DRUG & ALCOHOL FINDINGS *Matrix cell*

Alcohol Treatment Matrix cell B2

Practitioners; Generic and cross-cutting issues

At the front line the practitioner is to the patient the face of treatment. They can matter enormously – not so much in their formal credentials, but their manner with patients. Tour seminal and key studies which probe the heart of addiction treatment: relationships. See the remaining four cells in row 2 of the matrix for more on generic features of medical and psychosocial therapies.

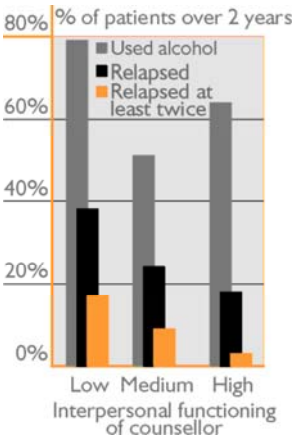
S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S 'Intractable alcoholics' transformed into normal patients (1970). Remarkable series of studies from the late 1950s saw US 'skid row alcoholics' elevated from virtually never engaging with alcohol treatment after emergency care to engagement patterns more typical of psychiatric patients. The strategy was not to try to directly change the patients, but to radically change how they were treated by staff, replacing hostility with warmth and respect. More on these studies in cell B3 (seminal study "It's the way you say it") and towards the end of a slide presentation on the matrices.

S Some counsellors inspire retention, others rapid drop-out (1976). Trainee alcohol counsellors at a US alcohol treatment clinic varied widely in their records of retaining patients; professional and personal experience of alcoholism did not account for the variation. For related discussion click and scroll down to highlighted heading.

S Therapy-related social skills of counsellors strongly related to post-treatment relapse (1981). US study at an inpatient alcohol unit found strong links between how many of their patients later relapsed and the empathy, genuineness, respect and 'concreteness' exhibited by their counsellors in response to brief written cameos of typical patient/family scenarios ▸ chart. Related study below. For discussions click here and here and scroll down to highlighted headings.



K Rapport-generating counsellors improve retention (2002). Replication at a Finnish outpatient alcohol clinic of US study listed above found that greater initial counsellor and client rapport was followed by more patients completing treatment, and that responses to the US cameos predicted which counsellors would on these measures be most effective. For discussion click and scroll down to highlighted heading.

K Can therapists be *too* accommodating? (2009). Rarely has counselling been so deeply analysed as in this US study which found that some counsellors generate relationships with clients which feed through to better outcomes – but also that the 'best' relationship builders are not on average the most effective. For discussion click and scroll down to highlighted heading.

R Some therapists are just better than others (2012; free source at time of writing). Ingenious analysis finds that across behavioural and mental health problems, the therapist's contribution to the creation of a strong client–therapist alliance and resultant improvement in outcomes exceeds that of the patient, suggesting that "some therapists develop stronger alliances with their patients (irrespective of diagnosis) and that these therapists' patients do better at the conclusion of therapy".

R Select and evaluate clinicians based on their 'track records' (2000; free source at time of writing). After exploring the evidence for just about every way you could think of to identify the most effective substance use clinicians, concludes that "assumptions that levels of training, experience, or other simple therapist variables" would act as quality markers are mistaken, and that there is no substitute for monitoring actual performance. Related review below. For discussion click and scroll down to highlighted heading.

R Clinician effects more important than specific treatments (2014; free source at time of writing). In substance use treatment, "one of the best indicators of clients' retention and outcome is the particular counselor to whom they happen to be assigned," was this essay's assessment of the evidence. Among the reasons were the clinician's expectations of good outcomes, allegiance to the treatment approach, and interpersonal skills (including empathy; related review below). Related review above. For discussion click and scroll down to highlighted heading.

R Complexity demands socially skilled and flexible clinicians (2016). Essay from Drug and Alcohol Findings emphasises that the complexity of the interacting patient characteristics clinicians have to respond to means there are no reliably effective, standardised ways of responding to any particular characteristic or need. There is no substitute for sensitivity, flexibility and social skills.

R Authoritative, evidence-based assessment of how best to relate to clients (American Psychological Association, 2011). Effective ways to relate to clients (including those with substance use problems) common to different therapeutic traditions, like forming a therapeutic alliance, demonstrating empathy (related review below), and adjusting to the individual. Also what to avoid, like confrontation, negativity about the client, and inflexible adherence to one method. For discussion click and scroll down to highlighted heading.

R Directiveness is a key dimension of therapeutic style (2006). We all know people who bristle when someone else tries to take the lead, others who gladly take a back seat. In substance use treatment too, the interaction of the 'directiveness' of the clinician with client preferences has emerged as the most consistently influential interpersonal factor. For discussion click and scroll down to highlighted heading.

R Is low therapist empathy toxic? (2012; free source at the time of writing). That was this review's title question, answered in the affirmative after amalgamating findings on the relationship between counsellor empathy and substance use outcomes. It also concluded that "empathy may exert a larger effect in addiction treatment than has been generally true in psychotherapy, accounting in some studies for a majority of variance in client outcomes". For discussion click and scroll down to highlighted heading.

G Official British guidance on how to assess and treat problem drinking (National Institute for Health and Care Excellence, 2011). Recommendations from Britain's health technology advisers on overall principles and particular interventions. Among the former are that therapeutic staff should aim to build a trusting relationship with clients and work in a supportive, empathic and non-judgmental manner.

G Principles of substance use treatment (2006; free source at time of writing). Journal article which integrates reviews and guidance commissioned by the American Psychological Association (APA), including the relationship factors reviewed in the relevant chapter of an APA book (2006). For clinicians, asserts that "Development of an effective therapeutic alliance is crucial" and recommends accurate empathy (related review above), respect for the client's experience, avoiding confrontational struggles, titrating confrontation to the client's "reactance" to such tactics (related review above), and providing goal direction and a moderate level of structure for the therapy.

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What is this cell about? In treatment the term 'common factors' is used to refer to influences on client engagement and progress underlying and shared by specific interventions, such as a 'healing context' and a plausible explanation for the patient's symptoms allied with a credible ritual or procedure for resolving them. Whether treatment is medical or psychosocial, chosen positively or under pressure, among these common factors is the patient's relationships with referral and treatment staff, the focus for the this cell; common factors more generally are dealt with in cell A2.

Relationships affect whether people want to start treatment after initial contact (for an example see document listed above), whether they stay (free source at time of writing), and the services they receive. Via these mechanisms and also directly (listed above), ultimately relationships can affect the degree to which treatment helps patients overcome their problems with drinking and improve their lives.

Clearly relationships are forged partly by the patient, but of greatest interest is the clinician's contribution, because this is what can be improved by levers available to service managers such as recruitment, training and experience. The interpersonal style and other features of treatment staff are much less commonly researched than the interventions they 'deliver', and intervention studies commonly try to eliminate the influence of the clinician (though it may still break through) in order to focus on the particular intervention. In doing so, they risk eliminating what matters (listed above) in order to focus on what generally matters little or not at all (1 2).

Though the importance of clinicians and relationships seems strongly supported, the nature of the research from which this impression emerges demands caution. Relative neglect of relationship issues means that associations between clinicians' behaviour or characteristics and retention or outcomes often surface from studies intended to investigate interventions, not interventionists. Without having randomly allocated patients to different clinical styles, it is usually impossible to be sure that these associations indicate causality – that clinical styles are actually an active ingredient rather than incidental or a by-product. Additionally, publicly- or insurance-funded treatment services are the typical locus for research. There are reasons to believe that while in these services relationships with clinicians are from the patient's point of view the key 'quality' dimension, in fee-paying services perceptions of quality are more about getting the outcomes paid for, structured therapeutic programmes, and what is seen as 'professionalism'.

Closely related to common factor theory is the concept of the 'placebo effect' – the way common factors can generate improvements in patients even though the treatment has no specific active ingredients. How the therapist relates to the client is an important component. An indication is that if counsellors are led to believe certain randomly selected clients are more likely to overcome their drink problem, then compared to others, those clients have actually been found more likely to more fully recover – a self-fulfilling prophecy. Even in medication-based treatment of physical as well as mental complaints, the physician's enthusiasm for and confidence in the therapy can potentiate improvements in response to a medication or placebo.

Such effects are, however, complex and not uniform. For example, sometimes they emerge only when the enthusiastic stance adopted by the doctor matches their real attitudes and expectations and those of the patients, and sometimes only when the doctor conveys warmth or the clinic environment bolsters the impression that they are competent, and maximally when both influences are in play – the findings of a randomised study (free source at the time of writing) of 'physical' reactions to a placebo treatment for an induced allergic skin reaction. You can find more on this study and on placebo effects in general in the corresponding cell of the Drug Treatment Matrix; open the supplementary text in paragraph beginning "From outside substance use treatment… ".

Where should I start? A review listed above comprehensively mapped the ways treatment practitioners of all kinds – medical, counsellors and therapists – might affect the quality and impact of treatment. Published in 2000, later studies may fine-tune the review's conclusions, but generally they remain robust, making it our favoured starting point. Among these conclusions are that practitioners can differ greatly in their records on retention (listed above) and outcomes (listed above), yet what accounts for this variation is hard to pin down.

Reinforced by later work listed above, one thing we do know is that formal quality indicators – like years of experience and

> *In substance use therapy, it is the relationship-building*

professional training and qualifications – usually bear no relation to outcomes. Across mental health conditions, it is also the case that the degree to which therapists stick (or 'adhere') to the intended programme or are competent in its delivery are so inconsistently related to outcomes, that overall there are no statistically significant links. Narrowing the focus to substance use studies, the same analysis found there was a near-zero relationship between outcomes and the therapist's adherence to the therapy, and a slight and non-significant *negative* link with competence.

qualities that matter

After comprehensively trawling the evidence, our starting-point review concluded that instead what matters are mainly relationship-building qualities: "The easiest clinician variables to measure are, unfortunately, some of the least relevant to quality of service delivery (eg, gender, race, age, training, years [of] experience). Variables with much more relevance to quality care include empathy, ability to establish an alliance, emotional reactions to patients, professional demeanour and recordkeeping, ability to enforce clinic rules and make appropriate referrals to further care, beliefs about substance use disorder topics, etc."

With no formal badges consistently predictive of effectiveness in achieving intended outcomes, the reviewers stressed that there is no substitute for evaluating clinicians based on how they perform with clients. However, this need not entirely be a 'suck it and see' experience, with clients as the guinea pigs. Using realistic therapy cameos, staff recruitment and evaluation procedures can get close enough to eliciting how the clinician *would* react to real clients to make this a worthwhile predictor of actual performance. For more on these studies click and scroll down to highlighted section below.

Note that this discussion has been about effectiveness in achieving intended outcomes, typically in the form of substance use reductions. There is much more to treatment, such as keeping patients safe and avoiding unwanted side effects. No matter how good their bedside manner and how great their patients' substance use reductions, a doctor who fails to spot conditions which might precipitate a dangerous reaction to a medication, or who over- or under-doses, cannot be considered to be delivering quality treatment, and nor can the counsellor who fails adequately to assess risk to patient or family. In these senses and others, experience, training, competence and adherence to procedure can be vital.

Highlighted study From the 1970s, a US study listed above illustrates how older studies can retain particular value. Notable for its large sample and random assignment of patients to counsellors, it predated the trend to test treatments so highly controlled and delivered by clinicians so highly standardised through selection, training and supervision, that the impact of variation in clinician quality (if assessed at all) would be minimised. Modern studies would probably have eliminated the least competent of the counsellors in the study or subjected them to further training and supervision until they met quality standards. Instead this early study sampled the wide range of competence levels seen in everyday practice, opening its eyes to the strong links between ratings of the empathy, genuineness, respect and 'concreteness' exhibited by counsellors and how many of their patients had relapsed two years after leaving inpatient treatment. Also special about the study was that these qualities were not assessed during treatment, but *before it* from the counsellors' written responses to cameos of typical patient/family scenarios. This procedure both precludes reverse causality (the possibility that these qualities were a *reaction* to the patient's progress, not a cause) and offers a way to assess quality *before* clinicians start affecting the lives of their patients.

Another special thing about the study was that these qualities were not assessed during treatment, but before it

In contrast to outcomes, the study found no link between these counsellor qualities and how long patients stayed in treatment – a surprise, because generally the client-therapist relationship is more strongly linked to retention than measures of substance use outcomes (an issue dealt with in the corresponding cell of the Drug Treatment Matrix; see also this sample alcohol study). However, the study's patients were sheltered in an inpatient unit; separated from friends and family and from substance use, conceivably patients more often terminated treatment for reasons other than their relationships with their counsellors. Over two decades later a similar study (listed above) was conducted in Finland, but with outpatients. This time it found that the same ratings of the counsellor's interpersonal therapeutic skills *were* related to treatment completion. At least partly linking the ratings to completion was the degree of 'rapport' generated between therapists and clients. Therapists who on average experienced more rapport tended to have clients who felt the same and who more often completed treatment, a proportion which for different therapists ranged from under 40% to nearly 90%.

Clues to what makes clients develop rapport with therapists and come to see them as partners in the therapeutic endeavour were probed by a study (2010; free source at time of writing) of counselling clients in Canada, of whom about 1 in 7 were being treated for their addictions. Each client rated the extent to which their counsellor had exhibited 15 behaviours known to affect the client-counsellor bond – 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". In such a study it is impossible to be sure what caused what, but face validity persuasively suggests such behaviours are (at least in similar societies) not just by-products of a good relationship, but help to generate it.

Issues to consider and discuss

Isn't it just a matter of being nice? Not, it seems, from an unusually deep analysis (document listed above) of data from five US outpatient counselling centres. How would you account for the key finding – that substance use reductions were best sustained by clients of counsellors rated only 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.

> *Counsellors poor at striking up a close alliance had worse outcomes, but so too did those especially good*

Note that in this study counsellors were generally good at generating positive relationships; it was only towards the *very* top of this range that outcomes started to worsen. Look at the questionnaire on which this finding was based and imagine the working style of a therapist, nearly all of whose clients ticked all those boxes (some are reverse scored). Perhaps at these levels, therapists were 'nice' to the point of focusing so much on the client's comfort that they were unwilling to generate some *dis*comfort by highlighting how the patient's actions contradicted their self-image and values. If so, even when this was called for, they would have failed to develop what psychotherapists characterise as change-promoting 'discrepancy' (document listed above). Perhaps too, they seemed less than 'genuine' to their clients – an important quality explored in cell B4, which sometimes demands responses not recommended or even disparaged by the therapeutic 'rule book'. But remember that while generating relationships at the very top of the alliance scale used in the study may not be the most effective strategy, you don't have to slip very far down before things start getting worse again. The findings are no *carte blanche* for neglecting alliance-building or being (in therapeutic terms) positively nasty, on which see the section below.

Lest we think this study a one-off, similar findings have emerged in general psychotherapy/counselling, and also in brief alcohol interventions for risky drinkers identified through screening, findings highlighted in cell B1 of the Alcohol Treatment Matrix.

Don't tell me what to do! There is a further twist to the issue discussed above – not the impact of being very 'nice', but of (in therapeutic terms) not being nice at all. On this front, in cell A2 we theorised that once would-be patients approach, knock on and seek to pass through doors to treatment, doing the 'right' thing helps, but more critical is to *avoid* the 'wrong' things – responses and attitudes which obstruct the process started by the patient, including confrontation which only provokes resistance or judgemental attitudes which alienate patients.

In medicine generally, comments seen as 'invalidating' the patient, like dismissing their views or not taking them seriously, have a detrimental impact thought to be greater than the positive impact of validating comments. In the substance use domain, how destructive the 'wrong' response can be has been most clearly demonstrated among risky drinkers intercepted by screening programmes, possibly because they are more easily derailed from a trajectory they never chose, but found themselves diverted to in the course of seeking some other kind of help. The impact of brief interventions to moderate their drinking can it seems be scuppered by just one or two instances of practitioners expressing the non-collaborative stance of someone who knows best, and is therefore in a position to confront, warn, direct, or advise the drinker.

The American Psychological Association has provided us (document listed above) with a handy list of what

not to do in therapy. It starts with the *opposite* of what *to do*, like *not* expressing accurate empathy. It moves on to hostile, pejorative, critical, rejecting or blaming comments, confrontation, assuming (without checking) that thing are going well, and centring on your own perspective rather than that of the client. But it ends with "inflexibly and excessively structuring treatment" and "using an identical therapy relationship (or treatment method) for all clients". The implication is that the previous 'rules' might sometimes need to be broken to tailor therapy appropriately.

The issue of "directiveness" offers a prime example of a rule sometimes best broken. As rules go, it has considerable backing. Probably the most well-evidenced way to obstruct the progress of substance use patients is to 'direct' through advice and warnings when the client is likely to react against being 'told what to do' – a counterproductive reaction which leads patients to dig in their heels, one motivational interviewing was designed to circumvent. Nevertheless, in some situations being directive is 'good', and failing to direct the client impedes their recovery.

This was one of the conclusions of a review from Drug and Alcohol Findings (listed above) dedicated to directiveness. Take a look, and while you do, think about your own relationships; as the review says, in principle things are no different in therapy. Some people, sometimes, and in some situations, expect and need direction, other times it will be resisted. Often we like to at least feel we are in the driving seat, but sometimes we just want to be driven. Such complications are why we have socially skilled therapists who can react appropriately, and are almost certainly among the reasons why counselling outcomes can be worse when, tightly constrained by a manual and supervision, therapists are prevented from reacting more appropriately.

What kinds of people do we need to handle these complexities, and how can they be identified or developed? One answer can be found in the "Highlighted study" section above.

▸ **Empathy: communicating understanding** Adding to those explored in the section above, another possible obstruction to treatment progress is failure to show you understand the client at a deep level: the quality of 'empathy'. Among people in treatment for substance use, insufficient empathy has been theorised (document listed above; free source at the time of writing) to be "toxic" by two researchers with an unparalleled record in analysing how motivational interventions work. Empathy helps, but the lack of it is powerful too: "Outlier therapists with outstandingly poor client outcomes are often found in addiction treatment studies. Available evidence … implicates low empathic skill as a marker of this outlier status."

The type of empathy the reviewers were talking about was "accurate empathy", identified in Carl Rogers' classic formulation as one of the six "necessary and sufficient conditions" for psychotherapy clients to improve (more on these conditions in cell B4). It combines understanding the client with communicating this and yet retaining emotional distance. In Rogers' words, it is to "sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it … When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware." Invert this definition, and it is easy to see how the opposite can be destructive, explicitly failing to validate the client's experience as understandable rather than an aberration.

But again, occasionally rules are best broken. Explicitly expressing empathy is usually good, but the truly empathic clinician knows when this is just going to rub the patient up the wrong way – when to keep empathy *im*plicit. Based on the work of a task force established by the American Psychological Association, in 2018 reviewers found evidence (quotes are from our analysis of the review) that "not all clients respond well to explicit empathic expressions, in particular clients who are highly sensitive, suspicious, poorly motivated, or who react against authority". The consequent practice recommendation was: "Empathy entails individualising responses to particular patients. For example, some fragile clients may find the usual expressions of empathy intrusive, while hostile clients may find empathy too directive, and others may find an empathic focus on feelings alien. Effective empathic therapists know when – and when not – to respond with more or less empathically oriented responses."

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