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ORIGINAL PAPER

Confronting Patients: Therapists' Model of a Responsiveness Based Approach

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Abstract Confrontation represents a way of challenging patients in psychotherapy to stimulate change. Confrontation draws attention to discrepancies, for example between elements in a patient's functioning. The present study was designed to construct a conceptual model of confrontation used by therapists when trying to address two main questions: what are the risks and opportunities of confrontation and how can these effects be influenced? Fifteen therapists from the Psychotherapy Outpatient Clinic of the University of Bern in Switzerland participated in semi-standardized interviews, which were analyzed using qualitative content analysis and thematic analysis. Several main themes merged into a dynamic, sequential model: groundwork required before a confrontation, shaping the confrontation, the (immediate) effects, and management of negative consequences. Therapists assume that a confrontation may induce insight and can strengthen the therapeutic relationship either directly or indirectly through the repair of a rupture in the alliance.

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Understanding Therapeutic Confrontation and its Effects

Balancing support and challenge is recommended for successful psychotherapy (Caspar 2007; Ribeiro et al. 2013). The safety of the therapeutic relationship provides support (Levitt and Williams 2010), while patients can be challenged through confrontation (e.g. Ribeiro et al. 2013) in order to encourage change. Confrontation is defined as an intervention focusing on discrepancies noticed by the therapist (Hill 1978; Polcin 2006). These discrepancies may lie within the patient (e.g., wish to enjoy social activities vs. fear of rejection in social settings), between patient and therapist (e.g., therapist sees avoidance of social events as problematic vs. patient sees no need to stop avoidance), or between patient and the patient's environment (e.g., patient wishes to see plays with friends vs. friends are only interested in watching sports). Although confrontation is widely mentioned and included in different rating instruments (Moyers et al. 2005; Ribeiro et al. 2013), little is known about the relevant features of successful confrontations and even less about therapists' opinion on the confrontation as related to the therapeutic relationship.

Many authors aim for an expansion of patients' awareness through confrontation (e.g. Meystre et al. 2015; Strong and Zeman 2010). Others mention possible disadvantages, such as provoking resistance or defensiveness (Reid 1986), or other a negative influence on the therapeutic relationship (Coutinho et al. 2011). Based on these assumptions, after a successful confrontation, a patient reacts by engaging in the session with no worsening of the alliance. In contrast, an

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unsuccessful confrontation is either not assimilated by the patient or there are signs of a deterioration of the therapeutic relationship. To differentiate the concept of confrontation from the concept of interpretation, therapists try to expand client's awareness through interpretation by pointing out unconscious determinants of behavior, while confrontation refers to observable facts the patient can readily become aware of (Reid 1986). Therefore, we define a confronting intervention as a *focus on discrepancies for which the patient may or may not be aware*. This includes the assumption of an already existing awareness of the patient that is supposed to be augmented or made more explicit through a confrontation seeking insight. Insight may in turn be an important mechanism to foster change (Murray 2002).

Aims

Our main objective was to construct a conceptual model of confrontation used by therapists that addresses two main questions: What are risks and opportunities of confrontation and how can these probabilities be influenced? The present study aimed to explore therapists' opinion concerning timing and shaping of confrontation, related processes and concepts as well as strategies of working with patients' reactions to confrontation. We aimed to explore a similar variety of therapists' opinions within the constraints of one outpatient clinic.

Method

Participants and Research Team

The sample consisted of 15 therapists that were recruited from the Psychotherapy Outpatient Clinic of the University of Bern in Switzerland by e-mail (sent to 18 experienced therapists and 85 in training) and by introducing the project in appropriate settings such as case conferences. Ten experienced therapists were enrolled as well as five that were still in training. There were eight female therapists. The age of the therapists ranged from 28 to 64 with a mean of 42.7 years (SD = 8.6 years). Ten therapists worked in their private practice and/or other clinics additionally to their work in the Psychotherapy Outpatient Clinic. Years of experience (working as a therapist) ranged from 1 to 40 years (mean: 12.9 years, SD = 9.2 years). The common theoretical background of the therapists lied in integrative cognitive behavioral therapy, complemented with Bernese concepts as they either had received a postgraduate training in the Psychotherapy Outpatient Clinic and/or worked there as therapists or supervisors. All three authors of this study are practicing therapists at the same Outpatient Clinic. The first and second author both partook as therapists in training; the third author co-founded the training program and is still actively involved in the underlying conceptual work as well as teacher/tutor/trainer.

In their daily work, the interviewed therapists use case conceptualizations that include Plan Analysis (Caspar 2007) and Motive Oriented Therapeutic Relationship (MOTR; Caspar 2007). MOTR[1] is a prescriptive approach to create a solid therapeutic relationship and suggests behaving responsive to patients by furthering their most important motives and needs that can be deduced by Plan Analysis. Plan Analysis focuses on the instrumentality between patients' verbal and nonverbal behavior and depicts the underlying motives and needs hierarchically with the observed behavior. By tailoring interventions to each patient's motives and needs, therapists can be complementary (by satisfying patients' motives) when using MOTR or anti-complementary (by threatening patients' motives), which tends to happen when confronting patients. When asked to assign themselves theoretically, six therapists explicitly mentioned integrating concepts and techniques (besides the ones already taught in Bern) from approaches such as emotion-focused or humanistic therapy. When asked, as how confronting they judged themselves from 1 (not confronting at all) to 100 (maximally confronting), the participating therapists ranged in estimations from 10 to 70. Upon agreeing to participate in the study, the therapists were given written consent forms and were informed regarding the data collection and analysis process. They were told that the focus of the study lied in analyzing therapists' opinion on confrontation and their use of it in psychotherapy.

Interview Process

The interview guide was developed by the first author and tested in a trial interview with the second author, based on which adjustments were made. A second trial interview with the third author as interviewee was included in the data for the analysis, as there were no more alterations to the interview guide afterwards. The ten core questions of the interview guide as used in the regular interviews were: Are there rules according to which you decide (not) to confront? Do you confront in every therapy/session? What impact do you expect from a confrontation? What connections do you see with other processes/aspects/factors of therapy? How are process aspects such as resource activation, problem actuation, mastery or clarification of meaning involved? How is the therapeutic relationship connected to confrontation? What is the role of the para-/nonverbal communication?

[1] The use of Plan Analyses and MOTR received empirical support in several studies (e.g. Grawe et al. 1990; Kramer et al. 2015).

How do you assess the effect of a confrontation? How do you react when a confrontation is not successful? When do you decide to confront? What aspects (e.g. conversation with other therapists) are important for you when planning a confrontation?

The Interviews were conducted by either the first author or one of two Masters students and were recorded with a voice recorder. After starting the recording, the interviewer introduced a definition of confrontation (discrepancies that the patient may or may not be aware of, initiated by therapist, anti-complementary regarding patients' plans, implicit or explicit, verbal or nonverbal) which was then discussed and the therapists were asked to provide examples to ensure a common understanding of the concept. The central questions from the semi-structured interview guide were asked next in an order fitting to the flow of the conversation. Finally, the interview was concluded by asking the therapists to estimate how confronting they are on a scale from 1 to 100 and whether there was something important not considered in the interview.

Data Analysis

After the interviews had been conducted, all audio recorded data was transcribed mostly verbatim (grammatical errors were smoothened, Swiss German was translated to High German) by the interviewers themselves. The resulting 15 transcriptions contained on average 2006 words (range 861–3634, SD = 554) and were analyzed in their entirety utilizing Thematic Analysis (Braun and Clarke 2006) by following six phases (familiarizing with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, producing the report) as suggested by the authors.

The familiarizing with the data (phase one) included whole interview summaries by the first author and regular discussions of past and future interviews between the three interviewers. Based on these discussions, an interview question ("How confronting do you judge yourself from 1 to 100?") was included after the first three interviews for an indication of the de facto diversity in usage of confrontation. During phase two (generating initial codes), the first author analyzed every interview separately and the resulting codes were integrated into one general coding system. Methods of Qualitative Content Analysis (Mayring 2014)—paraphrasing; generalization to required level of abstraction; reduction through selection, erasure, binding, construction and integration—were included during this phase as they entail more explicit heuristics to generate initial codes. Possible codes were also explored in the above-mentioned discussions with the other two interviewers. Exemplary codes that resulted from phase two were: *required work on the therapeutic relationship before a confrontation, shaping a confrontation—intensifying* or *strategies to assess patients' reaction*. When no more codes to be generated were found (and therefore saturation was reached) and the range of responses to the interview question above was deemed wide enough, no more interviews were conducted.

Next, the two mentioned and one additional Masters student coded the transcriptions; each interview was coded twice independently by two students. The first author and the three students then discussed divergent codes to reach a consensus (for instance by listening together to the original recording) as proposed by Hill et al. (2005): 18 (1.2%) codes were deleted and 111 (7.6%) were changed if they were used to code the same passage in the transcript and were closely related. If there was not enough information in the passage for both codes or the interpretation of the original coder could not convince the rest of the team, the codes were deleted or changed.

Within phase three (searching for themes), thematic maps were created by the first author to get a systematic overview of themes that were condensed into a dynamical, sequential model. These maps included codes from the coding system such as *insight as a consequence of confrontation* as well as newly formed concepts based on contents in several extracts relating to one specific code (exemplary code: *shaping confrontation by attenuating confrontation*, resulting concept based on corresponding extracts: *strengthen patient's self-esteem to attenuate confrontation*). Finally, phase four (reviewing themes) and five (defining and naming themes) consisted of: integration of participating therapists' comments after sending back the resulting model; discussion of the model with the second and third author and revision of themes and subcategories according to the number of therapists who gave their opinion in line with Hill et al. (2005). Consequently, the five resulting themes (see Fig. 1) were either categorized as general (14 or 15 therapists) or typical (7–13 therapists) and subcategories additionally also as variant (2–7 therapists). Since no obvious difference between experienced therapists and therapists still in training was observed during the coding of the interviews or the synthesis of themes, further analyses of possible subtle influences of experience were left out. Another reason was the small and unbalanced size of the subsamples.

Results

Groundwork Before Confrontation

The first theme (chronological order) contains specific requirements before a confrontation that may increase the probability of desirable patient reaction and consequences after a confrontation. Therapists assume that it is essential to achieve a *securing of the therapeutic relationship* (general)

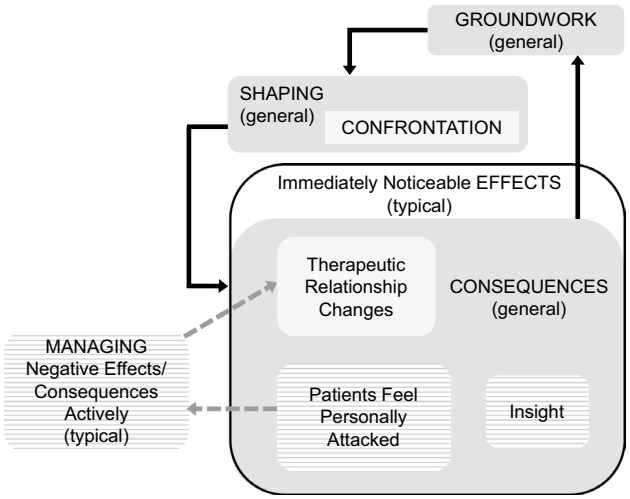

Fig. 1 A tentative conceptual model of a Responsiveness based approach when confronting patients as postulated by therapists in interviews. Arrows illustrate preceding themes/subcategories affecting subsequent themes/subcategories. Horizontally shaded boxes include partial occasional processes. Descriptions in parenthesis indicate categorization of themes according to Hill et al. (2005)

by overcoming problems with patients. This interaction is important in order for them to see that the therapist understands them and reacts appropriately when difficult situations occur. This might also help *strengthen patients' self-esteem* (variant), which interviewed therapists see as crucial, especially if it is very fragile at the beginning of therapy. This is formulated in the following statement: "If a patient is very shy, unsure, and cautious, I would firstly show them what they do well and make them feel comfortable." Thus, the chance is increased that patients don't experience the confrontation as a personal attack. Therapists also stress *clarifying goals of confrontations* (variant), for instance through explaining the importance of uncertainty and the opportunities painful processes bring along allowing to move forward in therapy. As one therapist expressed it: "I try to develop that with my patients in the first four, five sessions: 'I will hurt you, I will confront you.'" In addition, a *moderate arousal in patients* (variant) seems to be desirable to therapists, as they assume that this is an important factor for the patients´ ability to later process a confrontation. At last, therapists need a *specific reason to confront* (variant), which they derive from the case conceptualization.

Shaping the Confrontation

Therapists assume that the *therapeutic relationship* (typical) can be used explicitly to attenuate the contents of a confrontation by using specific nonverbal or paraverbal cues, for example friendly mimic or gentle voice, and thereby conveying acceptance, interest, respect, etc. One therapist stated: "I am sure that the patient pays attention to my nonverbal communication to assess whether I—as a therapist—am there with him or her." If therapists address the therapeutic relationship as the content of the confrontation, the intervention usually gets more intense. The therapists expect to *strengthen patients' self-esteem* (variant) by activating resources in the same intervention or explicitly showing faith in the patient as an attenuating strategy. They also mention *manipulating patients' control over the confrontation* (typical) by handing it over, for example by phrasing the confrontation as a proposal that can be rejected, or by restricting it, so patients get no way of deciding to change the topic. One therapist explained: "I am rather demanding: I start the intervention quickly, so the patient has no possibility to reflect." To give a specific example for the shaping of a confrontation: a therapist confronts a patient with social phobia mildly by formulating the intervention as a proposal: "I have a theory, and would be interested in hearing your opinion. It seems to me, that there are two parts in you that are completely opposed to one another: You greatly fear to be rejected in the presence of others, but long for company at the same time."

Consequences of Confrontation

Therapists often stated *Insight* (typical) as a desirable consequence of cognitive and emotional processes initiated by confrontation. As another possible consequence of confrontation, the *therapeutic relationship changes* (typical) by improving or worsening: If a confrontation is successful, it supposedly increases in strength, because therapists may show confidence in patients (which in turn boosts their self-esteem) and genuineness in their interactions, as one therapist remarked: "[confrontation] is also beneficial for the therapeutic relationship; it promotes its authenticity, because I address difficult topics." Therapists also anticipate ruptures in the therapeutic relationship, which in the worst case results in a discontinuation of the therapy. Therapists assume that *patients feel personally attacked* (typical) after an unsuccessful confrontation, because they feel misunderstood, devalued, offended or perceive the therapist as intrusive.

Immediately Noticeable Effects of Confrontation

Therapists also mentioned more directly noticeable effects in the patient, which we categorized focusing on emotion, verbal or nonverbal behavior (all typical). As part of a *desirable nonverbal reaction* a patient may turn quiet as a sign of reflection or start to show emotions, which were not shown or felt so far, such as crying to express his/her sadness. However, as part of an *unwanted nonverbal reaction*, the patient may also withdraw in the

contact to the therapist by falling silent or by simply not returning when the next session is due. In a different but related subcategory, therapists mentioned particular *emotions* in relation to general desirable effects, specifically irritation and uncertainty. One therapist explained: "One sees how vexed the patient gets. A process is initiated." These emotions were categorized as desirable, because therapists believed them to be part of a process of disruption necessary to encourage change through confrontation. Emotions related to an unwanted reaction were formulated as negatively connoted and revolve around anger, fear and shame.

On the *verbal level as part of a positive reaction*, the patient may show signs of elaboration and integration of the content of the confrontation, for instance by relating it to already talked about concepts. Important to note: the interviewed therapists did not express a wish for agreement with their intervention, but a general willingness to actively reflect on it. As part of an *unwanted reaction on the verbal level*, patients may justify themselves, agree over hastily or deflect. In the above example, the patient deflects: "Actually, being with others is not that important to me."

Managing Negative Effects/Consequences Actively

In case of an unsuccessful confrontation, this last theme is a necessary subsequent addition to end the intervention successfully according to the interviewed therapists. They talked about actively managing patients' unwanted reactions by addressing the situation either immediately in the same session or the following. In detail, three different strategies (which are not mutually exclusive) were mentioned. If patients' reactions are representative for their functioning or interactional behavior, the therapists use the current situation exemplary and *change to a meta-level* (variant), as conveyed in the following example by one therapist: "Or I change to the level of processing or the level of the therapeutic relationship: 'Obviously I hurt you, where else do you experience this?'" The second strategy, *Apologizing and taking the blame* (variant) probably has the strongest effect on the patient's self-esteem, which may have gotten hurt during the confrontation. Therapists also try to *resolve the situation* (variant) by explicitly including the patient in the clarification of the situation and explaining the procedure. In the above mentioned example, the therapist reacts to the patient's verbal deflection by apologizing and trying to resolve the situation: "I'm sorry, I have misunderstood you. How would you formulate these two parts in you, that don't seem to agree with each other?"

Discussion

It is common to focus on two characteristics of confrontation: expansion of patient's awareness as a positive consequence and weakening of the therapeutic relationship as a negative consequence (e.g. Boardman et al. 2006). While in our model, expanded awareness is clearly represented through insight, the therapists in our study did not see the association with the therapeutic relationship as irrevocably negative when talking about effects of confrontation. A confrontation can also strengthen the therapeutic relationship. In line with this, Moyers et al. (2005) found that confrontations were positively related to client involvement (which may be seen as related to a good therapeutic relationship). Successful confrontations may be perceived as genuine and authentic by the patients and may therefore even directly strengthen the therapeutic relationship, similar to assumptions that underlie Rogers' (1957) genuineness or congruence. The therapists in our sample assume that a confrontation may directly strengthen the therapeutic relationship as it might be complementary to specific patients' motives (for example to be perceived as strong or to work purposefully on problems). This overturns the initial placement of confrontation as a solely challenging technique in the balance construct around challenge and support as it appears that confrontation may include aspects of both.

Not every confrontation can be planned and shaped optimally. The interviewed therapists are aware of the risk to rupture the therapeutic relationship when confronting. We link alliance ruptures as defined by Safran et al. (1990) and possible negative short-term consequences of confrontation. Most of our participating therapists had either explicit knowledge of the concept alliance rupture or mentioned it in the interviews. The therapists in our study proposed different strategies in case of an alliance rupture, which all include an active management of the consequences of the confrontation, so a positive or even better than initial outcome is possible. These proposed strategies strongly correspond to the empirically informed model for successfully resolving ruptures (Miller-Bottome et al. 2017). Similar to the therapists' assumptions, (Safran et al. 2001) showed that the presence of rupture-repair episodes was positively related to good outcome. Therefore, if therapists have strategies for noticing and repairing alliance ruptures, confrontations might pose manageable risks, even in worst-case scenarios. Therapists can conceptualize a variety of responsive therapeutic strategies after a confrontation, whether to confront again by using the positive momentum of a successful confrontation or to manage an unwanted consequence and to repair a rupture in the therapeutic relationship.

Responsiveness is important for timing and shaping a confrontation. The therapeutic relationship plays a crucial role and represents a necessary premise as part of the

groundwork before a confrontation. Furthermore, during a confrontation, responsiveness can lead to attenuate the confrontation or to address the therapeutic alliance directly. The therapists propose different therapeutic processes when confronting as affected by emerging context (state of therapeutic relationship, success of confrontation), which fits the definition of Responsiveness as used by Stiles et al. (1998) or general psychotherapeutic concepts that focus on responsive therapeutic behavior, for example MOTR (Caspar and Grosse Holtforth 2009) or Brief Relational Therapy (Muran and Safran 2002). Accordingly, depending on the patient, confrontations can and should be widely different in timing, quality and quantity.

A responsive use of therapeutic strategies requires a reliable judgment of the patient's reaction after a confrontation, which might be even more difficult when a patient's behavior is part of a rupture characterized by withdrawing or disengaging. Negatively connoted emotions (such as uncertainty, irritation, fear and shame) were mentioned in our interviews, even when related to desirable consequences, which might increase the difficulty of classifying a patient's reaction correctly. However, uncertainty (Ribeiro and Gonçalves 2010) or a "heating up" of the system (Caspar et al. 1992) is a crucial part of change processes. Even sadness and hurt may be part of important insight events (Timulak and McElvaney 2013).

Limitations and Conclusions

While there was diversity in demographic variables such as therapist experience, gender or age, other characteristics of our sample limit the generalizability of the results, because participants were self-selected from a large pool of invitations. Especially with the therapists in training, it is possible that we missed therapists with less clear assumptions or less professional security. Opinions about and the reported use of confrontation were diverse, but we lack inclusion of extreme positions, such as complete resistance to use confrontation. Additionally, all recruited therapists were involved with the same Psychotherapy Outpatient Clinic and had a common background of cognitive behavioral therapy. Therefore, the constructed working model needs to be tested using observer-based data or therapists with different backgrounds. There also is no systematic comparison to other interventions, which could possibly need some groundwork beforehand and could similarly put strain on the therapeutic relationship when not successful, such as exposure to feared stimuli. Lastly, we used an intensive analysis approach that restricted our sample size. With these limitations in mind, we highlight three different process stages when confronting patients where practitioners might profit from a Responsiveness based approach as proposed by the therapists in our interviews:

1. Before: consideration of requirements such as establishment of therapeutic relationship.
2. During: shaping (intensify or attenuate) according to moment in therapy and patient's characteristics.
3. After: usage of positive momentum of a successful confrontation to further increase insight or work on strains on the therapeutic relationship based on patients' reaction.

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Compliance with Ethical Standards

Conflict of interest The authors declare no conflict of interest.

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