S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies
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Alcohol Matrix cell B4: Practitioners; Psychosocial therapies

S Fundamentals of effective therapy: genuineness, positive regard and empathy (1957). In psychosocial counselling and therapy, no paper has had more influence than Carl Rogers' formulation of the "necessary and sufficient conditions" for clients to get better, the foundation of much substance use counselling. Link is to a free 50-year anniversary reprint. See also commentaries (1 2). Discussion in bite's *Where should I start?* and *Issues* sections.

S Counsellors' relationship style affects patients' relapse rate (1981). US study found a strong link between higher levels of empathy, genuineness, respect, and concreteness exhibited by alcohol clinic counsellors and a reduced risk of their patients' relapsing after treatment. Discussion in bite's *Highlighted study* section.

S Empathy makes the difference (1980). Big differences in therapy content and duration did not affect the progress of US heavy drinkers. What seemed to for at least two years (1983) after treatment was the degree to which their therapists displayed "accurate empathy". See also this assessment of the impact of empathy in psychotherapy generally (2011). Discussion in bite's *Highlighted study* section.

K Therapist effects emerge even in one of the most highly controlled studies ever (1999). Despite exhaustive selection, training and supervision, some therapists in the US Project MATCH trial had on average worse outcomes (1998) than their peers and there was enough variation in the therapeutic relationship (1997) for this to influence engagement and later drinking. Session recordings exposed reasons for variation including the match between the therapist's directiveness (2009) (see review below) and whether the client reacts against direction. Project MATCH was the *Highlighted study* in cell A2.

K Social skills matter in motivational interviewing (2005). Link is to the Effectiveness Bank analysis; there is also a free source for the original paper. US study suggests that the quality of seeming 'genuine' can suffer if training mandates withholding natural responses, but also that departing from these mandates is risky unless done by a socially skilled therapist. See also this essay (2013) based on the same and other studies arguing that 'by the book' is not always best way to do therapy. Discussion in bite's *Issues* section.

K Rogerian non-directive listening was all these patients needed (2012). Link is to the Effectiveness Bank analysis; there is also a free source for the original paper. Adding motivational interviewing techniques directed at reducing drinking did not improve on (if anything, the reverse) 'Rogerian' non-directive listening in helping US heavy drinkers cut back – not the case in a similar earlier study (2001). Discussion in this bite's *Issues* section and also in cell A4.

K Counselling is a relationship business (2009). Penetrating study involving mainly alcohol- and cocaine-dependent patients found that some counsellors generated relationships with clients which fed through to better outcomes – but also that the 'best' relationship-builders were not on average the most effective. Discussion in cell B2.

R Effective ways to relate to clients (2011). US American Psychological Association task force reviews evidence and offers guidance on outcome-promoting qualities in relating to psychotherapy clients, like forming a therapeutic alliance (see below), being empathic, and appropriately adjusting to the individual (see below). Also offers guidance on outcome-harming qualities like being confrontational. Includes but not specific to substance use. See also this later (2014) and broader practice-oriented interpretation from same lead author, drawing on the task force's work.

R Therapists who form good therapeutic relationships have better outcomes (2011). One of the (see above) US American Psychological Association task force reviews. In substance use treatment and psychosocial therapy generally, a strong working relationship between therapist and client is "one of the strongest and most robust predictors of treatment success". Advanced analysis (2012) confirmed that some therapists consistently develop stronger relationships and have better outcomes.

R Adapt to the client (2011). US American Psychological Association task force (see above) judged that adapting psychotherapy to the client's reactance/resistance, preferences, culture, and religion/spirituality demonstrably improves effectiveness. Includes but not specific to substance use.

R Some clients like to lead, others to be led (2006). How directive the therapist is one of the strongest and most consistent influences on the outcomes of therapy. There is no single right degree of directiveness; it all depends on how the client reacts.

G Addiction counselling competencies ([US] Substance Abuse and Mental Health Services Administration, 2008). Includes competencies associated with positive outcomes and the knowledge, skills, and attitudes all substance use counsellors should have.

G What makes a good group therapist? ([US] Substance Abuse and Mental Health Services Administration, 2005). US consensus guidance on the different types of groups, how to organise and lead them, desirable staff attributes, and staff training and supervision.

G What makes a good case manager? ([US] Substance Abuse and Mental Health Services Administration, 1998). US consensus guidance including the staff skills, knowledge and attitudes needed to fulfil the key case management role orchestrating the range of services often needed to promote lasting full recovery.

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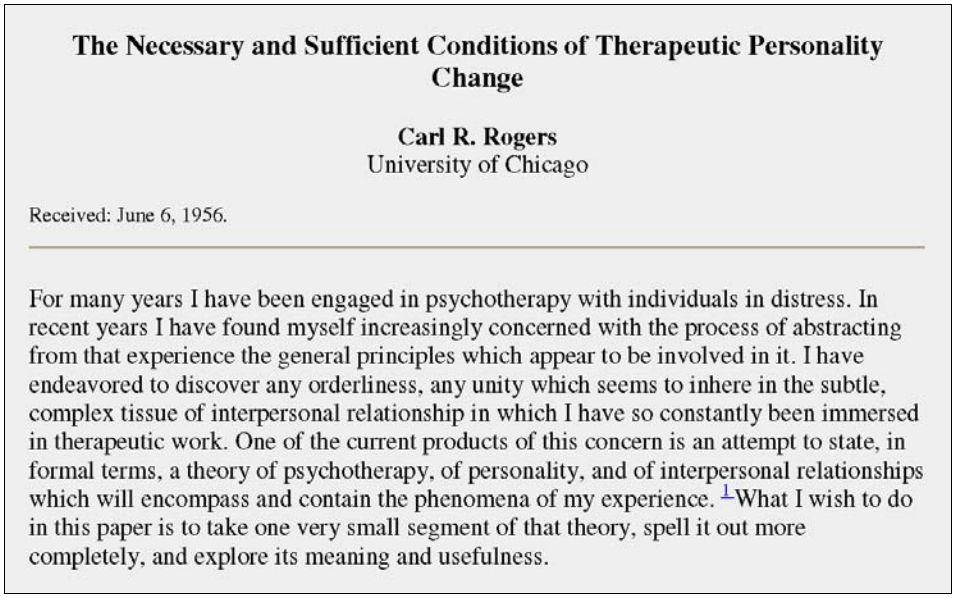
For subtopics go to the subject search page and hot topics on treatment staff and matching alcohol treatments to the patient.

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

What is this cell about? Every treatment involves direct or indirect human interaction, but this cell is about 'psychosocial' therapies in which interaction is *intended* to be the main active ingredient. These range in form from brief advice and counselling to extended outpatient therapies and all-embracing residential communities where clients stay for months. In their content and techniques therapies also differ, varying for example from the deep probing of psychoanalysis to the more skills-based cognitive-behavioural approaches. But as long as it is a well structured, *bona fide* treatment which 'makes sense' to patient and therapist, the 'common factors' shared by supposedly distinct therapies (on which see cell A4) seem more critical to their success.

For patients and researchers, how the therapist relates to the client is the main embodiment of the common factors shared by therapies and the most salient way they affect engagement and outcomes. We have seen this generally across treatment and in respect of medical treatments. Unsurprisingly, the evidence is strongest for psychosocial therapies, when the structured enactment of the therapist-client relationship *is* the treatment, forcing attention to it even in studies designed to minimise such influences. In this cell we focus on client-worker relationships, and on whether some therapists are more successful because they more strongly forge the right kind of relationships – 'therapeutic' relationships. Before moving into that territory, a reminder that therapists and counsellors typically work in organisations which limit or enhance their ability to maximise client progress, an issue explored earlier in this matrix in the context of the influence of practitioners in medically-based treatments. The same issue will emerge in this cell from a study (described in the supplementary text towards the end of this 'bite') which identified significant relationships between abstinence and the characteristics of the treatment organisation, but not (once organisational factors links had been taken into account) between abstinence and the client-worker relationship.

Where should I start? With arguably the most fertile source for practice and research in psychosocial therapy for substance use problems – Carl Rogers' classic formulation of the "necessary and sufficient conditions" for therapeutic progress: the communication of genuineness; unconditional positive regard – no 'ifs' or 'buts' qualifying the therapist's acceptance of the patient; and accurately empathic understanding of clients in need of help to get their actions, thoughts and self-perceptions in line. The 'seminal' credentials of this paper are indicated by its being reprinted 50 years later (the version listed), and by the fact throughout the matrices (including practically every entry in the current cell) you will find these qualities continue to emerge as significant in engaging problem drinkers in effective treatment.



The Necessary and Sufficient Conditions of Therapeutic Personality Change

Carl R. Rogers
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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"

Despite his focus on the universals of relating to clients, Rogers did not dismiss specific techniques like offering interpretations of the roots of the client's feelings and behaviour, exercises weighing up the pros and cons of change, analysing what triggers unwanted behaviour, and training in social and self-control skills. In his schema, these were not active ingredients in themselves, but also not trivial, because it is partly through such techniques that relational qualities like positive regard are communicated, and communicating these was seen as one of the essentials of effective therapy. From the *Highlighted study* in cell B3 and from the comments of treatment clients in eight European countries, we know that these qualities – especially unconditional positive regard – are also what substance use patients seek in a helper. Across psychotherapy more broadly they have stood the test of time and their significance has increasingly been acknowledged.

You can see Rogers in action in the (within psychotherapy circles) legendary 'Gloria' videos of his encounter with a psychotherapy client who was also filmed in sessions with two other leading therapists of the time, produced in 1965 as training aids. See these accounts (1 2) for more on the videos and their importance in the

history of psychotherapy.

Carl Rogers's insights have been further specified and translated into practice, among which in 1967 was the influential book, *Toward Effective Counseling and Psychotherapy: Training and Practice*. Based on work with Carl Rogers, it argued that "genuineness or authenticity is most basic to a relationship", a quality explored below. Having established this foundation, the therapist or counsellor communicates warmth and respect for the client and proceeds to the work of therapy via their "moment to moment *empathic grasp* of the meaning and significance of the client's world". The understanding of 'genuineness' in the book entails "openness to experience" rather than defensively retreating behind a facade or role, among which for therapists is that of the 'technical expert' in their profession. Since then, in various guises openness to experience has emerged as a quality underlying effective practitioners and effective organisations; for more see the supplementary text towards the end of this 'bite'.

Highlighted study The case for empathic, responsive and socially skilled therapists who build strong relationships with troubled clients hardly seems to need to be argued or researched, any more than (as a famous article put it) the case for strapping on a parachute before leaping from a plane. But in fact, though counsellors and therapists undoubtedly differ on these dimensions, the evidence that as a result their patients do better or worse is far from consistent. At least part of the reason could be methodological issues; though this would be the ideal randomised trial format, it would be unethical to deliberately and at random send vulnerable and disturbed people to non-empathic, phony, hostile and incompetent versus better counsellors, just to see what happens.

However, you *can* randomly allocate clients to *different* therapists, some of whom will happen to be better than others. Go back in time to an era when trials were less tightly controlled, and you might find the wide variation in therapist competence probably seen even today in the 'real world' beyond controlled trials. Such a study would effectively (since these qualities tend to go together) randomly allocate patients to counsellors with high versus low levels of empathy, understanding, and warmth. That's what a seminal US study (listed above) did, and it remains the most convincing test of the effect of these qualities on drinkers seeking treatment in the normal way. As noted in cell B2, the study found a strong link between the empathy, genuineness, respect, and 'concreteness' of counsellors – seemingly an amalgam of good communication and accurate empathy – and a reduced risk of their patients relapsing after treatment. Here we can add that these are the very qualities Carl Rogers expected (section above) to be positively related to patient improvement. If you read our analysis of the study, you will see that it cannot be said on its own to settle the issue of the impact of Rogerian qualities on substance use problems – but with others, it makes a persuasive case.

Among these other studies is another seminal work which randomly allocated clients to therapists, whose degree of "accurate empathy" was rated by observers behind one-way mirrors. The study was led by Bill Miller, originator of motivational interviewing, the main contemporary inheritor of Rogers's legacy. Conducted in the pre-motivational interviewing era, it was intended as a trial of alcohol therapies differing in intensity and in the breadth of issues addressed, all benchmarked against self-help. 'No significant difference' was the conclusion, but the "surprised" researchers stumbled across a "serendipitous finding" which drew their attention in a very different direction, helping to found motivational interviewing. While huge differences in the extent and content of therapy made no difference to drinking, the *style* in which the therapies were delivered was strongly related to drinking: across their admittedly small caseloads, the greater the average degree of accurate empathy exhibited by therapists over the eight months of the study, the more likely their clients were to have improved in their drinking by the end. The range was from 100% improvement among clients of the most empathic therapist to 25% among the least, a variation in effectiveness which would have been ironed out in studies with more selected and sifted therapists.

Issues to consider and discuss

▸ **Is Rogerian listening really *all* that's needed?** Read Carl Rogers' paper and our comments on it above and you will see that he never said empathic and accepting listening was *all* that was needed to maximise client progress. Nevertheless, at least two studies have tested this interpretation of his model by adding extra elements to a Rogerian approach to see if they improve outcomes. The extra elements were those which transform the non-directive Rogerian approach into directive (but not *explicitly* directive) motivational interviewing. Though motivational interviewing "rests explicitly in Carl Roger's approach", it sharpens it into a goal-directed strategy which "presupposes that the therapist prefers one outcome over another" and tries to get to that outcome by "responding preferentially to language that indicates a desire, ability, reason, need, or commitment from the client" to make the desired changes. In different ways, both the studies below stripped out these directive elements to see whether they really did make a difference. See what you make of them.

First take a look at our analysis of the most recent of the studies; there is also a free source for the original paper. Conducted in the USA, it found that adding the directive elements of motivational interviewing to Rogerian reflective listening did *not* improve drinking outcomes. Research staff gave all the patients feedback on their assessment results, categorising their drinking by degree of severity from low risk in stages up to possible physical dependence. For some this was followed by an instruction to try to change their drinking on their own, after which they were left to their own devices, never having seen a therapist. The remainder were allocated to four therapy sessions of either motivational interviewing or Rogerian reflective listening – effectively, motivational interviewing stripped of its more directive techniques intended to provoke a commitment to reduced drinking. The result was unexpected: improvements all round, but no significant differences on any of the measures of drinking or its consequences. On each measure, if anything Rogerian reflective listening bettered motivational interviewing. In this study the patients were relatively stable, moderately dependent drinkers. To join the study they had to be aiming for moderation rather than abstinence, socially stable, and not severely mentally ill or seriously involved with other drugs. Typically they were in their 30s and 40s, employed, well educated and had never been treated for drinking problems. If the study's version of non-directive listening was all that was needed, that was the case for a caseload much less severe than typical in public sector treatment services.

> *If anything, basic Rogerian reflective listening bettered motivational interviewing*

About a decade before, a similar sample had been recruited in New Zealand for a similar study, but one which found the opposite to the US study: frequent heavy drinking *was* further significantly reduced when motivational interviewing techniques were added to non-directive listening. Without motivational interviewing's directive elements, around 64% of patients engaged in this pattern of drinking over the six-month follow-up; with these elements, just 43%. The study also found that non-directive listening was no better than doing nothing except the basics provided to every patient – feedback on the extent of their (excessive) drinking over the past six months, diagnosis of the severity of their drinking, and advice to cut down to within national guidelines.

Why the difference? See if you can get a copy of the earlier article (we were unable to find a free web-available version) and compare the two studies. Note that the earlier study's non-directive listening was *very* non-directive – to the point that if patients wanted to talk about the weather, that was fine. Here's how the researchers described this, perhaps to both patients and therapists, strange 'therapy': it "consisted of nonstrategic reflective listening ... in which subjects were invited to talk about anything they wanted, not necessarily issues related to drinking. The direction of content throughout the treatment was intentionally left for subjects to determine. [Non-directive listening] was Rogerian counseling cut back, restricting therapist responses to the barest minimum (ie, nondirective reflective listening while maintaining rapport) and retaining the same therapeutic stance irrespective of the content being offered by the subject."

In everyday language, no matter what the patient said or how they behaved, their distress or their elation, the therapist acted as a friendly, absorbent, but essentially unresponsive sounding board. It might have puzzled and disappointed patients who (unlike in the later study, which used ads to solicit participants) had all gone to a specialist substance use clinic seeking help with what was diagnosed as dependent drinking. Recall the conclusion to which Project MATCH researchers were driven, that treatment is a "culturally appropriate solution to a socially defined problem". Could it be that such a stance violated patients' culturally shaped expectations of what 'treatment' should look like? Perhaps too, the limitations placed on non-directive listening stopped therapists *communicating* empathy and acceptance, one of Carl Rogers's essentials for effective therapy, and forced them to respond to patients in an unnatural way. If that was the case, the effect would probably have been to undermine perceptions of the therapist as being genuine – another quality of effective therapy ▸ below.

▸ **Does being genuine sometimes mean breaking the rules?** As a psychosocial therapist influenced (perhaps indirectly) by motivational interviewing and Rogerian therapy, you know you are not supposed to insist clients 'must do' something, even less to warn of the consequences if they don't, and still less to express disapproval of their choices, but biting your tongue just doesn't feel right – doesn't feel like you are being *you*. You also know you are supposed to *be* you – to be 'genuine', not put on an act. There seems a conflict between these demands, all of which Carl Rogers saw (see *Where should I start?* above) as essential to effective therapy. What should you do?

For guidance, turn to this study (free source at

Entirely avoiding directive advice can

time of writing) of the training of addiction counsellors and clinicians, the implications of which are perhaps most easily absorbed from this brief, informal account. Read at least this.

seem as uncaring and unnatural as suggesting to a pedestrian heading towards a pit that they consider the pros and cons, but in the end it is up to them; the natural and caring response is to shout, 'Stop.'

Are you convinced by the conclusion that (in the context of a caring relationship and a socially skilled therapist) "warning and directive advice which conveys and comes from concern for [the patient's] welfare and respect for [them] as an equal" can be beneficial, and that artificially eliminating these sorts of comments can make you feel and sound less than genuine? Was it naive to reassure counsellors that "Everyone knows the difference between warning, advice and concern which conveys and comes from care and respect for one as an equal, and that which comes from and conveys accusation, denigration, and an attempt to exert control." Is such a departure from a Rogerian stance and motivational interviewing's 'rules' too risky, easily seeming to the patient to represent a degeneration into negativity and confrontation? If so, we know (see cell A4) the results are often counterproductive.

At this stage it might help to remind yourself of the 'small print' of the study: that *only when the counsellor was relatively socially skilled* did 'breaking the rules' in these ways enhance the effect their skills had on client engagement. Like a skilled barber wielding a cut-throat razor, they were able turn what could have been inadvertently harmful into something which added an extra sheen to the therapeutic relationship.

▸ **If therapists are influential, why don't more studies register their effects?** In the modern era, therapist effects are more often obscured than highlighted by the control researchers exercise over trials, including the counsellors and therapists. With random allocation to what are designed to be bad versus good therapists out of the question (▸ *Highlighted study* above), proving therapists have an impact on substance use outcomes and why they have that impact is not straightforward. It may also (if findings on the treatment of depression apply) require an unusually large study and unusually complete monitoring of client-therapist relationships, offering sufficient assessments for a reliable average to be computed and also taking these measures early in the therapeutic programme, before the relationship begins to *reflect* rather than promote client progress.

In practice, evidence for therapist effects has often been gathered as a by-product of a study whose main aim was to evaluate an intervention, not the interventionists. To show whether a psychosocial intervention can work, it has to be given a good chance to succeed. Usually that means selecting highly competent therapists and/or training them to meet the study's standard for delivering the intervention, without alienating patients to the point that many disengage from therapy and from the study. No surprise, then, that often patients do about as well whichever therapist they have been assigned to; the surprise is that sometimes therapist effects nevertheless emerge, even in the most highly controlled studies.

In the supplementary text (click to unfold) we offer examples of modern-day studies. They illustrate the difficulties of finding therapist effects and even more so of pinning these down to what the better therapists are doing which makes them better, but they also show these effects can be found and are related to patients' substance use outcomes, and more so, to their engagement with therapy and satisfaction with the therapist. Among the findings, you will come across that same "openness to experience" which became seen in the 1960s as the foundation of effective therapy and counselling.

Supplementary text. Click to close

Example one derives from a large US trial spotlighted in cell cell A3 because it demonstrated the power of a placebo 'dummy' medication. Primarily it was intended to assess the relative impacts on alcohol-dependent patients of different medications allied with different psychosocial support programmes. In the process it gathered unusually good data for assessing therapist effects, because therapy sessions were recorded and rated by observers for (among other things) the degree of empathy demonstrated by therapists. Tapes from 38 therapists and 700 clients revealed (free source at time of writing) that the performance of therapists significantly varied when assessed in terms of amounts their clients drank at the end of treatment. Some had on average better results, others worse, though with just 11 clinics, no attempt was made to rule out organisational factors – which the second example (below) shows can create the illusion that therapists are having an influence. Next the researchers tested whether therapist empathy accounted for their varying outcomes. The answer was negative; across their caseloads, therapists differed in their outcomes, but not

because they also differed in average degree of empathy with their clients. That analysis probed for differences between therapists. Another instead asked whether the more empathy a *given* therapist showed to an individual client, the less they drank. This time the answer was positive, but it could have been because clients who do what therapists want elicit greater empathy. As an aside, neither the degree of experience of the therapists, nor whether their ethnicity or sex matched those of their client, bore any significant relationship to client drinking – common findings.

But before we conclude that employing empathic therapists makes no difference, recall that this study was intended to test interventions, not therapists. To level the playing field, before being allowed into the study therapists had been "rigorously screened for their use of empathic listening skills", were then "extensively and explicitly trained in the interpersonal context" of the intervention, and finally "monitored in their expression of empathy as the trial progressed and ... red-lined (ie, stopped from taking clients) if empathy ratings were unacceptably low". The variation in empathy to be expected in normal practice had been ironed out to a small wrinkle, and was (or was no longer) a salient variable affecting therapist performance in terms of drinking among their clients.

Second example was again a by-product of a large US randomised trial, this time of providing feedback to counsellors on the strength of the relationship with their clients and how well they were doing in reducing their substance use. On this score it promoted neither patient progress nor their relationship with the counsellor. Though it entailed abandoning the level playing field created by randomisation, the researchers searched for other influences which did affect the patients. Their analysis capitalised on the fact that the substantive study required repeated measurement of how the clients saw the relationship with their counsellor, enabling researchers to investigate whether clients did better if they had been allocated to counsellors who on average built stronger relationships. Had they conducted a less sophisticated analysis, they might have concluded this was the case, because which clinic a counsellor worked at was related both to the strength of the client-counsellor relationship and to substance use outcomes, easily creating the illusion that it was the counsellors who were the active ingredient. But the analysis was able to tease these influences apart and assess whether *within each clinic*, counsellors who built stronger relationships had better client outcomes. Essentially, there was no reliable evidence that this was the case. There was a residual, small therapist effect which fell short of statistical significance, but it was much smaller than the relationship between the clinic's record of forging strong alliances with patients and those patients' avoidance of drinking and/or drug use. In contrast, when the analysis focused on differences between the clients of an individual counsellor, the better the relationship, the more likely the client was to be abstinent from drink and/or drugs – perhaps a sign that client-counsellor pairings who get along are most therapeutic, but perhaps also that clients who are going to do well anyhow are more appreciative of their counsellors, and vice versa. The latter interpretation means a good relationship is a *product*, not a cause, of client progress.

There were several reasons why therapist effects might have been obscured or absent in the trial described above, not least that the therapy was conducted in groups, with all the extra influence exerted by other group members. But it did show that other analyses which failed to account for organisational influences could have falsely allocated those influences to individual counsellors or therapists.

A third example of the many we could have selected takes us to Finland and the work of Pekka Saarnio, who has done much to highlight the attributes of effective counsellors (see this study discussed in cell C2). For current purposes, the study focused on here had the great advantage of within each of seven clinics randomly allocating new clients to the therapists in the study, of which there were 33 in total. Nearly all their clients were problem drinkers, though most had already been abstinent for a time before the study made its baseline assessments. Of most interest is the relationship between the therapists patients were allocated and their abstinence from drinking as assessed six months after treatment started. Once initial abstinence levels had been taken into account, it was zero or near zero – a remarkable finding, because these were simply the clinics' normal therapists, neither specially selected nor specially trained, and allowed to implement their own preferred programmes. One measure on which there was a relatively substantial variation between therapists was the degree of satisfaction with them expressed by their clients.

Here we can see a possible reason for the finding in a synthesis of relevant research (mostly of drug users but including some studies with problem drinkers in their samples) that the client-worker relationship is more strongly related to engagement and retention in treatment than to substance use outcomes. If the main driver of recovery is the patient, given a half-decent counsellor or therapist – and in the Finnish study, from the clients' points of view, they were all more than half decent – the patient's progress will largely reflect their own resources and motivation. Nevertheless, as in everyday life, some therapists will be liked more than others, and patients will be happier to extend their contact with the more likeable personalities. Where we are likely to see an impact on substance use is from therapists who are well below half decent, to the point where the client's impetus is obstructed. That returns us to the importance (discussed in cell A2) of *not* doing

the wrong thing – from some studies, seemingly more influential than being very good at *doing* the right things.

Stepping outside the substance use field offers a further perspective on therapist effects. The step is to the UK's drive to improve access to mental health care via the Improving Access to Psychological Therapies (IAPT) programme launched in 2008. It entailed recruiting "Psychological Wellbeing Practitioners" to extend low intensity, cognitive-behavioural support to a greater number of depressed and anxious patients than previously reached. The interventions mounted by the practitioners were in line with guidelines set by the National Institute of Health and Care Excellence and followed set protocols.

According to a study of their impacts, they were a varied set of people, who also significantly differed in the degree to which their patients experienced improved psychological health. Patients seen by the top five of the 21 practitioners were over twice as likely to reliably improve on measures of depression and anxiety. What characterised the seemingly most effective practitioners was their "proactivity" in developing their skills though online research, observing others in clinical practice, and actively participating in supervision. Effective practitioners also took pains (so they said) to explain the rationale for the programme to clients, and were confident enough to adapt it to the individual. Their supervisors described the best as open to discussing the difficulties of their work, an openness to learning not encountered among the least effective practitioners. For the researchers, their results "challenge the notion that protocol-driven therapies are wholly uncontaminated and unadulterated by the skills of the practitioner delivering the intervention". Slipping across to the drug matrix, we can see a parallel here with findings suggesting that practitioners and services characterised by openness to experiences, learning and ideas, most effectively engage their clients.

Close supplementary text

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.

Close Matrix Bite