DRUG & ALCOHOL FINDINGS *Hot topic*

Below is one of our selection of Hot Topics, important issues which sometimes generate heated debate over the facts or their interpretation. Click the GO button or the Blue title to trigger a customised search for relevant FINDINGS documents. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text.

Send email for updates
your.email@address
SEND About updates

▶ Title and link for copying ▶ Comment/query to editor ▶ Other hot topics ▶ Tweet

GO Treatment staff matter

If considered at all, addiction treatment research generally dismisses the impact of the *therapist* as 'noise in the system' to be eliminated in order to focus on the specific *therapy* – a narrowing of perspective which risks eliminating what matters in order to focus on what (within the boundaries of bona fide, structured therapies) generally does not, both in substance use and across psychosocial therapies for mental health problems. To help redress the balance, this hot topic focuses on the recruitment and development of the workforce, and on the influence of how they treat patients in the ordinary sense of the word 'treat'.

Influentially formulated by Carl Rogers in the mid-1950s, the centrality of the relation between therapist and client has long been acknowledged, but became overshadowed by a mechanistic ethos which sought to legitimise psychosocial therapies by analogy with interventions based on 'hard science' like pharmacology. The implicit model was that if the remedy keyed adequately into the disorder, and was administered as intended and in a sufficient 'dose', it had the potential to unlock the cure – whoever administered it, with whatever attitude to the patient, whether they were caring or cold, and regardless of the context.

> **The Necessary and Sufficient Conditions of Therapeutic Personality Change**
>
> **Carl R. Rogers**
> University of Chicago
>
> Received: June 6, 1956.
>
> For many years I have been engaged in psychotherapy with individuals in distress. In recent years I have found myself increasingly concerned with the process of abstracting from that experience the general principles which appear to be involved in it. I have endeavored to discover any orderliness, any unity which seems to inhere in the subtle, complex tissue of interpersonal relationship in which I have so constantly been immersed in therapeutic work. One of the current products of this concern is an attempt to state, in formal terms, a theory of psychotherapy, of personality, and of interpersonal relationships which will encompass and contain the phenomena of my experience. [1] What I wish to do in this paper is to take one very small segment of that theory, spell it out more completely, and explore its meaning and usefulness.

Introduction to Carl Rogers' seminal paper, "The necessary and sufficient conditions of therapeutic personality change"

That this was a misguided vision has been suggested by studies which found therapists varied greatly in their performance (1 2 3 4 5). Even in studies designed for other purposes or which actively sought to eliminate it from the analysis, the influence of the therapist and how they relate to substance using clients has forced its way to the surface. In 2000 reviewers commented: "This finding has emerged repeatedly in a variety of studies, although, paradoxically, this result was rarely the intent of the studies. It is a finding that has been called 'surprising' and 'serendipitous'. Yet to most front-line clinicians, program administrators, and patients, this result would seem obvious; it is widely known that some practitioners are highly regarded whereas others are avoided."

In this respect, substance use research is catching up with findings from general psychotherapy, where client-therapist relations have been endorsed in reviews commissioned by the American Psychological Association as the root of several of the common factors which affect outcomes across different therapies. Techniques such as motivational or cognitive-behavioural exercises can be seen not as active ingredients in themselves, but as vehicles for communicating what to many substance use clients will be the revelation that someone sees them as worth devoting time and attention to and is optimistic about what they can become, offering a credible schema of how they got into trouble with substances, and how they find a way out.

This hot topic focuses on the impact of the 'proximal' client experience face-to-face with their carer, but we should acknowledge that this encounter is merely the sharp end of all the organisational influences on how that counsellor feels they should and can behave and on how the client interprets the encounter. Oranisational context is the subject of another hot topic, which describes a classic series of British studies which though focused on the therapeutic alliance – the core of the client-carer encounter – found this depended on the workplace environment, including whether it engendered the feeling in the carer that tackling drinking was a legitimate role supported by their organisation. The studies turned the focus on the messages staff receive about the organisation's priorities as expressed in its policies, resource allocation, and the perceptions induced in staff about whether working with drinkers is a valued and worthwhile use of their time.

Complexity belies easy answers

Among the documents retrieved by the GO-button search are some of our own *Manners Matter* series devoted to the roles played in treatment by sensitivity, helpfulness, and the systematic implementation of a personal, welcoming response. But such generalisations cannot mechanistically determine treatment at the individual level, where there are no hard and fast formulas for success, and the patient is the greater part of the equation. Treatment is or should be an individualised and collaborative venture whose pattern is worked out between client and patient rather than directly transferred from research. Across psychotherapy, evidence is strongly in favour of patients and therapists collaboratively agreeing goals and how they will go about reaching them. Paradoxically, collaboration can sometimes

Web2PDF
converted by Web2PDFConvert.com

mean adopting the role of an expert telling the patient what they should do. While researching *Manners Matter*, we discovered solid research support for therapists matching how directive they are to the patient's inclination to be led or to take the lead. *My way or yours?* related these findings to everyday experience: "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."

However, many more dimensions are involved than directiveness, and they interact. For example, in one of the studies we reviewed, the biggest influence on drinking outcomes was not directiveness, but whether therapists addressed the emotional state of highly distressed patients. Had they avoided doing so for fear of being over-directive, they might have done more harm than good. Then there is the possibility that adopting an interpersonal style which does not come naturally or contradicts the realities of the situation will violate another tenet of effective therapy – being and seeming genuine. It all means there are no set recipes for success, rather broad principles and multiple influences whose complex interactions change depending on the context, underscoring the importance of socially skilled, empathic, and client-centred staff capable of and willing to react appropriately and incorporate patient preferences in treatment decisions.

> *The complexity of interacting influences demands socially skilled therapists who can react appropriately*

Given this complexity, it is no surprise that while research has shown outcomes differ for different therapists, distilling the essence of what makes a therapist better or worse has been difficult. It might, for example, be thought that those more competent in the therapy or who more conscientiously implement its prescribed style and techniques would prove more effective. Then the route to effective therapy would be clear – select, train and supervise to make sure therapists do what they are supposed to do well, and do lots of it. But that route was confounded by a synthesis of studies of psychosocial therapies which had assessed therapist competence in and adherence to the therapy and related this to outcomes: "The most striking result is that variability in neither adherence nor competence was found to be related to patient outcome and indeed that the aggregate estimates of their effects were very close to zero." Among the substance use studies in particular there was a near-zero relationship between adherence to the therapy and outcomes, and a slight and non-significant *negative* one for competence. Similarly, in substance use studies, outcomes can be worse when therapists are trained and tightly supervised to ensure they implement the therapy manual.

Just too good!

The authors of the research synthesis referred to above advanced several possible reasons for their findings. One was that therapists in research studies are often selected, trained and supervised to ensure they are *all* good at the therapy, leaving little scope for different degrees of goodness to affect outcomes. Then too, therapists may ease off when patients are doing well, and intensify therapy implementation when they are not, creating spurious relationships in the 'wrong' direction. But the most interesting reason why higher competence and adherence does not necessarily generate better outcomes is that something happens when therapists are very, very good at the therapy, which makes them less effective than their peers who are (as usually assessed by trained observers) merely good or very good.

This puzzling result can it seems happen in brief alcohol interventions for risky drinkers identified through screening. It emerged in a Swiss study which set out to reveal the impact of the counsellors by deliberately recruiting 18 who differed widely in professional status, clinical experience, and experience of motivational interviewing, the basis for the intervention. Left to their own widely differing devices, they also delivered interventions which while modestly effective in reducing drinking and overall of good quality, varied widely around this average. The advanced motivational interviewing skill of complex reflections – reflecting back the client's comment but in a way which adds or alters meaning – seemed to make sessions more effective in reducing drinking. But in surprising contrast, simply accreting more of the other responses considered compatible with motivational interviewing actually seemed counterproductive. The study is discussed further in cell B1 of the Alcohol Treatment Matrix.

Similarly, therapists who act in ways which generates a *very* close alliance with their clients can weaken outcomes. An unusually penetrating analysis of motivational counselling at US substance use services found that substance use reductions were best sustained by clients of counsellors rated about average in terms of their clients' experiences of working with them. Counsellors who had been relatively poor at striking up a close alliance had worse outcomes, but so too did those who had been especially good. Similar findings have emerged in general psychotherapy/counselling. Note that in the US study counsellors were generally very good at generating positive relationships, so it was only towards the *very* top of this range that outcomes started to worsen. As discussed in cell B2 of the Alcohol Treatment Matrix, perhaps at these levels therapists were too 'nice' or focused too much on the client's comfort, failing to develop change-promoting "discrepancy", even if highlighting how the patient's actions contradict their self-image and values causes discomfort.

Given this complexity, it seems more understandable that a review published in 2005 found that therapeutic alliance early in substance use treatment was more consistently related to engagement and retention than to longer term substance use. It is important, however, to remind ourselves that patients get more out of treatment than what we choose to judge as success; even if a very close relationship with a counsellor does not further reduce substance use, it might foster other psychological and social benefits valued by the client – the reasons why they tend to stay longer.

Some easy answers

Among this complexity and paradox, there are some findings supportive of simple relationship-builders familiar from our everyday lives. For example, counselling clients in Canada rated the extent to which their counsellors had exhibited 15 behaviours thought to affect the client-therapist bond. They were not esoteric counselling skills, but simple things like maintaining eye contact and not fidgeting. Researchers then related these ratings to the degree to which the same client reported a strong working alliance with the counsellor. Once inter-relationships between the behaviours had been adjusted for, three stood out as predicting the strength of the alliance: making encouraging comments; making positive comments about the client; and greeting the client with a smile – all of which the researchers said "may be interpreted as behaviours that communicate a sense of positive regard or liking towards the client".

Working out what the findings mean is hampered by a common inability in such research to be able to pin down which side of the related variables was chicken and which egg. For example, did greeting with a smile help generate a strong alliance, or did counsellors smile more at some clients because they already had a good relationship – or a mixture of both? However, face validity and general psychotherapy research persuasively suggests such behaviours are not just an epiphenomenon of a good relationship, but help generate it and improve outcomes.

Given expectations that this would be the case, it is worth noting that assigning therapists of the same race or sex as the patient does not provide a simple shortcut to good therapeutic relationships, though it may help in other ways. To

Web2PDF
converted by Web2PDFConvert.com

the patient does not provide a simple shortcut to good therapeutic relationships, though it may help in other ways. To narrow in on these studies run this search. One of the hits will be these unpublished notes on relevant studies.

Illegal drug use is unconventional; maybe counsellors should be too

Rather than stolid conservatism, 'openness to change' has emerged as an overarching feature of good addiction treatment services and staff – receptiveness to new ideas, new ways of working, and to developing skills and knowledge. The most wide-ranging investigation ever of the organisational health of British drug and alcohol treatment services found that staff working in an atmosphere of support, respect, and concern for their development, tended to have clients who also felt understood, respected, supported and helped. Most striking were the roles of openness to change and openness to the drivers of change in the form of staff who suggest innovations (facilitated by an environment which encourages open communication) and training and educational inputs. The study serves as a reminder that no matter how good the counsellor, they will not be able to maximally flourish – and neither will their patients – unless they are appropriately supported by the organisation within which they work.

Also from the UK, another study threw up the intriguing possibility that non-conformist drug workers who value hedonism and stimulation help marginalised drug users most because their values match those of their clients – in some ways the opposite to what one might expect. Again, the underlying pattern in the findings was that workers who conservatively valued stability and established order had worse outcomes, while those characterised by openness to change had better client outcomes. The plausible presumption is that 'openness to change' values also typified their clients – users of illegal drugs.

> *Non-conformist drug workers who valued hedonism and stimulation helped marginalised drug users most*

Not too much should be made of this small one-off study, especially since the client outcomes were rated by the workers themselves: they might falsely *perceive* greater improvement in clients whose values are (or are becoming) more like their own. But despite its limitations, the congruence between the British findings and the limited amount of allied substance misuse research suggests the findings may reflect a real phenomenon.

In particular, findings from the British study resonate with those of a Norwegian study which was one of its inspirations. This found that confluence in values between psychotherapists and their clients was associated with (from the patient's point of view) a stronger therapeutic relationship. Across psychotherapy including substance misuse therapy, feelings of empathy and being understood are associated with better outcomes. It could be that these feelings are strongest between like-minded therapists and patients.

In Norway, more significant yet were aspects of the therapist's personality, regardless of whether these matched those of their clients. In the British study too, perhaps workers open to change were also more open to *all* their clients and better able to adapt to their needs and preferences, and/or were more willing to risk departing from normal or accepted practice to meet those needs. Preparedness to depart from a set treatment protocol has been associated with better substance use outcomes. So too has being responsive enough to the patient to match your approach to their mood, personality and recovery preferences, even if that means departing from state-of-the-art manuals. After being trained in motivational interviewing, in one study addiction counsellors who occasionally violated the approach's principles had clients who were better engaged and more forthcoming in therapy than more conformist trainees – but only as long as the entire interaction was characterised by socially skilled empathy and caring.

These findings are also reminiscent of a US study of ex-addict methadone counsellors published in 1974, which found that rather than the 'perfect' profile of a stable psychologically healthy therapist, "deviant" personalities who shared the insecurities and edginess of their patients and had a suspicious outlook on life had patients who engaged better and used drugs less.

Important even in brief interventions

The importance of the counsellor stretches even to very brief encounters with risky drinkers and drugtakers identified in general medical services or other settings. This finding emerged from one of the deepest and most painstaking analyses ever undertaken of what makes for a successful brief intervention. Set in a Swiss emergency department, it focused on five counsellors with similar qualifications and experience and uniform preparatory training, who nevertheless ended up at one extreme with patients who on average drank nine UK units fewer a week, at the other, 18 units more. What partly accounted for this was how far the counsellor was *actually* able to deliver the intervention in the intended motivational style – not in minute or tick-box detail, but in a broad-brush and consistent manner.

Central to this style was reflective listening, also found in another study to be a key skill in motivational brief interventions. It may seem straightforward – instruct your counsellors to selectively reflect back the client's comments – but it is in fact difficult to do consistently, going against the grain of much human interaction and the hierarchical relationship inherent in therapist-client and doctor-patient encounters.

Get the right people to begin with

The "Practitioners" columns of our alcohol and drug treatment matrices provide a shortcut to significant seminal and contemporary studies on the influence of the practitioner. In these we sought to redress the relative neglect of getting the right staff to begin with, rather than the more commonly studied training route to effectiveness.

Among the highlighted studies is this seminal US trial from the 1970s. Notable for its large sample and random assignment of patients to counsellors, it also predated the trend to test treatments so highly standardised, and delivered by counsellors so highly selected, trained and supervised, that the impact of counsellor quality (if assessed at all) is minimised. With a set of counsellors who exhibited the wide variation seen in everyday practice, the study was able to find a strong link between the avoidance of post-treatment relapse and ratings by research staff of the empathy, genuineness, respect, and concreteness shown by the counsellors in their responses to counselling scenarios.

In this study patients were contained in an inpatient setting, likely to be why there was no relationship between retention and ratings of the counsellors. Over two decades later a similar study conducted in Finland with outpatients found that the same ratings were indeed related to how long patients stayed in treatment.

Across psychotherapy, similarity of social and intellectual values between therapist and client has been found to promote improvement. If (▶ above) something like this is also the case in substance misuse treatment, it suggests that effective drug workers are as likely to be 'naturals' by virtue of their personalities, values and social skills, as to be created by training or identified by their qualifications. It may be possible for such attributes to be recognised in advance by the reactions of relatively untutored observers to how workers say they would behave in different counselling scenarios.

Web2PDF
converted by Web2PDFConvert.com

counselling scenarios.

An argument for focusing on recruiting the right staff also emerged from a a training study featured in the drug matrix. It found that recruiting the 'right' therapists who had not been trained in motivational interviewing would have been better than choosing the 'wrong' ones who had been trained. Not only did the former start from a higher level, they went on to absorb and retain more of what they had learnt.

But that study was of just a workshop training session, an experience which might impart theory and techniques but would be unlikely to alter attitudes or develop the stance and flexibility needed to conduct effective therapy. Conceivably, more extended training or training supplemented by feedback and expert coaching could develop not just skills in the particular therapy, but also empathy, social skills and other generic attributes of an effective therapist, even among people who seemed less promising trainees. This could be why therapy training has been found to improve client outcomes only when accompanied by ongoing expert coaching.

Running this search takes you straight to all our workforce-related analyses, an under-examined but (as when asked, patients and clients often testify) critical dimension of treatment effectiveness.

Thanks for their comments on this entry to David Skidmore based in England, former probation officer, addiction counsellor and regional manager with the National Treatment Agency for Substance Misuse. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 31 August 2016. First uploaded 01 March 2010

- Comment/query to editor
- Give us your feedback on the site (two-minute survey)
- Open Effectiveness Bank home page
- Add your name to the mailing list to be alerted to new studies and other site updates

Web2PDF
converted by Web2PDFConvert.com