DRUG & ALCOHOL FINDINGS *Matrix cell*

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

S Fundamentals of effective therapy: genuineness, positive regard and accurate 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 – arguably all effective – substance use counselling. See also commentaries (1 2). For discussion click and scroll down to highlighted heading.

S Connection with counsellor promotes client progress (1997). Findings at a US drug treatment service led researchers to argue that "providing the opportunity to develop appropriate relationships may be one of most important contributions made by treatment". Psychologically healthy patients forged better initial relationships with their counsellors, but across all patients better relationships were followed by greater improvements in psychological health. For related discussion click and scroll down to highlighted heading.

K Treat manuals as guides not scripts (2006). Especially when the therapeutic relationship is not going well, counsellors should be prepared to depart from the counselling 'script' without altogether abandoning it. That implication came from a national US study (1999) of cocaine dependence treatment, which also found typical drug counselling at least as effective as psychological therapies. 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 involving mainly alcohol- and cocaine-dependent patients. Expected finding was that some counsellors generate relationships with clients which feed through to better outcomes; less expected was that the very 'best' relationship builders were not on average the most effective. For discussion click and scroll down to highlighted heading.

K Authenticity and social skills in motivational interviewing (2005). 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. For discussion click and scroll down to highlighted heading.

R Effective ways to relate to clients (2011). US American Psychological Association task force reviews evidence and offers guidance on outcome-enhancing 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 good working relationship between therapist and client is "one of the strongest and most robust predictors of treatment success". An advanced analysis (2012; free source at time of writing) confirmed that some therapists consistently develop stronger relationships and have better outcomes.

R Adapt to the client (2011). US American Psychological Association task force (overall report 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 during the treatment is one of the strongest and most consistent influences on outcomes. There is no 'right' degree of directiveness; it all depends on how the client reacts.

R Strong therapeutic relationships mean patients stay longer (2005). The therapeutic relationship between patient and worker early in treatment was more consistently related to engagement and retention than to substance use, especially when use was assessed at times distant from the assessment of the alliance. See this study (2002) for an example of the review's findings. For discussion click and scroll down to highlighted heading.

G Implementing NICE-recommended psychosocial interventions ([English] National Treatment Agency for Substance Misuse, 2010). Report from the British Psychological Society on how to implement recommendations in guidance from the UK's National Institute for Health and Care Excellence; includes competencies and attributes of therapists.

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. First step is to "Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy."

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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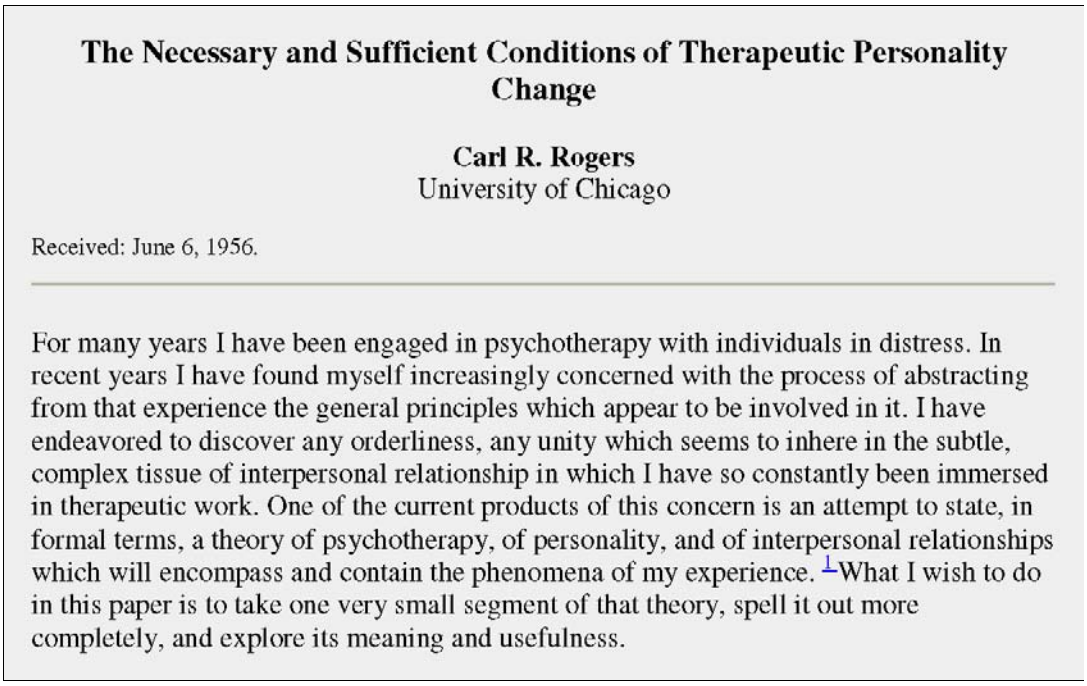
What is this cell about? Every treatment involves direct or indirect human interaction, but this cell is about treatments in which interaction is *intended* to be the main active ingredient – 'psychosocial', or more colloquially, 'talking' therapies. They attempt to change how the patient behaves directly by 'shaping' it through rewards and sanctions, or indirectly via their beliefs and attitudes, how they relate to others, and how others relate to them. Interventions vary in type, intensity and duration; see cell A4 for more on these variations.

Of course, what is done in therapy matters, but as long as this is a well structured, *bona fide* treatment which 'makes sense', the 'common factors' shared by different therapies seem more critical to their success. For the patient, the main embodiment of these factors is how the therapist relates to them, the influence of which is apparent in substance use treatment generally and in respect of medical treatments. Unsurprisingly, the evidence is stronger still when the structured enactment of that relationship *is* the treatment. In this cell we focus on the client-worker relationship, and on whether some therapists are more successful because they more strongly forge the right kind of relationships – 'therapeutic' relationships.

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 above), 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 substance users in effective treatment.



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. 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 problem drinkers investigated in a seminal British study and from the comments of drug and alcohol 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, and that they promote access to and retention. Across psychotherapy, they have (review listed above) stood the test of time, increasingly being acknowledged rather than becoming overtaken by alternative theories.

Produced in 1965 as training aids, 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 being treated by two other leading therapists of the time. See these accounts (1 2) for more on the videos and their importance in the history of psychotherapy. An obituary records that his theories emerged from an iconoclastic figure who "did not care about appearances, roles, class, credentials, or positions, and [who] doubted every authority including his own," and from someone (for his time) distinctively devoted to subjecting theory to scientific tests of validity in practice.

Carl Rogers's insights were 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 under the heading, "Being genuine sometimes mean breaking the 'rules'". 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. In various guises openness to experience later emerged as a quality underlying effective practitioners and effective organisations in addiction treatment. That finding seems also to extend to the therapists engaged by the UK's drive launched in 2008 to improve access to mental health care; unfold the supplementary text to read about the study.

Close supplementary text

From 2008 the Improving Access to Psychological Therapies (IAPT) programme sought to extend access to mental health care by recruiting 'Psychological Wellbeing Practitioners' to deliver low intensity, cognitive-behavioural support to a greater number of depressed and anxious patients than previously reached. The interventions mounted by the practitioners followed set protocols in line with guidelines set by the National Institute of Health and Care Excellence.

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 five most effective 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 willing to discussing the difficulties of their work, an openness to learning not encountered among the least effective practitioners. For the researchers, their results "challenge[d] the notion that protocol-driven therapies are wholly uncontaminated and unadulterated by the skills of the practitioner delivering the intervention".

Close supplementary text

Motivational interviewing is the guise in which Carl Rogers' insights will be most familiar to addiction therapists. A direct inheritor of his person-centred focus, it differs in the therapists' "intentional and strategic use of questions, reflections, affirmations, and summaries to strengthen the client's own motivations for change" – though these strategies do not necessarily augment outcomes.

Highlighted study Decades of searching have failed to find a recognised drug-based treatment for dependence on cocaine, and no specific psychosocial therapy has been constructed which can fill the

therapeutic gap. That leaves standard counselling focused on drug use as the dominant response, one the definitive national US evaluation found at least as effective as sophisticated psychological therapies.

Derived from the same evaluation, our highlighted study listed above went on to explore what it was which made the manualised counselling programme more or less effective. Read our analysis and you will see that its large sample enabled it to probe for complex patterns in the results, which lumped together generated the misleading impression that for drug use outcomes, neither the client-counsellor relationship nor the counsellor's flexibility in implementing the programme mattered.

Both *did* matter, but not in a linear 'more is best' manner. Improvements in drug problems were greatest when counsellors had stuck moderately well to the manual, and worse to roughly the same degree when they had either been unusually diligent or unusually lax in implementing the intended programme. This pattern was most marked when patients reported a relatively weak relationship with the therapist. When relationships were good, patients tended to do well regardless; moderate adherence to the manual's programme was still best, but outcomes suffered less from the extremes.

What sense can we make of these findings? First, we cannot dismiss the possibility that despite statistical significance, they are anomalous or chance findings. But the large sample, the care taken over the analysis, concordance with other findings (see *Is it best to busk it?* in cell B2's bite), and the fact that the findings 'make sense', argue for them to be taken seriously.

What sense they *could* make was explained by the authors: "Very high levels of adherence might reflect a lack of flexibility on the part of the therapist in responding to patients' needs, whereas very low levels might reflect an inability to translate a therapeutic model or theory into practice as prescribed … practicing in a way that is responsive to the clinical situation may, on occasion, require a deviation from a treatment manual even while maintaining overall adherence." This flexibility – or to put it another way, being patient-centred as opposed to programme-centred – seemed especially important when patient and counsellor had not rapidly forged a good working relationship. In turn, another US study suggests this could be due to the more psychologically weak and distressed patients (anxiety, depression, and self esteem were assessed) being unable to rapidly form a trusting and open emotional connection with the counsellor within which they can receive the help on offer. These patients might particularly benefit from attention to their needs, even if that means departing from the prescribed programme.

Remember though that the highlighted study's finding emerged from highly selected, experienced and trained counsellors, who could presumably exercise discretion wisely. Interpreting these and other findings, we saw the evidence "converging on the proposition that outcomes improve when skilled therapists are able and willing to depart from manualised regimens no matter how expertly these have been drafted, so long as a coherent structure is retained for the therapy which makes sense to the client".

▸ **Being genuine sometimes mean breaking the 'rules'** As a psychosocial therapist influenced by motivational interviewing and Rogerian principles (section above), 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 as essential to effective therapy. What should you do?

For guidance, turn to a study listed above of the training of addiction counsellors and clinicians, the implications of which are most easily absorbed from a brief, informal account by Drug and Alcohol Findings. Read at least this.

Entirely avoiding directive advice can 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 our interpretation 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 withholding such 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 this clear 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 from a review listed above that 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 with a cut-throat razor, they were able turn what could have been inadvertently harmful into something which could help get the job done by strengthening the therapeutic relationship.

▸ **Isn't it just a matter of being nice?** Not, it seems, from a penetrating analysis 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 about average in terms of their clients' experiences of working with them? Counsellors who had been relatively poor at generating a close 'helping alliance' from the client's perspective 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 pretty 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. 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 focusing too much on being 'nice' or on the client's comfort, failing to develop 'discrepancy' when needed – unwilling to generate change-promoting discomfort by highlighting how the patient's actions contradict their self-image and values. Perhaps too, they seemed less than 'genuine' to their clients – an important quality which sometimes means (section above) making interventions which contravene guidance and theory. But remember that while generating scores at the very top of the helping alliance scale may not be ideal, you don't have to slip very far down before outcomes start getting worse again; this is no *carte blanche* for neglecting alliance-building.

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.

▸ **If therapists are influential, why don't more studies register their effects?** Across psychotherapy more effective therapists "generally form better alliances with their patients and have better facilitative interpersonal skills, and provide an emotionally activating relationship". But in the substance use field we find a clash between frequent reports from patients that a particular therapist, counsellor or keyworker was the catalyst for their recovery, and trials which often find no significant signs that helpers differ in effectiveness. Are these trials missing something obvious (free source at the time of writing) to patients and clients and patently observable in normal practice? With random

allocation to what are designed to be bad versus good therapists ethically ruled out, proving therapists have an impact on substance use outcomes and establishing the reasons are not straightforward. Looking into these difficulties offers a case study of the limitations of usual scientific methods, ill-suited in this case for establishing that what *seems* valid and important, really is.

One limitation is that therapist effects are often obscured by the control researchers exercise over trials, including over therapists. Data on these effects is usually gathered as a by-product of a trial designed 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, leaving researchers with a partly untreated, small and probably unrepresentative follow-up sample. 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 of studies.

Where there is a therapist effect, a strong candidate for how it occurs is via the relationships therapists establish with their clients. At this point, disentangling what caused what becomes a major obstacle. Rather than relationships causing therapeutic progress, it could be that patients who are in any event going to do well – or are already doing well when the relationship is measured – form stronger relationships with their therapists and vice versa, each tending to be more appreciative of the other when their goals are being achieved. However, across psychotherapy there is evidence that more is going on than a good relationship merely being an epiphenomenon of a good prognosis – that relationships do actually account for part of the difference in how well clients do.

Establishing a link between the client-worker relationship and outcomes may also (if findings on the treatment of depression apply) require an unusually large study and unusually complete monitoring of those relationships, offering sufficient assessments for a reliable average to be computed – and also taking these measures early on in therapy before the relationship begins to *reflect* rather than promote client progress.

Then there are complexities which confound simple analyses. For example, usually researchers test whether the stronger the relationship, the better the outcomes. But what if the association between the two is not linear, but 'curved' – relatively weak and *very* strong relationships both being associated with poorer outcomes? In this scenario, such analyses might fail to find an association even if there really was one. If that seems fanciful, look back at the previous section and the evidence that there may well be a curve in the association between relationships and outcomes.

A further complexity is that therapeutic relationships matter more in some circumstances and for some people than others. If this is the case, rather than casting doubt on the existence of any relationship effect, inconsistent findings are only to be expected. An example emerged from a large and careful study of the US national drug treatment system, which suggested that relationships matter more for clients and patients with prior experience of treatment than those for whom this is a new experience. Explore the intriguing implications of this study by clicking on the eye-opener icon.

Close supplementary text

Generally treatment-repeaters had worse drug use and crime outcomes than first-timers, probably because they had relatively resistant drug use problems. But given a good relationship with their counsellors, in methadone maintenance they did better than equivalent first-timers; given a poor relationship, they did worse. Similarly, in non-residential drug-free services, relatively high rates of counselling and of compliance with the programme – indicative of a positive interaction between treatment staff and the client – were associated with better cocaine use outcomes for the repeaters, but were much less influential among the first-timers.

It was as if for first-timers the unfamiliar experience of being in treatment was so powerful that its quality was less influential. Obviously too, with no direct comparator from their past, they had less of

a basis for assessing quality. In contrast, experienced clients seemed to respond less to treatment as such than to what they see as good treatment, or perhaps needed very good treatment – including good therapeutic relationships with treatment staff – to dent more entrenched problems. There was no such effect in the residential programmes researched in the same study, where the impact of individual staff would have been diluted and being removed from one's usual drug using environment would have tended to overwhelm other factors.

Close supplementary text

The varied measures used to assess therapeutic relationship usually largely reflect the degree to which client and therapist collaborate in the work of therapy – they are task-oriented. In turn this collaboration is based partly on how they get on as two human beings encountering each other. A major dimension of this so-called 'real relationship' is how genuine you feel the other person is being, seemingly important in therapy generally and in substance use treatment in particular (see section above). Another dimension is seeing and reacting to the other person as they are rather than as an unreal projection – not far from being aware that the individual before you is not the standard client envisaged in therapy manuals, and that a sharp departure from those manuals is called for – also highlighted above. If these dimensions were given greater prominence, might relationships emerge more strongly as an influence on outcomes?

The research has been like probing for signs of the 'big bang' with a toy telescope pointed at the ground

Relationships are complex and their impacts on treatment outcomes not straightforward. Searching for proof of these impacts using methodologies designed for the simplicity of testing intervention versus no/alternative intervention, and in studies where relationships are not the main interest, might be likened to probing for signs of the 'big bang' origins of the universe with a toy telescope pointed at the ground. You might not see any signs, but that doesn't mean that the 'big bang' was a trivial event without consequences. Perhaps this is why a review of relevant research in the treatment of problem drug use (listed above) found client-worker relationships only inconsistently related to substance use outcomes. The same review found relationships were more consistently associated with engagement and retention in treatment, suggesting the less sanguine interpretation of the findings advanced in cell B2: that better relationships make clients want to stick around but do not make them better – though of course, for some treatments (especially those based on medications), 'sticking around' is vital to their effectiveness.

Search back through your experiences as a patient, client, therapist, counsellor, keyworker, adviser or advised, supporter or supported, and use these experiences as a prism through which to assess the adequacy of the research. If somebody did have a profound effect on you, or you had that effect on someone else, how might this have been demonstrated – how could it have been proved to scientific standards?

Close Matrix Bite