5
Content, Structure and Purpose:
Some Constraints on the Effectiveness of Alcohol and Drug Counselling

John Caygill

Abstract

This article outlines the nature of alcohol and drug counselling in terms of its particular clinical context, the variability of contents on offer, and the basic structural dimensions of goals and timeframe, along with the essential element of purpose. Starting with a response to research-based doubts about the effectiveness of much current treatment for serious substance-use problems, it is noted that no one content approach or simple combination of structural variables can provide a straightforward solution to the many clinical challenges in the work. Certain difficulties in sustaining purpose are discussed, and some suggestions for enhancing purposefulness are offered.

Introduction

"*… most clients initiate behaviour change before accessing a treatment service*" (MacEwan, 1999, p.10);

"*… the effects of treatment are often modest and time-limited*" (Ibid., p.13);

"*… there is little of enduring value from intensive treatment for alcohol dependence*" (Ibid., p.14).

These research-based conclusions proclaim serious reservations about the effectiveness of treatment for alcohol and drug problems. This poses a challenge to counsellors, who comprise the bulk of the alcohol and drug treatment workforce and deliver the principal mode of treatment for many clients. Doubtless already aware of their often limited effectiveness, their immediate response might be as follows.

a) These conclusions are generalisations to which we know there are some specific exceptions. Furthermore, they are dwarfed on the one hand by the overarching generalisation that some treatment is better than no treatment, and on the other hand by the humanitarian imperative to respond to the misery and damage accompanying substance use disorders. Between one and four billion dollars a year in the full social costs to New Zealand of alcohol alone is a lot of problem to ignore (Devlin et al., 1997).

b) From time to time counsellors see their clients making remarkable and enduring changes, where the benefits of not drinking/using spread across their lives like ripples on a pond. This is the notion of recovery, which some counsellors have experienced at first as well as second hand. It really is nice to be alongside this process – even if it would have occurred without the counsellor's intervention.
c) However we rate our effectiveness "at the cutting edge" in the struggle with dependency, we also know there are many other situations in which we can easily be useful. Alcohol and drug counselling is a multi-faceted enterprise that includes focused assessments, "gate-keeping" referrals, provision of information, guidance through life crises or development delays, social-work support to minimise long-term harm – as well as the neat and clean "magic bullet" series of sessions that supposedly will stimulate an enduring recovery from a serious substance-use problem. Even without this last string to our bow, counsellors can easily be very busy and feel very useful.

This paper discusses the nature of alcohol and drug counselling in terms of content, structure and purpose, and considers some of the constraints to effectiveness that are inherent in the modality.

Content and structure

Alcohol and drug counselling takes place in a special clinical context where ambivalence is the norm and where the client's subjective awareness is a strategically significant variable (e.g. Miller & Rollnick, 1991). These particular conditions compel a stance of empathic attention to each client's unique concerns. This involves the avoidance of labelling and of judgement (despite dealing with moral issues much of the time), and the side-stepping of "resistance" or "denial", which very often precede the making of a painful choice.

Not surprisingly, the enterprise often appears quite formless and fluid. Engagement commences with an individualised assessment, covering predictable territory but administered with sensitivity to each client's particular concerns and their own understanding of their situation. The nature of the talk that follows will vary widely with the presenting clinical issues, as well as with the counsellor's own training and personal predilections, and with the "philosophy" of the agency. Client-counsellor undertakings may be restricted to abstinence as the only "legitimate" objective, or expanded to allow controlled use, or opened right out to include any substance use that is less harmful than it might otherwise have been. The contents of alcohol and drug counselling are as diverse as motivational enhancement, problem-solving and social work, cognitive-behavioural skills training, "12-step facilitation", social network therapy, and psychotherapy.

Presuming a satisfactory engagement, is there one particular content approach that clearly surpasses the others, and are there standardised and streamlined modes of delivery? Project MATCH answers "no" to the first question (Hall, 1999), while experience with treatment "packages" such as Motivational Enhancement Therapy (Miller, 1996) and Guided Self Change (Sobell & Sobell, 1998) shows that these often provide only a "first phase" rather that the "whole deal". In practice such packages are likely to be partially dismantled and incorporated into client-driven approaches rather than delivered in pure form. Furthermore, as evaluation of treatment has frequently shown, the quality of engagement is at least as important as the content (e.g. Asay & Lambert, 1999; Bachelor & Horvath, 1999).

While content issues have been extensively researched and debated over several decades (see summaries such as Heather & Tebbutt, 1989; Hester & Miller, 1995; Holder at al., 1991) much less has been said at the level of process. What are the salient features of effective engagement, and what constitutes optimal involvement? More concretely, where are the guidelines for deciding to commence or terminate counselling? Are there determinable aspects of process that will lead to predictably better outcomes in particular counselling situations?

Such matters are most often decided at counsellor level by intuition and personal preference. While this provides maximum freedom of choice for the counsellor, and may also allow for a high degree of client-centredness, it is arbitrary and open to question in the light of limited resources, increasing demands for services, and the expectation from service funders that service providers will be able to justify the cost-effectiveness of what they do.

The structure of treatment includes such basic factors as a goal orientation and a time frame. Common sense alone suggests that cost-effective resource allocation would be enhanced in a situation where the goals and the duration of treatment were negotiated at the outset. However, as all alcohol and drug counsellors know, such situations often do not prevail. Using a simple heuristic grid to combine these two purely contingent "dimensions" of counselling praxis, various prototypical alcohol and drug interventions can be allocated to particular quadrants.

	Goal specified	Goal open
Term specified	A	B
Term open	C	D

Time-limited interventions with clearly defined goals, such as organising detoxication,

referral for residential treatment, or a short treatment "package" like the Guided Self-Change, fit in box A. A structured Brief Intervention (Heather, 1995) or Motivational Enhancement Therapy package would be in box B, where the client is at the pre- or contemplative but not action stage, as would a treatment "package" such as the Guided Self Change where the client is initially undecided on the actual change goal.

But whatever the attraction (perhaps illusion) of "neatness" provided by boxes A and B, it is clear that much counselling work actually fits in boxes C and D, either as planned interventions or as "slippage" from an initially "tight" set of treatment conditions. Box C includes on-going goal-directed counselling in the "action" phase of the Cycle of Change (Prochaska at al., 1992), perhaps following on from detoxication and residential treatment, where the realities of major behaviour change and the vicissitudes of learning from relapse ("two steps forward, one back") preclude or overturn any preset time frame. This quadrant also includes open-ended harm minimisation situations where the goal is clear (though relative rather than absolute) but the duration undefined, and therapeutic gains occur by default: a crisis averted or a final collapse forestalled, rather than recovery achieved.

While box D seems intrinsically non-productive and purposeless, it may be reached by "slippage" from box C, through the loss of clear objectives initially intended under a rubric of harm minimisation. Increasingly often, situations of no agreed goal and no time-frame also arise in response to inter-agency pressure for the alcohol and drug case-worker to remain involved with particular clients as monitor and "social control" agent.

What can be concluded from this crude analysis of structural elements? Perhaps only that the inherent "messiness" of much alcohol and drug work evades a simple structural framework as much as it does a single content approach. If valid, this is in itself a useful conclusion (especially when the appearance of "mess" provokes the urge to "tidy-up"), and certainly not a dead end. For there are other key aspects of the counselling process to consider: in particular, the dynamic element of *purpose*, crucial to the carrying forward of the work.

Purpose defined

The notion of purpose is not as arbitrary or intangible as it might sound. It is an implicit emergent quality at the level of structure, where counselling without goals and/or a time frame risks drifting aimlessly. It is present in the process of engagement, which is not a matter of mutual attraction but a relating with intent. Conceptually, it is indicated in any intervention that challenges the ambivalence and paradoxes of dependence (logic without purpose would be ineffective), and it is immanent in the

now-axiomatic Trans-theoretical Model of Change (Prochaska at al., 1992), which is a progressive cycle. At the level of content, purpose is an explicit dynamic variable in the non-directive but highly directed techniques of Motivational Interviewing (Miller & Rollnick, 1991).

In the client, purpose is manifested as the crucial "motivation to change". In the counsellor, purpose is manifested in the directedness of interviewing techniques designed to elicit self-motivating statements from the client and "support self-efficacy" without promoting resistance. Between counsellor and client it is expressed in a negotiated treatment undertaking infused with a sense of hope. Where the client's growing awareness of their substance problems is marked by profound ambivalence, and the counsellor's skills in maintaining empathy can as easily promote stasis as movement out of contemplation, then the notion of purpose is more than a platitude.

Purpose defeated

Purpose can ebb and flow at different stages of the work, and in different circumstances. There may be patterns for each counsellor in regard to certain types of client. Obviously, it may remain unmobilised in the "precontemplative" or the highly ambivalent client – in which case the counsellor's own purpose will be to engage the client and work on enhancing their motivation to change. Or a purposeful commitment to change may subsequently collapse beyond revival, following a major relapse.

Apart from such overtly challenging situations, the crucial element of purpose can be misdirected or weakened almost paradoxically as an outcome of the very preconditions under which counselling has commenced. As already noted above, and as Miller (1998) reminds us, an empathic attentiveness to the client and their situation is a necessary (though not sufficient) condition for promoting therapeutic change. In our functioning as health professionals who are paid to listen and to talk, counsellors generally are perceived by their clients as being more than simply skilled technicians. Assuming the common situation in which the client has less awareness than the counsellor of what counselling is supposed to entail, it is likely that the "counsellor" role will be assimilated in the client's understanding to a more familiar social role such as "guide" or "mentor", "friendly helper" or even "substitute parent". It is also likely that the counsellor will to some degree conform to the client's implicit expectations – or at least signal a presumed conformity to the client simply by the quality of the counsellor's attention to the client's unique story as it unfolds.

Obviously, some role-relationships are better vehicles for a therapeutic purpose than others. "Experienced guide" implies expert assistance made available to a client on a journey of change. "Mentor" becoming "guru", however, implies a client whose

own awareness can't be trusted. "Parent" – whether "nurturing" or "controlling" – is complemented by a dependent and perhaps rebellious "child". "Concerned friend", with its assumed mutuality, implies cosy chats and avoidance of sensitive issues, inviting transition to "helpless bystander" in the face of relapse.

At a simpler level, purpose can be defeated by a situation in which both counsellor and client shrink from confronting or undermining each other. Typically in this situation the client is experiencing a crisis of dependence: desperately wanting to break free, but fearful of simply stopping. The counsellor is fully attentive to this drama, and imposes a minimum of structural preconditions on the therapeutic undertaking. The client assimilates the counsellor's empathy and encouragement, and their own longing to be free, into a fantasy of "this time it will be different", which helps them to rise above despair and also to avoid the painful reality of giving up their much needed but monstrously demanding substance.

As progress stalls beyond the initial burst of hope, the client avoids disappointing the counsellor and losing the happy fantasy by not saying how difficult it really is to give up, and the counsellor colludes by not wanting to undermine the increasingly illusory picture for fear of either provoking despair or simply offending the client by not taking their progress reports at face value. Once such collusion starts, it becomes increasingly difficult for either party to confront the underlying reality, though probably both perceive the "stuckness" of the undertaking and feel bad about it. Generally the client soon finds a reason not to come back – at which point the counsellor feels some relief, and perhaps a little guilt as well.

A complementary "purpose trap" arises where some real initial progress is followed by stasis, in which the counsellor has become a relied-upon "support person" rather than a facilitator of change. The pressure now is to avoid "kicking out the props", as opposed to "pricking the bubble". The tenor of such situations may have contributed to a recent dismissive definition of "general alcohol counselling" as "brief discussions with case workers or approaches in which counsellors do little more than listen while clients report how it's going each week" (MacEwan, 1999, p.29). Implicit in this characterisation is the absence of purpose.

Purpose enhanced

How can the vital element of purpose in alcohol and drug counselling be made more explicit in useful ways, and the various "purpose traps" be avoided? The following suggestions may help. At the outset:

- Simple preliminary explanation to the client of the counselling process.
- Skilful and directed use of Motivational Interviewing techniques, especially in the

early stages.
- Goals of intervention that are "negotiated, appropriate, attainable and meaningful" (MacEwan, 1999, p.13), in accordance with the Cycle of Change.

When goals are defined (and purpose can start to run aground):
- A "standing agenda" in the counselling that seeks a "contract" at the start of each session ("What do you want to achieve from your time here today?" "What's your purpose for today?") and addresses progress towards goals.
- Regular contract reviews, serving as a basis for negotiating further goals and time frames.
- Optional use of content-appropriate treatment "packages", where overt structure would help to maintain the undertaking.
- On-going process evaluation in the work itself; i.e., attending to "the here and now" to highlight helpful or unhelpful role expectations, "mixed messages", "the unsaid", etc.
- Constant attention to the ambivalence and the manifest or veiled emotions (e.g. anxiety, resentment, grief) that are associated with a change in substance use, and that enhance or weaken purposeful change.

In support of the above, and to extend and challenge the counsellor in their work:
- External process evaluation via good clinical supervision.
- The development of further specialist skills for use within the work, such as advanced cognitive behavioural therapy or motivational interviewing, rational emotive behaviour therapy, transactional analysis, social network therapy, etc.

Conclusion

Of course, most of the above items are themselves problematic in some way. For example, explanations of the counselling process can seem pedantic. A contracting and review framework may be constraining or withholding. Treatment packages may be perceived as irrelevant or impersonal (and should always be worked through in a client-responsive style rather than just handed out). While meta-observations are often potent, they may be experienced as intrusive, baffling, or gratuitous. Clinical supervision can end up simply reassuring rather than challenging the counsellor. A deeper view of process can also be more narrow.

There are no tidy answers to the question of what produces effectiveness in an inherently messy enterprise. If it works at all, alcohol and drug counselling is a purposeful craft – not just a treatment delivery system or compendium of techniques – that faces challenges arising from its own mode of application as well as from the complex bio-psycho-social problems it is intended to address.

References

Asay, T. & Lambert, M. (1999). *The empirical case for the common factors in therapy: Quantitative findings.* In M. Hubble, B. Duncan & S. Miller (Eds), The heart and soul of change: What works in therapy. Washington DC: American Psychological Association.

Bachelor, A. & Horvath, A. (1999). The therapeutic relationship. In M. Hubble, B. Duncan & S. Miller (Eds), *The heart and soul of change: What works in therapy.* Washington DC: American Psychological Association.

Devlin, N., Schuffham, P. & Bunt, L. (1997). The social costs of alcohol abuse in New Zealand. *Addiction, 92* (11):1491–1505 .

Hall, W. (1999). Patient matching in treatment for alcohol dependence: Is the null hypothesis still alive and well? *Addiction, 94* (1): 52–54.

Heather, N. (1995). Brief intervention strategies. In R. K. Hester & W. R. Miller (Eds), *Handbook of alcoholism treatment approaches: Effective alternatives.* Boston, MA: Allyn and Bacon.

Heather, N. & Tebbutt, J. (1989). *The effectiveness of treatment for drug and alcohol problems.* National Campaign Against Drug Abuse Monograph Series No. 11. Canberra: Australian Government Publishing Service.

Hester, R. K. & Miller, W. R. (1995). *Handbook of alcoholism treatment approaches: Effective alternatives.* Boston: Allyn and Bacon.

Holder, H., Longabaugh, R., Miller, W., & Rubonis, A. (1991). The cost effectiveness of treatment for alcoholism: A first approximation. *Journal of Studies on Alcohol, 52* (6): 517–40.

MacEwan, I. (1999). *Overview of specialist alcohol and drug assessment and interventions in the New Zealand context.* ALAC Occasional Publication No. 10. Wellington: Alcohol Advisory Council of New Zealand.

Miller, W. R. (1996). Motivational Interviewing: Research, practice and puzzles. *Addictive Behaviours, 21* (6): 835–42.

Miller, W. R. (1998). Why do people change addictive behaviour? *Addiction, 93* (2): 163–72.

Miller, W. R. & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour.* New York: Guilford Press.

Prochaska, J. O., Diclemente C. C. & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviours. *American Psychologist, 47:* 1102–114.

Sobell, M. & Sobell, L. (1998). Guiding self-change. In W. R. Miller & N. Heather (Eds), *Treating addictive behaviours* (2nd ed.). New York: Plenum Press.

The author would like to thank Seán Manning for his editing advice, and Dr Doug Sellman and Dr Grant Paton-Simpson for their helpful comments on an earlier draft.