

Confrontation in Addiction Treatment



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The use of confrontational strategies in individual, group and family substance abuse counseling emerged through a confluence of cultural factors in U.S. history, pre-dating the development of methods for reliably evaluating the effects of such treatment.

Originally practiced within voluntary peer-based communities, confrontational approaches soon extended to authority-based professional relationships where the potential for abuse and harm greatly increased. Four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects, particularly for more vulnerable populations. There are now numerous evidence-based alternatives to confrontational counseling, and clinical studies show that more effective substance abuse counselors are those who practice with an empathic, supportive style. It is time to accept that the harsh confrontational practices of the past are generally ineffective, potentially harmful, and professionally inappropriate.

Treatment for substance use disorders in the United States took a peculiar turn in the mid-20th century. There arose a widespread belief that addiction treatment required the use of fairly aggressive confrontational strategies to break down pernicious defense mechanisms that were presumed to accompany substance use disorders. Although this approach was emulated to some extent in certain treatment centers outside the United States, such reliance on confrontation was predominantly an American phenomenon. As discussed below, there was some broader exploration of confrontational therapies, but nowhere did they take such deep root as in U.S. addiction treatment. Indeed, few would now regard such harsh methods as therapeutic for any other Axis I disorder in The Diagnostic and Statistical Manual of Mental Disorders.

What accounts for this odd detour in American addiction treatment? In this article we trace the historical roots of belief in and practice of confrontational treatment, and explore relevant scientific evidence on the effects of such methods. We then offer summary conclusions and recommendations for treatment of substance use disorders in the 21st century.

A history of confrontational therapies — What is confrontation?

Therapeutic confrontation has been defined as the process by which a therapist provides direct, reality-oriented feedback to a client regarding the client's own thoughts, feelings or behavior. Such communications may spring from compassion and concern, or from exasperation and contempt. They also vary in their intent, timing, intensity, emotional content, accompanying interventions, and the relationships and organizational contexts within which they occur.

In the mid-20th century, addiction counselors developed and advocated a particular style of direct verbal confrontation of those with alcohol and other drug problems. These communications varied from frank feedback to profanity-laden indictments, screamed denunciations of character, challenges and ultimatums, intense argumentation, ridicule, and purposeful humiliation. Confrontation marked a dramatic break from earlier therapeutic traditions premised on the importance of neutral exploration, empathy, compassionate support, and positive regard for clients.

Many examples of allegedly therapeutic confrontation can be found in the addiction literature of the 1960s and 1970s. Two brief examples serve here as illustrations. The first is from the front page of the January 13, 1983, Wall Street Journal, describing a physician-led intervention with a corporate executive: They called a surprise meeting, surrounded

him with colleagues critical of his work and threatened to fire him if he didn't seek help quickly. When the executive tried to deny that he had a drinking problem, the medical director . . . came down hard. "Shut up and listen," he said. "Alcoholics are liars, so we don't want to hear what you have to say" .

The second comes from Chuck Dederich, the founder of Synanon, counseling a Mexican-American addict in a therapeutic community, who balked at being ordered what to do:

Now, Buster, I'm going to tell you what to do. And I'll show you. You either do it or you'll get the hell off Synanon property. You shave off the mustache, you attend groups, and you behave like a gentleman as long as you live here. You don't like it here? God bless you, I'll give you the same good wishes that I gave other people like you when they left and went off to jail. That's the way we operate in Synanon; you see, you're getting a little emotional surgery. If you don't like the surgery, fine, go and do what you have to. Maybe we'll get you again after you get out of the penitentiary or after you get a drug overdose. "Nobody tells me what to do!" Nobody in the world says that except dingbats like dope fiends, alcoholics, and brush-faced-covered El Gatos.

Theoretical foundation

Although treatment systems for alcoholism and for narcotic addiction constituted two separate professional domains during much of the 20th century, both fields developed parallel theories that fostered confrontational approaches to therapy. Between the 1920s and 1950s, U.S. theories of narcotic addiction shifted from biological models of causation to models that posited the source of addiction as lying within the flawed character of the addict. Dr. Lawrence Kolb, a prominent psychiatrist and the first medical director of the Federal Narcotic Hospital in Lexington, Ky., was an early figure in this shift of perspective. Kolb observed that the dominant profile of addiction had shifted from the "innocent" addict who had accidentally become drug dependent as a side-effect of medical treatment, to the "vicious" addict who sought narcotics as a source of excitement and pleasure. In Kolb's view, the latter type of addict had a defective, psychopathic personality with a prolonged history of social maladjustment and enmeshment in deviant criminal subcultures . This led initially to a view of treatment as requiring a period of quarantine with a structured program of institutional care that could enhance personal maturation and pro-social values. It was assumed that a drug-free social adjustment in the institution would then transfer to a similar style of adjustment in the community. The failure of this assumption, confirmed by reports of very high post-discharge relapse rates, created a climate of frustration that fostered a search for alternative treatments — alternatives that included confrontational therapies.

Dr. Harry Tiebout's psychoanalytic observations in the 1940s and 1950s on alcoholics and their recovery process the stage for confrontational therapies in the treatment of alcoholism. Tiebout contended that alcoholism was rooted in character malformation that consisted of ego inflation (narcissism, grandiosity, dishonesty); self-encapsulation (disconnection from and suspiciousness of others); inner tension and hostility (guilt, anger, resentment); and a preoccupation with power and control (resistance to external influence, defiant individuality). The alcoholic, in his view, was incapable of accurate self-perception due to an elaborate system of defense mechanisms (e.g., denial, projection of blame) that simultaneously justified drinking and buttressed self-esteem. Tiebout believed that this defense structure became entrenched over the long course of alcoholism until the alcoholic hit bottom and experienced full surrender (conversion) — a disciplining process that produced deflation of the infantile ego, self-acceptance, humility and inner peace.

The task of the professional helper, according to Tiebout, was to move the alcoholic from superficial verbal compliance (and behavioral defiance) into and through a process of surrender, personality reconstruction and the development of a disciplined way of life — an early source of the aphorism, "Break 'em down to build 'em up." Tiebout's influence was significant due to his close association with Alcoholics Anonymous (AA), the widespread dissemination of his writings, and his prominence as a speaker at professional alcoholism conferences. He suggested that therapists could hasten the alcoholic's recovery process by puncturing narcissistic encapsulation, confronting faulty reasoning processes, inducing a surrender experience and facilitating reconstruction of personal identity and relationships.

Without the legitimizing theoretical foundation laid by Kolb, Tiebout and others, the emergence of harsh confrontation techniques in the late 1950s and 1960s might have been viewed as countertransference run amok, and gross violation of professional ethics. Instead, it came to be viewed as a necessary approach to treatment, "the only language they can understand." Therapeutic confrontation was essentially founded on four interrelated assumptions (Bassin, 1975).

1) Addiction is rooted in an immature, defective character encased within an armor-plated defense structure. Indeed, in DSM-II alcoholism and drug dependence were classified as personality disorders. Vernon Johnson (1973) opined that "the alcoholic evades or denies outright any need for help whenever he is approached. It must be remembered that he is not in touch with reality." (p. 44).

- 2) The seemingly passive methods of traditional psychotherapies are hopelessly ineffective in penetrating this defensive structure and altering deformity of character.
- 3) The addict/alcoholic can therefore be reached only by a “dynamite charge” that breaks through this protective shield.
- 4) Verbal confrontation is the most effective means of engaging and changing addictive behavior.
- Following its introduction in addiction treatment, there was some short-lived exploration of broader uses of confrontational therapies in the United States “to separate what a man is from what he seems to be, states himself to be, or would have us believe he is” (Weisman, 1973).

Cultural context

Trends in psychotherapy mirror evolving cultural temperaments. Confrontational therapies were diffused into addiction treatment during a decade (the 1960s) rife with social confrontations and challenges to existing values and traditions. New therapy centers promised cathartic, life transforming experiences through vehicles such as psychodrama, Gestalt therapy, Erhard Seminars Training (EST), Primal Scream, regression therapies, and confrontation or attack therapies. Elements of these new therapies seeped into the larger cultural phenomenon of “sensitivity training.” The National Training Laboratories in Bethel, Maine and the Esalen Institute in Big Sur, Calif., became centers for the dissemination of many of these therapeutic techniques and an incubation chamber for the larger “human potential movement.” It is doubtful that confrontation therapies could have been so extolled and diffused so widely and rapidly in any period other than within the social turmoil and “free-for-all approach to psychotherapy” and personal growth of the 1960s and 1970s (Singer & Lalich, 1996).

The theoretical premise of these cathartic therapies was that a wide spectrum of human suffering was rooted in repressed feelings and that such suffering could be alleviated through techniques that facilitated emotional release. The human being was pictured as a pressure cooker of repressed emotions that, if not released, manifested themselves in a plethora of physical, emotional and relationship problems. Great curative properties were attributed to the venting of emotions. Attack therapies, in this view, functioned to tear down the masks that contained repressed emotions, allowing the individual to get “real” with themselves and others. Confrontational tactics spread beyond therapeutic settings to such wider movements of the 1970s as encounter groups, Lifespring, Mind Dynamics, Insight Seminars and Erhard Seminars Training (EST). The broader adoption of confrontational techniques by allied professional fields and the larger community seemed to validate the addiction field’s use of such techniques. Fritz Perls’ use of the “hot seat” in Gestalt Therapy and William Glaser’s Reality Therapy were particularly influential in justifying the use of confrontation in addiction treatment.

Synanon and therapeutic communities

In January 1958, Charles Dederich, less than a year sober in AA, began hosting a weekly discussion meeting for alcoholics in Ocean Park, Calif. In these “loud and boisterous” meetings, a freewheeling style of verbal confrontation emerged that was used to “let the air out of pompously inflated egos.” The communication style within the meetings was an extension of Dederich’s own loud, bombastic, gruff and profane style. By summer, the numbers of those attending these meetings had grown to the point that Dederich was forced to rent a clubhouse. A number of self-described “hope-to-die dope fiends” enmeshed themselves in the life of the clubhouse and got clean for the first time in years. When conflict between Dederich’s growing legion of alcoholics and addicts and local AA groups reached a crisis in September 1958, Dederich and his followers left AA en masse and formed Synanon — the first ex-addict directed therapeutic community.

Synanon became a self-supporting, peer-based recovery community. Within this community, pro-social behavior was rewarded with increased role responsibilities and status, and anti-social behavior was immediately and intensely confronted. The paucity of viable addiction treatment alternatives and the riveting redemption anecdotes of its members contributed to Synanon’s early professional and cultural popularity. By the mid-1970s, more than 500 addiction treatment programs in the United States were modeled on Synanon, and more than 2,000 non-addicts were paying to participate in Synanon’s no-holds-barred groups .

Synanon’s (and Dederich’s) subsequent rise and fall over the following decades is beyond the scope of this article (see Janzen, 2001; Mitchell, Mitchell, & Ofshe, 1980), but Synanon’s role in the history of confrontation in addiction treatment is a crucial one. Synanon’s aggressive confrontation techniques were transmitted to second-generation therapeutic communities (TCs) such as Daytop, Phoenix, Gateway, Gaudenzia, The Family and Walden House, and were then widely diffused into the larger emerging treatment system in the 1970s. The thousands of professionals

trained by Synanon and the immense popularity of Synanon's "game club" (Synanon-facilitated groups for non-addicts) spread confrontational techniques into broader schools of psychotherapy and into the larger human potential movement of the 1960s and 1970s.

Early TCs utilized many mechanisms of confrontation, including:

Motivational Litmus Tests at Admission: Forced confession at the end of a confrontational intake interview that one was a baby, was stupid and needed help, and the surrendering of something of value to demonstrate one's commitment to recovery (e.g., money, property, one's hair).

Pull-ups: Immediate feedback from one community member to another regarding inappropriate behavior.

Image work: Demands to change physical appearance and demeanor (everything from how one talked to how one walked).

Haircut: A group session in which a relatively new member is "taken apart" by community elders and given prescriptions for improving his or her attitudes and behavior.

Learning Experience: An assignment intended as a form of self-confrontation and communication to other community members. Examples include being "busted" from a higher status position to the dishpan; wearing a diaper, a toilet seat or a sign (e.g., "I'm a baby. Please help me grow up.") for a prescribed period of time; or having one's head shaved.

The Synanon Game: A no-holds-barred group therapy that utilized verbal attack and ridicule to strip the participant's exterior image and defenses while supposedly toughening them on the inside.

Probes, Reaches, Trips, Marathons & Stews: Versions of the Synanon Game that could extend for prolonged periods of time (six to eight hours, to days).

The Fireplace Ritual (General Meeting): Meeting called of the whole community to confront a single individual's behavior.

The centerpiece of the TC experience and the engine that fueled the TC community was the Game — a leaderless group experience that was a mix of verbal brawl, group confessional, confrontational theater and improvisational comedy. Dederich described the Game as "a full unfettered expression of the most intimate and inner-most thoughts, feelings, fears, ambitions, obsessions, convictions, hatreds, prejudices, joys and hopes" (quoted in Olin, 1980). The goals of the Game were to shed the "code of the streets," drop one's "dope fiend" image, honestly face oneself, and to dump your "emotional garbage" inside the Game so that you could be happy and act responsibly outside the Game (Gerstel, 1982). The explicit lack of confidentiality related to anything disclosed during the Game added to its power. One's "jacket" (psychological profile) was broadly disseminated to all TC members with the expectation that feedback and support related to needed behavioral changes would be consistent in all of one's peer interactions. The gross effect was intended to be a form of psychological and behavioral surgery: the removal of unhealthy character defenses and behaviors and the implantation of healthier defenses and behaviors. The Game was nested in a vibrant recovery community whose mutual support was as intense as the confrontations for which it was better known. A core of early TC "graduates" quickly moved into staff positions in the 1970s within the growing network of addiction treatment programs, and, in a process akin to intergenerational hazing, replicated use of these techniques with new clients throughout the United States and beyond.

Confrontation in the Minnesota Model

In the late 1940s and early 1950s, a synergy between three alcoholism treatment programs — Pioneer House, Hazelden and Willmar State Hospital — birthed an approach to the treatment of chemical dependency that was widely replicated in the following decades. Confrontation was not a technique used within the original Minnesota Model, but was gradually introduced in stages. The first stage was the emergence of "tough love" — a concept from Al-Anon that when interpreted within the treatment context, argued that the alcoholic needed to be confronted directly about his or her behavior and held accountable for the consequences of that behavior. An important corollary was the concept of "enabling." This concept depicted well-intentioned attitudes and behaviors exhibited by those around the alcoholic that, by protecting the alcoholic from the consequences of his or her behavior, inadvertently sustained the alcoholic's drinking and related problems.

While the concepts of tough love and enabling eased the way for the introduction of confrontation techniques, it is surprising that group confrontation would emerge within a model of treatment so heavily influenced by AA. AA and the peer-based lay psychotherapy models that preceded it were distinctly non-confrontational, with AA even discouraging crosstalk at its meetings. In the AA meeting culture of the 1930s and 1940s, members did not provide direct feedback

or advice to one another, but responded to any disclosure by sharing their own related experience. Confrontational therapies are clearly not rooted in the origins and core literature of AA.

Confrontational techniques emerged within Hazelden as staff sought new ways to engage and manage a subset of clients they perceived as having severe characterological problems. In the late 1960s Hazelden began treating younger opiate and polydrug addicts whose behaviors were harder to manage within the treatment milieu. Seeking solutions to this dilemma led Hazelden staff to visit Eagleville Hospital in Pennsylvania which was pioneering “combined treatment” (integrated treatment of alcoholics and addicts). Eagleville had emulated the confrontation techniques of Synanon, Daytop and other early TCs and became the conduit for introducing these techniques at Hazelden. Openness to such confrontation techniques at Hazelden came in part from working with addicts who were perceived as “sicker” and harder to reach.

In 1967, Hazelden started a “Repeaters’ Program” and began using a peer evaluation (“hot seat”) technique within the group therapy session on this unit. In this technique, a member of the group occupied a center chair within the group, and his/her attitudes and behaviors were critiqued by other group members using an inventory sheet of 23 items, 22 of which were character defects; e.g., resentful, prideful. By the mid-1970s, the use of the “hot seat” technique had spread to all units at Hazelden and commonly included the use of derogatory language and labels. This technique was spread into the larger field by former Hazelden staff and the large numbers of people who received training at Hazelden.

In the late 1970s, the use of confrontation was re-evaluated at Hazelden. The use of the “hot seat” in the women’s units was stopped when it came to be viewed as too harsh and disrespectful. The use of confrontation on the men’s units also changed. A new inventory was integrated into the peer evaluation process that included character assets, and the person being evaluated was moved from a center chair to a chair within the group to reduce his or her vulnerability. To emphasize this change, the “hot seat” was re-christened the “love seat” and an emphasis was placed on the use of “compassionate confrontation.” By 1985, Hazelden was already describing confrontational counseling as a thing of the past:

There was a time when the dominant mode of chemical dependency treatment was based on a “tear ‘em down to build ‘em up” philosophy. . . Counseling sessions sounded disrespectful and dehumanizing. And they were . . . Patients . . don’t need to be “put down” to deal with symptoms . . they need to be treated as individuals, with the same rights and respect we expect for ourselves. We’re concerned because many treatment programs still use these confrontational techniques. Some even call themselves Hazelden or Minnesota models. It’s true that we once used confrontation. But we found a better way (Hazelden Foundation, 1985).

Through the 1980s and 1990s, the emotional tone of treatment within the Minnesota Model further changed from a harsh challenging of the person to a respectful process of inquiry about incongruity of a person’s words or behaviors (e.g., using clarifying questions in response to discrepancies between what a person said yesterday versus what he or she is saying today; what a person reports versus what his or her family members report; and discrepancies between a person’s words and his or her behavior). Profane confrontations came to be viewed as disrespectful, ineffective and professionally inappropriate. The earlier emphasis on personal confrontation by professional staff or one’s treatment peers shifted in these decades to a preference for self-education (bibliotherapy); self-evaluation (via structured self-assessment exercises); experience sharing (staff and peer self-disclosure); open-ended and cross-checking questions; and structured opportunities to see oneself in the stories of others.

The story of confrontation within the Minnesota Model and the larger alcoholism field would be incomplete without reference to constructive confrontation in the workplace and family intervention. Constructive confrontation was a strategy utilized by workplace supervisors to address alcohol-related deterioration in employee work performance. The strategy was heavily promoted in the peak period (1960s to 1970s) of occupational alcoholism programming (Trice & Beyer, 1984). Many alcoholism treatment organizations trained local workplace supervisors in the use of this approach which focused on confronting alcohol-related work problems and linking the problem employee to professional assessment and treatment services via a company-sponsored occupational alcoholism consultant.

During this same period, three propositions emerged about family adaptation to alcoholism: 1) alcoholism is a family disease; 2) the homeostasis of the alcoholic family is maintained through elaborate defense mechanisms of all family members, e.g., denial (portrayed metaphorically as the elephant in the living room that no one acknowledges); 3) family members inadvertently support the continued course of alcoholism through their enabling (e.g., excuse-making, over-compensating, rescuing) . In other words, the early model of alcohol/addiction as a disorder of individual character was broadened to conceptualize the family as pathological and heavily defending the status quo. Education of family members encouraged a strategy of “tough love” that was thought to speed up the day when the alcoholic would “hit bottom” and initiate recovery.

In 1973, Reverend Vern Johnson proposed use of a technique of family “intervention” through which the bottom could be raised to meet the alcoholic. In this technique, family and significant others staged a professionally-facilitated confrontation with the addicted individual to share detailed feedback on the person’s drinking and its effects on others and to request that the individual take specific actions to resolve his or her drinking problem. The technique gained considerable prominence when First Lady Betty Ford entered alcoholism treatment in 1978 following a family intervention organized by her daughter, Susan Ford Bales.

Family intervention became quite popular and developed as a sub-industry within the field of addiction treatment.

Subsequent developments

There were some important transition points in the history of confrontation techniques emerging from early TCs. The first was the extension of confrontation used to treat hard-core street addicts to the treatment of individuals with less severe problems, and in some cases, very fragile defense structures (e.g., adolescents, persons with severe mental illness). A second transition point was the shift in the use of confrontation within a close-knit peer community in which everyone both delivered and received verbal confrontations, to the use of one-way confrontation within a hierarchical professional counseling relationship in which the client, but not the staff, could be confronted. A third transition was of confrontation from voluntary participation in a closed, supportive community to its injection into mandated treatment and relationships of extremely disproportionate power.

These transitions heightened the potential for abuse and harm emanating from confrontation techniques. Such potential for harm increased as these techniques were adopted within total institutions (e.g., juvenile boot camps and prisons). David Deitch, a leader and astute observer of the TC movement, lamented in the early 1980s that the explosive spread of the TC model had regressed to “inane cruelties” that constituted a “caricature of the negative elements of Synanon, without its redeeming qualities.” Deitch contended that the original art form of the Synanon game and its placement within a rich cluster of group-oriented self-awareness processes and the mutual affection and support within the Synanon community mutated in other settings to a singular technique that was little more than a “verbal fistfight.”

In response to growing criticism of confrontation techniques, particularly when applied to marginalized populations, these techniques softened in the 1980s and 1990s as: the TC was adapted for adolescents; the percentage of professional staff increased; lengths of stays shortened; and outpatient services were expanded. Group technique within the TC evolved from “one of harsh confrontation to one of dialogue and discussion” (Broekaert, Vadevelde, Shuyten, Erauw & Bracke, 2004). This softening did not, of course, end issues of ineffectiveness, harm and abuse. Perhaps most controversial was the application of confrontation techniques with juveniles in diversion programs such as Scared Straight and in extended treatment programs such as The Seed and Straight, Inc. — and of which have come under severe criticism for exaggerating program benefits while remaining silent about or minimizing program risks. The abuses within the troubled teen industry led to the creation in the 1990s of such reform-minded organizations as Families Against

Destructive Rehabs

Early claims of the superior effectiveness of confrontation and counterclaims that it was ineffective and potentially harmful relied primarily on statement of opinion buttressed by anecdotes. With the emergence of more science-grounded treatment approaches in the 1980s and 1990s came studies that began to tip the scales of this debate. Two recent reports, however, suggest that confrontation still has its proponents. A 2001 study on staff attitudes toward addiction treatment found that 46 percent of those surveyed agreed that “confrontation should be used more” (Forman, Bavasso & Woody, 2001); and a 2004 ethnographic survey of adolescent addiction treatment in the United States commonly encountered programs that were “explicitly designed to demean and humiliate” (Currie, 2004).

Scientific evidence on confrontation

As the preceding history reflects, the use of confrontation in addiction treatment was based not in science, but in a confluence of cultural factors and personalities. It was primarily an American phenomenon, with very limited diffusion to other nations. We turn now to a review of relevant science on the outcomes of confrontational therapies and their conceptual underpinnings.

An addictive personality?

As described earlier, Tiebout’s primary rationale for authoritarian confrontation was his belief that people with alcohol and drug use disorders possess a characteristic pathological personality structure involving immaturity and

egocentricity, which rendered them incapable of perceiving reality. This addictive personality was alleged to include a cluster of ingrained defense mechanisms such as denial and rationalization, as well as outright dishonesty. Aggressive high-volume confrontation was believed to be the only way to break down or through the formidable wall of defenses. This thinking was subsequently extended to family members as well, alleging that an aberrant “co-dependent” personality rendered them equally pathological as their addicted loved ones .

There never has been a scientific basis for believing that people with substance use disorders, let alone their family members, possess a unique personality or character disorder. Quite to the contrary, research on virtually any measure reflects wide diversity of personal characteristics among people with addictions, who are about as diverse as the general population, or as snowflakes. Studies of defense mechanisms among people in alcohol treatment have found no characteristic defensive structure, and higher denial was specifically found in a clinical sample to be associated not with worse, but with better treatment retention and outcomes (Donovan, Hague & O’Leary, 1975).

What might account, then, for the robust belief in an addictive personality with characteristic immature defense mechanisms, a professional view that persisted for decades? Surely the writings and speeches of Tiebout and others were not in themselves sufficient to crystallize this view. Counselors genuinely experienced their clients as inevitably mired in denial. If their clients did not walk through the door all the same, how did this belief become so widespread?

An answer, perhaps, is that confrontation and denial form a complementary and self-perpetuating cycle. Defensiveness is a normal human response when one is accused, demeaned, labeled, disrespected or threatened. In other words, suspicion and confrontation are self-fulfilling prophecies. Confronting evokes client defensiveness, which in turn appears to confirm the diagnosis and bolsters the belief that such clients are typically defensive and intransigent. Clinical experiments have demonstrated that clients’ levels of resistance are very much under the control of the counselor, and influenced by therapeutic style (e.g. Miller, Benefield and Tonigan, 1993). Counselors can drive client resistance up and down within the same session, simply by switching between a directive-confrontive and a listening-supportive style.

It was also believed that the emotions and other reactions that are predictably evoked by confrontation were therapeutic. Again research paints a different picture. Expressed resistance in counseling sessions predicts a lack of subsequent behavior change, a finding that would not be intuitively surprising to most counselors. It makes little sense, then, to counsel intentionally in a way that increases client resistance and defensiveness.

If this line of reasoning is sound — that confrontation evokes resistance which in turn predicts a lack of change — then confrontational counseling would be expected to have a poor track record in outcome research. What do treatment outcome studies show?

Efficacy of confrontational counseling

Some of the first data on the effects of confrontational counseling came not from substance abuse treatment, but from research on the more general outcomes of encounter groups. Few differences or beneficial effects were found across a range of different encounter group styles. There was one style of group leader, however, who stood out from all the rest, and did so by producing an uncommonly high level of harmful outcomes: the aggressive confrontational leader.

The clearest evidence, however, regarding the efficacy of a treatment (or lack thereof) comes from randomized clinical trials, a number of which have specifically focused on confrontational therapies. The earliest of these was conducted in an inpatient alcoholism treatment facility near Bergen, Norway, where 46 patients were randomly assigned to receive or not receive an intensive “encounter group” experience in addition to treatment as usual. Contrary to prediction, no significant difference was observed in drinking outcomes at six months, with the control group showing a slightly higher abstinence rate.

In the first U.S. randomized trial, which was conducted in Mississippi (P.M. Miller, Hersen, Eisler & Hemphill, 1973), confrontational group therapy was used as a comparison group in a study of aversion therapy. Men in inpatient treatment for alcoholism showed no better outcomes when assigned to confrontational therapy, versus electric shock aversion therapy.

Another randomized trial compared behavioral group therapy with a confrontational group designed to trigger insight. The dropout rate was four times higher from the confrontational group, and even among treatment completers there was no significant difference in outcomes, with the direction favoring the behavioral group. In a small study, MacDonough similarly compared outcomes for alcoholism patients on a behavioral (token economy) ward versus those in intensive confrontational therapy. Contrary to prediction, the improvement rates were 50 percent and 0 percent, respectively. A randomized trial in Australia found no outcome differences between those treated by a seven-week “didactic, confrontational approach” versus a minimal intervention consisting of a single session of advice.

In a Canadian study, 100 adult offenders with substance use disorders were randomly assigned to routine institutional treatment or an intensive eight-week confrontational group therapy. Overall, the added confrontational therapy group produced no better outcomes than those of the control group receiving institutional treatment as usual. There was evidence, however, that offenders with low self-esteem were differentially harmed by the confrontational therapy, showing higher rates of recidivism when placed in this treatment.

A quasi-experimental study compared outcomes for inpatients receiving “a combination of persuasion, health education and gentle confrontation” versus a group of patients referred elsewhere (primarily to medical care) because admissions to the inpatient unit were temporarily closed. No significant differences in drinking outcomes were reported, but treated patients had significantly more rehospitalizations than did referred patients. A nonsignificant trend indicated more deaths in the referred group.

Two inpatient alcohol treatment programs were compared in a randomized clinical trial with 137 older patients treated at a Veterans Affairs Medical Center in Dallas, Texas (Kashner, Rodell, Ogden, Guggenheim & Darson, 1992). One was run by empathic staff and emphasized the development of self-esteem. The comparison traditional care program emphasized confrontation of patients with past failures and current problems. At 12-month follow-up, those treated in former program showed an abstinence rate more than double that for patients treated in the confrontational program.

Two reports evaluated a 15-hour “DWI therapy workshop” that used “confrontation to develop personal awareness” (Swenson & Clay, 1980; Swenson, Struckman-Johnson, Ellingstad, Clay & Nichols, 1981). Over 18 months of follow-up, there were no significant differences in outcomes for offenders randomly assigned to the DWI therapy workshop, as compared with an untreated control group given home-study alcohol education materials.

Another clinical trial directly compared confrontational versus client-centered counseling styles. Problem drinkers were randomly assigned to one of these two therapeutic styles, both of which were delivered by the same counselors. Those assigned to the client-centered condition showed larger reduction in alcohol use (69 percent vs. 41 percent), although with a small sample this difference was not statistically significant. Because the same counselors delivered both styles and differed in their skillfulness in doing so, the authors analyzed audiotapes of counseling sessions to study what was actually done in counseling. They discovered that a single therapist response predicted how much clients were drinking a year later ($r = .65$): the more the counselor confronted, the more the client drank.

Videotape self-confrontation

Another set of clinical trials focused on a particular form of confrontational intervention. In the 1950s, a French psychiatrist named Carrère introduced a procedure called “cinematographic psychoshock.” He videotaped patients while they were grossly intoxicated and undergoing detoxification, then showed them the film while they were sober as a “self-confrontation.” He optimistically reported that 45 percent of 65 patients given the treatment had remained abstinent for an unspecified period of follow-up .

In the first randomized trial of this method, however, self-confrontation triggered increased treatment dropout (56 percent vs. 10 percent in a control group) without producing therapeutic benefit, even among those who remained. In the videotape self-confrontation condition, 100 percent relapsed shortly after discharge. Other trials reported a high relapse rate shortly after the self-confrontation therapy (Faia & Shean, 1976; Feinstein & Tamerin, 1972), and no benefit of videotape self-confrontation when added to treatment as usual . Treating alcoholism at a state hospital, Faia and Shean randomly assigned lower social class patients to a confrontational “aversion” therapy or to a treatment-as-usual discussion group requiring comparable time.

The aversion treatment began with a one-hour videotaped interview with two therapists who “made every effort to elicit defensive reactions . . . by confronting him with his self-defeating behaviors.” The tape was then edited to 25 minutes containing the most conflictual parts, and in subsequent sessions the patient was forced to watch the tape while the two therapists kept up “continuous verbal prodding and confrontation.” Followup at six to nine months indicated abstinence rates of 14 percent in the confrontation group, and 25 percent in the control group; not a statistically significant difference. In several other studies, adding videotape self-confrontation to treatment produced no significant change in drinking outcomes (Vogler, Weissbach, Compton & Martin, 1977; Vogler, Weissbach & Compton, 1977; Baker, Udin & Vogler, 1975; Crawford, 1982).

Another study noted that videotape self-confrontation produced strong negative emotional responses in patients, particularly those with low self-esteem .

A different use of videotape confrontation was reported by Annis (1979). Within a minimum security correctional facility, 150 inmates were randomly assigned to usual institutional conditions (control group) or to daily "intensive, 150 inmates were randomly assigned to usual institutional conditions (control group) or to daily "intensive, highly confrontational, two-hour "awareness groups." Half of those in the confrontational therapy were further assigned to watch videotape of the prior session and received confrontational feedback. Relative to the control group over one year of follow-up, those in the confrontation group (with or without video feedback) showed no better outcomes on any measure including employment, alcohol and drug use, arrests or re-incarceration. Contrary to prediction, however, those who received confrontational treatment showed significantly lower self-esteem. Davis found no significant improvement in outcomes with outpatient confrontational group sessions reviewing tapes of prior sessions, as compared with individual psychotherapy.

The Johnson Institute intervention

As described earlier, a particularly potent form of confrontation was introduced by Rev. Vernon Johnson. He worked with family members and significant others concerned about a loved one with alcohol/drug problems who refused to seek help. They were coached and prepared for a surprise group meeting in which each of the concerned others would confront the person with their concerns and the ways in which his or her alcohol/drug use had impacted them. Sometimes they would also announce consequences that would ensue if the person did not enter treatment.

Early uncontrolled and anecdotal reports suggested that "the intervention," when completed, was remarkably effective in engaging unmotivated alcoholics in treatment (Logan, 1983; Loneck, Garrett & Banks, 1996). One study found, however, that of families being prepared for a confrontational Johnson intervention, 71 percent decided not to go through with it (Liepman, Nirenberg & Begin, 1989).

A large clinical trial randomly assigned 130 concerned significant others to receive one of three forms of counseling: Al-Anon facilitation, the confrontational Johnson intervention, or a behavioral therapy (community reinforcement and family training) (Miller, Meyers & Tonigan, 1999). Of those counseled in the Johnson approach, 70 percent declined to go through with the confrontational meeting, replicating the earlier report by Liepman (1989). Treatment engagement rates did not differ significantly for the Al-Anon and Johnson groups (21 percent), whereas those receiving behavioral treatment showed a threefold increase in engagement (64 percent). In another randomized trial (N = 278), a modified Johnson Institute intervention offered prior to discharge from inpatient alcoholism treatment had no significant impact on post-treatment abstinence.

MADD victim impact panel

Seeking to reduce the frequency of recidivism, Mothers Against Drunk Driving (MADD) developed an intervention termed the Victim Impact Panel (VIP) in which drunk drivers are confronted with the real-life consequences caused by other offenders. People whose lives have been devastated by a drunk driver, often through the loss of a loved one, volunteer to speak to an auditorium of offenders, who typically are court-ordered to attend. The presentations are usually heart-rending, with high emotional impact from these first-person stories.

Does attending a MADD-VIP prevent future offenses? One study followed 6,702 drunk driving offenders who reported whether or not they had been mandated to attend a VIP (C'de Baca, Lapham, Liang & Skipper, 2001). Among first offenders, VIP attendance had no effect on the likelihood of a subsequent offense. Among female repeat offenders, however, those who attended a VIP were twice as likely to be re-arrested for drunk driving, even after controlling for other risk factors. The study was uncontrolled, however, and a more definitive trial was recently conducted by Woodall and colleagues. In this study, judges were persuaded to randomly assign drunk driving offenders to attend or not attend a VIP in addition to the usual legal consequences. The findings were similar. Among first offenders there was no effect on the likelihood of recidivism, but for those with more than one prior offense, attending the VIP was associated in both men and women with significantly higher rates of repeat offense.

Why were such interventions ever expected to work? The underlying mental model for confrontation seems to be that "if you can just make people feel bad enough, they will change." Confrontational strategies have been designed to make clients feel scared, ashamed, or humiliated, with the assumption that such experiences are curative. In the Woodall study, exit interviews with offenders leaving the MADD-VIP experience confirmed that in general they felt terrible about themselves: embarrassed, ashamed, humiliated, guilty. The result was not less, but more drunk driving.

Discussion

Reviewing four decades of treatment outcome research, we found no persuasive evidence for a therapeutic effect of confrontational interventions with substance use disorders. This was not for lack of studies. A large body of trials found no therapeutic effect relative to control or comparison treatment conditions, often contrary to the researchers' expectations. Several have reported harmful effects including increased drop-out, elevated and more rapid relapse, and higher DWI recidivism. This pattern is consistent across a variety of confrontational techniques tested. In sum, there is not and never has been a scientific evidence base for the use of confrontational therapies.

An alternative to confrontation

The confrontational counseling style that evolved in U.S addiction treatment in the latter half of the 20th century was first and foremost authoritarian. Clients were viewed as out of touch with reality, dishonest, incapable of responsible self-direction, deficient in knowledge and insight, and pathologically defended against change. The counselor's role was one of correcting error, combating delusion, taking charge, educating, breaking down defenses, and being the client's link to reality. The fundamental message to clients was that "I/We have what you need," and the task was essentially one of installing missing pieces, the clients' deficits.

A mirror opposite of authoritarian confrontation is the empathic, client-centered way of counseling that was introduced by psychologist Carl Rogers. It is a collaborative partnership that respects the client's capacity for and inalienable right to self-determination. The counselor's role is to hear and understand the client's dilemma, and evoke the client's own motivations for change. Rogers trusted in the natural desire and ability of people to grow in a positive direction given the proper conditions. He taught that when people feel unacceptable as they are, they are immobilized and unable to change.

Experiences of shame, guilt and humiliation favor the status quo: more of the same. Indeed, if suffering cured addiction, there wouldn't be any. What people need instead, Rogers believed, is to experience understanding and acceptance, enabling them to see themselves as they really are. Here is the paradox: that in experiencing understanding and acceptance as they are, people are freed to change. Are human beings really wired in such a strange way?

To test his theory, Rogers carefully defined three conditions that he believed a counselor should provide in order to foster positive change: empathy, honesty and acceptance. Of these, empathy has been most studied, and perhaps most misunderstood. The word "empathy" could imply having had similar experiences that allow one to understand and identify with the client. It is a very consistent finding, however, that counselors who are themselves in recovery are neither more nor less effective in treating addictions (e.g., Empathy might also be thought of as a feeling, as sympathy with the person's condition. What Rogers meant, however, was a definable and learnable counseling skill, the ability to listen to one's clients and reflect back to them the meaning contained in what they say (Truax & Carkhuff, 1967). It is an art that looks simple when done by someone who is good at it, but in fact accurate empathy is a complex skill at which one can continue to improve throughout a lifetime of practice.

Rogers himself never undertook treatment of addictions, but his client-centered counseling methods have been studied by others in this field. Ends and Page studied outcomes for clients assigned to one of three kinds of group therapy for alcoholism: client-centered, psychoanalytic or learning theory, all led by the same therapists. The largest improvement at 12- and 18-month followup was found for those treated in the client-centered format.

In two studies, clients with alcohol problems were randomly assigned to counselors who varied in their level of skill in client-centered counseling. One study involved nine counselors, all of whom were delivering the same manual-guided behavior therapy for problem drinkers (Miller, Taylor & West, 1980). Before collecting outcome data, their supervisors independently rank-ordered the nine counselors on their skill in accurate empathy, based on observation (via one-way mirror) of treatment sessions. Inter-rater agreement was high, and when follow-up data became available, client outcomes were examined.

The proportion of poor outcomes varied from zero (for Counselors 1 and 3) to 75 percent (Counselor 9). As is apparent, although the clients were all ostensibly receiving the same behavior therapy, the single best predictor of their post-treatment drinking was the counselor to whom they had been randomly assigned. Specifically, the more empathic their counselor, the less clients were drinking at six, 12 and 24 months (Miller & Baca, 1983; Miller et al., 1980). A larger multi-site trial similarly found significant outcome differences across the case loads of counselors delivering standardized manual-guided treatments, despite intensive training and monitoring.

In a second study randomly assigning cases the counselors, Valle studied counselors' level of skilfulness in providing the conditions of client-centered counseling (empathy, honesty, acceptance). Figure 2 shows relapse rates in the

in the caseloads of counselors with low, medium, and high levels of client-centered skills. Once again, a primary determinant of clients' outcomes was the counselor to whom they had been randomly assigned. At 6 months the likelihood of relapse was 4 times higher with low relative to high-empathy counselors, and even at 24 months the ratio remained over 2 to 1.

These counselor differences are some of the largest therapeutic effects found in the substance abuse treatment literature. We believe that the evidence supports using skillfulness in accurate empathy as a central qualification when hiring new addiction counselors (Miller, Moyers, Arciniega, Ernst and Forcehimes, 2005).

More recently, the client-centered method of motivational interviewing has come to be widely used in the treatment of substance use disorders. Motivational interviewing is essentially an evolution of Rogers' humanistic counseling style, manifesting an empathic, respectful and collaborative approach. A large body of randomized clinical trials now supports the efficacy of this approach in treating alcohol/drug problems.

Rethinking confrontation

The clinical method of motivational interviewing has historically been taught as an alternative to confrontation, a diametrically opposite style. In watching demonstrations of this approach in workshops, however, counselors have at times observed, "This is actually very confrontational." Exploring just what they meant by this led to a different way of conceptualizing what confrontation is, and we believe it is time to rehabilitate this concept.

In its etymology, the word "confront" literally means "to come face to face." In this sense, confronting is a therapeutic goal rather than a counseling style: to help clients come face to face with their present situation; reflect on it; and decide what to do about it. Once confronting is understood as a goal, then the question becomes how best to achieve it. Getting in a person's face is rarely the best way to help them open up to new perspectives. There is, as Hazelden observed in its 1985 recanting of aggressive confrontation, "a better way." People are most able and likely to re-evaluate reality within safe, empathic, supportive and nonjudgmental interpersonal relationships that do not necessitate defensiveness.

The confusion of confrontation as a therapeutic goal versus a harsh counseling method continues to create confusion by mixing together quite diverse treatment approaches (Polcin, 2003). A recent Romanian study (Mihai, Damsa, Allen, Baleydir, Lazignac & Heinz, 2007) reported outcomes of having patients view videotapes of themselves that had been made while they were suffering delirium tremens during alcohol withdrawal. This was introduced by the authors as an "unusual" treatment method, without any reference to the 10 previously conducted randomized clinical trials of videotape self-confrontation described earlier in this review. Unlike prior trials, Mihai and colleagues reported significantly lower relapse rates in patients randomly assigned to the videotape exposure group (though it should be noted that all follow-up data were collected by the first author, who delivered the treatment and was aware of group assignment). The treatment was described as "presenting the tape individually to the patient after recovery and explaining the symptoms viewed." In an accompanying comment, this was interpreted as a "confrontational" intervention (Bühringer & Hoch, 2007), although the study authors themselves did not use this term to characterize it.

One can imagine a wide range of methods that might be used to pursue a therapeutic goal of confrontation — to help clients come face to face with a difficult reality and allow it to change them. The literature thus far points to the consistent failure of an aggressive or authoritarian, in-your-face style of counseling. Allowing patients to view their own detoxification, with gentle expert explanation of the symptoms that are occurring, may have quite a different impact from the confrontational intervention styles evaluated in earlier studies. Giving heavy drinkers personal feedback by mail to help them compare their own alcohol use with social norms can significantly reduce consumption, even with no personal contact (e.g., Agostinelli, Brown & Miller, 1995). It is important to separate the goal of helping people to ponder their present reality, from counseling styles that try to force them to do so.

Time for change

In the addiction field as in the annals of prevention and treatment efforts, more generally, there is a long history of iatrogenic insults, of interventions that inadvertently do harm. They are done with the best of intentions, by practitioners who firmly believe that they are helping. The problem is that it is difficult to recognize such practices within one's own era. They are easier to see in retrospect.

It is time to declare a final moratorium on the use of harsh, humiliating confrontational techniques in addiction treatment.

It is time to lay to rest once and for all the arrogant notion that we should or even can dismantle other human beings and then put them back together in better and wiser form. With impressive consistency, research tells us that authoritarian confrontation is highly unlikely to heal and may well do harm, particularly to the more vulnerable among those we serve. Within this context, such confrontational treatment is professionally unethical, and is doubly problematic when used with coerced populations such as court-ordered or employer-mandated populations.

American addiction treatment took an aberrant detour and went far afield with confronting in aggressive and even cruel ways. This created a self-fulfilling cycle whereby clients became defensive, thus reinforcing the belief that still more forceful confrontation was required. It is time to conduct a historical self-inventory of such practices, admit that these practices were ill-chosen, end their use, make amends where we can to those injured by such practices, and embrace different practices that are more effective and more respectful. There is now a strong science base for addiction treatment, and a related menu of evidence-based treatment methods that provide ample alternatives .

It can be difficult to change established mental models. The Hungarian physician Ignaz Semmelweis discovered in 1847 that the deaths of mothers from childbed fever could be dramatically reduced if doctors washed their hands before delivering each baby. His discovery was adamantly rejected, however, and he was fired from his hospital position in Vienna. His subsequent studies demonstrated conclusively that handwashing could virtually eliminate these preventable deaths. He published his findings in a book in 1861, but his data clashed with medical theories of the time, and were widely rejected. Practitioners continued to deny the evidence, rather than facing the terrible truth that they had killed countless women simply by not washing their hands. In 1865, at age 47, Semmelweis was involuntarily committed to a mental asylum, where he was beaten to death two weeks later. Another generation passed before handwashing became routine when attending childbirth, and in the interim, thousands of women died needlessly.

As is true for our clients, it is painful sometimes to face reality and change our ways. But it is time, long since time, to wash our hands of authoritarian confrontation, and to listen instead to the co-therapist we have within every client.

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