research Group "Project MATCH secondary a priori hypotheses." *Addiction*: 1997, 92 (12), p. 1671–1698.

14 Karno M.P. *et al*. "Less directiveness by therapists improves drinking outcomes of reactant clients in alcoholism treatment." *Journal of Consulting and Clinical Psychology*: 2005, 73(2), p. 262–267.

15 Karno M.P. *et al*. "An examination of how therapist directiveness interacts with patient anger and reactance to predict alcohol use." *Journal of Studies on Alcohol*: 2005, 66(6), p. 825–832.

16 Project MATCH Research Group. "Therapist effects in three treatments for alcohol problems." P*sychotherapy Research*: 1998, 8(4), p. 455–474.

17 Karno M.P. *et al*. "Interactions between psychotherapy procedures and patient attributes that predict alcohol treatment effectiveness: a preliminary report." *Addictive Behaviors*: 2002, 27, p. 779–797.

18 Gottheil E. *et al*. "Effectiveness of high versus low structure individual counseling for substance abuse." *American Journal on Addictions*: 2002, 11, p. 279–290.

19 Thornton C.C. *et al*. "High- and low-structure treatments for substance dependence: role of learned helplessness." *Am. J. Drug and Alcohol Abuse*: 2003, 29(3), p. 567–584.

20 Thornton C. *et al*. "Coping styles and response to high versus low-structure individual counseling for substance abuse." *Am. J. Addictions*: 2003, 12, p. 29–42.

21 Personal communication from Charles Thornton, 2003.

22 Miller W.R. *et al*. "A small study of training in motivational interviewing: does one workshop change clinician and client behavior?" *Behavioural and Cognitive Psychotherapy*: 2001, 29, p. 457–471.

23 Moyers T.B. *et al*. "What makes motivational interviewing work? Therapist interpersonal skill as a predictor of client involvement within motivational interviewing sessions." J. *Consulting and Clinical Psychology*: in press.

24 Carroll K.M. *et al* "One-year follow-up of psychotherapy and pharmacotherapy for cocaine dependence: delayed emergence of psychotherapy effects." *Archives of General Psychiatry*: 1994, 51, p. 989–997.

25 Carroll K.M. *et al*. "Choosing a behavioral therapy platform for pharmacotherapy of substance users." *Drug and Alcohol Dependence*: 2004, 75, p. 123–134.

26 Hettema J. *et al*. ""Motivational interviewing." *Annual Review of Clinical Psychology*: 2005, 1, p. 91–111.

27 Project MATCH Research Group. "Matching patients with alcohol disorders to treatments: clinical implications from Project MATCH." J. *Mental Health*: 1998, 7(6), p. 589–602.

28 Norcross J. *et al, eds. Evidence-based practices in mental health: debate and dialogue on the fundamental questions*. American Psychological Association, 2005.

29 Beutler L.B. *et al*. "Resistance in psychotherapy: what conclusions are supported by research." *Journal of Clinical Psychology*: 2002, 58(2), p. 207–217.

30 Personal communication from Mitchell Karno, April 2006.

Many of the young recruits who followed Kitchener's lead were soon killed in gruesome battles, such as that of the Somme. Being reactive and oppositional may not always be bad.

LINKS Nuggets **14.1 12.5 9.3** *The motivational hallo*, issue 13