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Nugget 9.3

Therapy: how you do it matters

Findings New US research has confirmed the importance of *how* therapy is delivered and suggested that outcomes improve when different types of patients are 'matched' to different therapeutic styles.

Reports **1** and **2** are from a study of clients seeking outpatient treatment at an inner city clinic. Cocaine was the dominant drug problem and typically clients were poor, black, single unemployed men. Those who agreed to participate were randomly allocated to 12 weekly sessions of two kinds of individual therapy designed to be in some ways at opposite poles. In the highly structured option focused on behaviour, the counsellor directed the client to identify concrete behavioural goals, taught cognitive-behavioural strategies for reaching those gaols, and reviewed progress. In the less structured version focused on feelings, the counsellor followed the client's lead, providing a sounding board for exploration of feelings and the development of the client's own awareness and understanding. The same counsellors delivered both.

At the time of the earlier report (**1**)[1] 80 patients had been randomised and by the second (**2**), 143.[2] Neither during treatment nor at a follow-up nine months after treatment entry (when 71% of the sample was interviewed) was there any sign that overall one therapy was better than the other. Clients improved substantially in both. However, certain types of clients were more able to stay drug free during one treatment than during the other. Specifically, more depressed clients or those who felt unable to control their everyday lives did much better when the counsellor took the lead and the focus was on behaviour rather than emotions. Less depressed clients and those who felt more able to control their lives did better when they themselves took the lead. Treatment readiness at the start of treatment was a factor in whether clients maintained abstinence in highly structured therapy, but not in the other option. Combining the relevant psychological, treatment readiness and coping style variables improved the ability to predict who would do well in the two approaches.

In context These and other studies suggest that dimensions of therapy such as directiveness and the degree to which the focus is on feelings rather than actions are important and could be used to match patients to what for them is the best approach. They also suggest that a 'match client characteristic A to therapy B' approach should be replaced by an approach which matches a multidimensional client profile to a multidimensional therapeutic mix.

Such thinking has been most extensively developed and tested on psychotherapy clients[3] but has also recently been extended to alcohol patients engaged in outpatient couples therapy.[4] In this study patients who started therapy with relatively high levels of emotional distress cut their drinking most when the therapist focused on emotional experiences, but the same focus led to worse outcomes for patients relatively low in distress. Also, patients who were more highly defensive and who reacted against attempts to influence them did best when the therapist had a less directive style, worse when the therapist was more directive.

The latter finding is in line with findings from psychotherapy research. It also chimes with the Project MATCH finding that relatively angry alcohol-dependent outpatients did best in motivational therapy[5] because this achieved to a greater reduction in the client's resistance to treatment[6] – a presumed benefit of the training motivational therapists are given in not reciprocating hostile client responses and in a non-directive style which does not provoke a defensive response. There is no direct parallel in the featured study, but it seems plausible that clients who feel unable to control their everyday lives and are more depressed are also less prone to angry defensiveness. These clients did better in the therapy which entailed more directiveness by the counsellor.

The featured study, another of a similar set of clients[7] and another of 'heavy social' drinkers[8] call into question the belief that highly structured, behavioural therapies are preferable to usual drug counselling. However, all seem to have involved relatively low severity clients,[9] and there is reason to believe (partly from an earlier report of the featured study[10] – see *Additional reading*) that cognitive-behavioural therapy's advantages lie with more severely dependent clients.[11]

In another study self mastery – feeling in control of your life –was negatively related to how confident residents in a 12-step based residential facility felt in their abilities to remain abstinent and to their general optimism about their future.[12] The presumption was that though self mastery may be beneficial for other therapies, 12-step programmes require the opposite – surrender to higher powers. Perhaps too people who feel they have messed up their lives feel that the more they control what happens the worse things will be. In any event, the presumption that feeling in control of you life is a good thing in recovery terms seems not to be a universal truth – it depends on the therapy.

Practice implications The evidence is strong enough to support the deployment of a non-directive therapeutic style with clients whose anger or defensiveness would otherwise lead to a counter-productive reaction. Beyond this, as yet there is insufficient research on substance misusers to be confident about which therapeutic styles work best with which types of people in which situations. However, what is now clear is that therapeutic style matters, and often matters more than which therapy is formally being delivered. Dimensions such as directiveness, emotional

versus behavioural focus, and the degree to which painful emotions are addressed, could be monitored and related to the therapist's performance with different clients. Therapists can be trained to deploy approaches at opposite poles of these dimensions, raising the possibility that they can also be trained to assess which mix is likely to suit which clients, an adjustment perhaps made 'instinctively' by experienced and effective therapists. The ability to make this assessment and adjust accordingly could be one mechanism through which empathy and good communication with the client improve outcomes.

Featured studies 1 Gottheil E. *et al.* "Effectiveness of high versus low structure individual counseling for substance abuse." *American Journal on Addictions*: 2002, 11, p. 279–290. **2** Thornton C. *et al.* "Coping styles and response to high versus low-structure individual counseling for substance abuse." *American Journal on Addictions*: 2003, 12, p. 29–42. Copies: apply DrugScope.

Additional reading Thornton C.C *et al.* "Patient-treatment matching in substance abuse. Drug addiction severity." *Journal of Substance Abuse Treatment*: 1998, 15(6), p. 505–511. Copies: apply DrugScope.

Contacts 1 Edward Gottheil, Department of Psychiatry and Human Behavior, Thomas Jefferson University, 833 Chestnut Street East, Suite 210-E, Philadelphia, PA 19107, USA, edward.gottheil@mail.tju.edu **2** Charles Thornton, mailing address as above, charles.thornton@mail.tju.edu.

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Appendix to Nugget 9.3

The featured study is suggests that dimensions of therapy such as directiveness and the degree to which the focus is on feelings rather than actions are important and could be used to match patients to what for them is the best approach. It also suggests that a 'match client characteristic A to therapy B' approach should be replaced by an approach which matches a multidimensional client profile to a multidimensional therapeutic mix.

Such thinking has been most extensively developed and tested on psychotherapy clients.[13] The featured study represents an extension to (mainly) cocaine users. Other similar work has involved alcohol patients engaged in outpatient couples therapy.[14] In this study a cognitive-behavioural approach aiming for abstinence after the first 12 weeks was compared to family therapy in which patients and their partners agreed their own goals. Using videotapes, early sessions were rated on the degree to which the therapist focused on painful or emotionally charged topics, on insight versus behaviour change, or actively directed therapy. Drinking frequency after the first 12 weeks until treatment ended was assessed using a combination of measures. It was significantly less among the patients in cognitive-behavioural therapy but this overall difference was due to an advantage among patients who started therapy without high levels of emotional distress. This effect was itself due to the degree to which therapists focused on emotional experiences. For distressed patients this focus led to better drinking outcomes, for patients relatively low in distress it led to worse outcomes, the reverse of the effect expected from psychotherapy research. There was no significant interaction between the two

therapies and the clients' externalised versus internalised coping styles, failing to confirm psychotherapy research (and some research on alcohol patients[15]) indicating that internalising clients respond best to insight-oriented rather than behavioural therapies. There was a significant interaction such that patients who were more highly defensive and who reacted against attempts to influence them did best when the therapist had a less directive style, worse when the therapist was more directive.

The latter finding is in line with findings from psychotherapy research and similar to the Project MATCH finding that relatively angry outpatients did best in non-confrontational motivational enhancement therapy and that low-anger clients did best in the other options (12-step and cognitive-behavioural therapy).[16] Further investigation revealed that this effect was not due to any reduction in the tendency to be angry but to a greater reduction of the client's resistance to treatment in motivational enhancement therapy. This in turn is presumed to be a benefit of the training motivational therapists are given in not reciprocating negative client responses and in a non-directive style which does not arouse defensive responses.[17] There is no direct parallel in the featured study, but it seems plausible that clients who feel unable to control their everyday lives and are more depressed are also more open to influence by others and less defensive (low in reactance). These clients did better in the therapy which entailed more directiveness by the counsellor.

Researchers on the featured study suggest that their findings call into question the current stress on highly structured, behaviourally oriented treatments. The same conclusion was reached in a recent study of a similar population which tested 'strict', manual-driven cognitive-behavioural therapy against a looser version in which therapists could vary the programme and bring in other elements, and against usual drug counselling.[18] However, both studies seem to have involved relatively low severity clients,[19] and there is reason to believe that cognitive-behavioural therapy's advantages lie with more severely dependent clients. An earlier report of the featured study on 60 patients among whom cocaine was the main misused drug, found that those with the greatest pre-treatment drug problems benefited most from the highly structured behavioural therapy.[20] They attended more sessions, produced fewer 'dirty' urines during treatment, and at the end of treatment their counsellors rated them as having benefited more. A series of studies on cognitive-behavioural therapy at Yale University (summarised in their treatment manual[21]) found that less severely dependent cocaine using clients benefit equally from a variety of good quality treatments including routine clinical care. However, compared to psychotherapy or clinical care, cognitive-behavioural therapy consistently emerged as the treatment of choice for the more severely dependent clients.

The featured study does not report how many clients seeking treatment at the clinic refused to participate in the study. If this was common it would undermine confidence that the findings would be replicated across the clinic's caseload. Clients and independent observers both rated the therapeutic styles as differing in the intended ways on all the dimensions, though how big the gap was is not specified.

1 Gottheil E. *et al.* "Effectiveness of high versus low structure individual counseling for substance abuse." *American Journal on Addictions*: 2002, 11, p. 279–290.

2 Thornton C. *et al.* "Coping styles and response to high versus low-structure individual counseling for substance abuse." *American Journal on Addictions*: 2003, 12, p. 29–42.

3 Beutler L.E. *et al.* "Tailoring interventions to clients: effects on engagement and retention." In: Onken L. S. *et al, eds. Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment.* NIDA Research Monograph 165, 1997.

4 Karno M.P. *et al.* "Interactions between psychotherapy procedures and patient attributes that predict alcohol treatment effectiveness: a preliminary report." *Addictive Behaviors*: 2002, 27, p. 779–797.

5 Project MATCH Research Group. "Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes." *Alcoholism: Clinical and Experimental Research*: 1998, 22 (6), p. 1300–1311.

6 Waldron H.B. *et al.* "Client anger as a predictor of differential response to treatment." In: Longabaugh R. *et al, eds. Project MATCH hypotheses: results and causal chain analyses*. US Department of Health and Human Services, 2001, p.134–148.

7 Morgenstern J. *et al.* "Testing the effectiveness of cognitive behavioral treatment for substance abuse in a community setting: within treatment and posttreatment outcomes." *Journal of Consulting and Clinical Psychology*: 2001 69, p. 1007–1017.

8 Källmen H *et al.* "The effect of coping skills training on alcohol consumption in heavy social drinking."*Substance Use and Misuse*: 2003, 38(7), p. 895–903.

9 The featured study excluded patients who required intensive treatment. Few were excluded for this reason possibly because they did not seek help from an outpatient service or did not volunteer for the study.

10 Thornton C.C *et al.* "Patient-treatment matching in substance abuse. Drug addiction severity." *Journal of Substance Abuse Treatment*: 1998, 15(6), p. 505–511.

11 Carroll K.M. *A cognitive-behavioral approach: treating cocaine addiction.* Therapy manuals for drug addiction. Manual 1. US National Institute on Drug Abuse, 1998.

12 Majer J.M. et al. "Is self-mastery always a helpful resource? Coping wiith paradoxical findings in relation to optimism and abstinence self-efficacy." American Journal of Drug and Alcohol Abuse: 2003, 29(2), p. 385–399.

13 Beutler L.E. *et al.* "Tailoring interventions to clients: effects on engagement and retention." In: Onken L. S. *et al, eds. Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment.* NIDA Research Monograph 165, 1997.

14 Karno M.P. *et al.* "Interactions between psychotherapy procedures and patient attributes that predict alcohol treatment effectiveness: a preliminary report." *Addictive Behaviors*: 2002, 27, p. 779–797.

15 Kadden R.M. *et a*l "Matching alcoholics to coping skills or interactional therapies: posttreatment results." *Journal of Consulting and Clinical Psychology*: 1990, 57, p. 698–704. Cited in: Beutler L.E. *et al.* "Tailoring interventions to clients: effects on engagement and retention." In: Onken L. S. *et al, eds. Beyond the therapeutic alliance: keeping the drug-dependent individual in treatment.* NIDA Research Monograph 165, 1997.

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