CLIENTS' AND COUNSELLORS' PERCEPTIONS OF HELPFUL AND HINDERING EVENTS IN OUTPATIENT DRUG ADDICTION COUNSELLING

by

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ABSTRACT

The aim of the study was to compare clients’ and counsellors’ perceptions of helpful and hindering events in outpatient drug addiction counselling. It attempted to answer the following questions: what do clients and counsellors consider as helpful events in drug addiction counselling? What do clients and counsellors consider as hindrances in counselling? How similar are these perceptions for clients and their counsellors? Comparisons between clients and counsellors in fields other than the addictions, have in general demonstrated differences in perceptions. While clients tend to give more importance to factors related to the counselling relationship and the feeling of relief from problems as a channel for change, counsellors have emphasized the use of techniques and cognitions as important ingredients for change. In the addictions field, studies comparing clients’ and counsellors’ are lacking. The study set out to undertake this comparison. Seven clients recovering from a drug addiction and their counsellors were interviewed separately within a year of ending their participation in counselling. The Critical Incident Technique, (Flanagan, 1954) and time-line methodology (Chell 1998) were used as a means to identify helpful and hindering incidents in the therapy process. Helpful and hindering incidents were extracted from the transcribed interviews for both clients and their counsellors separately and than compared. General agreement between clients and counsellors was observed in this study. The agreement was explained in terms of the special characteristics of the sample and the successful nature of the counselling experience. Although some interesting differences were uncovered, the general congruence in the comparison between clients and counsellors challenged some developing notions about disparities between the two parties.
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CHAPTER 1

INTRODUCTION

"Counsellors kept on visiting us even though we gave them a hard time, I understood that we counted!"; “I happened to come to the group on my first day of prison, the counsellors noticed I was distressed and came to talk to me after the session”; “The counsellors didn’t push me into participating”. These are some of the evaluatory comments from young offenders who completed a three-month psycho-educational programme at a correctional facility. To my surprise many of the answers to the question “what did you find helpful in this experience?” had nothing to do with the content of sessions. My colleague and I had expended a huge amount of energy in the preparation of each session and expected that the content and methods used would feature more prominently in the evaluation. Although the content of the sessions did feature in their evaluations, elements related to the process were more pronounced. This experience seems to fit the growing understanding that clients’ and counsellors’ perceptions do not seem to be as congruent as one may expect. It also fits the widespread understanding that the development of a strong therapeutic alliance is critical to achieve positive outcomes. As Hanna, Hanna and Keys (1999) note, “dozens of studies have provided evidence of the importance of an empathic therapeutic relationship in achieving positive outcome in general” (p. 396). Sexton and Whiston (1994) provide a review of such studies on the counselling relationship.

This introductory chapter will provide a background to the study. First an outline of research areas directly related to the question will be laid down. The purpose and aims of the study, research questions and rationale will follow. Definitions and a short section in which personal assumptions are bracketed are provided at the end.
Background to the Research Question

Around 25 studies from the past 20 years have been found in the published literature comparing clients and their counsellors on different elements related to the therapeutic process. The more recent ones include such comparisons in relation to family court counselling (Davies & Ralph 1998); personal characteristics (Dolinsky, Vaughan, Luber, Mellman & Roose, 1997); trust in the therapeutic relationship (Preschken & Johnson, 1997); client/counsellor similarity (Herman, 1998), effectiveness of short-term counseling (Rogers & Mc Leod, 1995, Cummings & Barak, 1995); therapeutic change in couples’ therapy (Wark, 1994); perceptions of solution-focused therapy (Metcalf & Thomas, 1994); effect of social and physical contact on therapeutic process (Ramsdell & Ramsdell, 1994); and perceptions toward money (Sitkowski & Herron, 1991). The value of such studies has been in uncovering various discrepancies between the clients’ and counsellors’ perceptions. In general, clients tend to give more importance to factors related to the counselling relationship and the feeling of relief from problems as a channel for change, whereas counsellors have emphasized the use of techniques and cognitions as important ingredients for change. Such studies, that will be looked at in depth in the literature review section, have important implications for practice. They highlight the need for counsellors to understand the clients’ experience and to examine practices and theoretical approaches in the light of the client’s experience. They indicate the need for counsellors to check more deliberately with their clients in order to create a stronger therapeutic alliance.

In the addictions field, five studies have set out to compare counsellors’ and clients’ on different factors. Walton, Blow and Booth (2000) compared substance abuse clients’ and counsellors’ perceptions of relapse risk. In an earlier study, Nurco, Shaffer, Hanlon, Kinlock, Duszynski, and Stephenson (1988), examined the relationship between the degree of agreement
(congruence) among clients and counsellors at the beginning of therapy and the treatment
outcome of opiate-addicted clients. Friedman, Glickman and Kovach (1986) compared
perceptions of the environments of adolescent drug treatment residential and outpatient programs
by staff and clients. In another study perceptions of treatment needs by clients and counsellors
were studied (Jordan, Roszell, Calsyn, and Chaney, 1985).

Only one study in the drug addiction field compared clients and counsellors on what they
think was most effective in treatment. Kaminer, Tarter, Bukstien and Kabene (1992), evaluated
the level of agreement between staff of an adolescent substance abuse treatment program and 98
clients (aged 13 to 18) regarding their perception of the efficacy of treatment modalities.
Although agreement was found on seven of the variables studied, significant differences were
discovered in the perception value of three other modalities: individual treatment contracting,
therapeutic community meeting and educational counselling. Similar to studies in other fields,
this indicates that in drug addiction treatment disparity between clients and counsellors may also
exist. However the picture is far from clear and more studies need to be carried in this field.

In the substance abuse treatment arena, research is indicating that outcome seems to be
independent of the form of treatment (Mclellan, Alterman, Metzger, Grissom, Woody, Luborsky
& O'Brien, 1994). In the latter study, clients who received any of three different treatments
benefited and the benefit was not related to time in treatment. This finding emphasizes the need
to understand the ingredients that are helpful in recovering for an addiction.

The Study

The study attempted to extend the current body of research by carrying out a qualitative
comparison of clients’ and counsellors’ perceptions of what they found helpful or hindering in
the outpatient addictions counselling experience - an area in which such comparisons have not as
yet been attempted. It aimed at gathering in-depth information of what clients and their counsellors consider as critical factors in their journey towards recovery from drug addiction.

The proposed study attempted to answer the following research questions: what do clients and counsellors consider as helpful events in outpatient drug addiction counselling? What do clients and counsellors consider as hindrances in counselling? How similar are these perceptions for clients and their counsellors?

Seven clients and their counsellors were interviewed after ending their participation in counselling. The critical incident technique as developed by Flanagan (1954) and the timeline methodology (Chell, 1998) were used to identify helpful and unhelpful events in the therapy process.

Rationale for the Study

In the two years prior to taking up graduate study, my work as a drug prevention counsellor brought me in contact with many youth vulnerable to substance abuse. In my interactions with these youth I always asked myself how best to interact in a therapeutic way and what best to do in order to provide the best therapeutic milieu. I tried to keep updated with effective treatment approaches through in-service training. Most of this training was delivered by professionals and experts practitioners. Although such training experiences were extremely valuable I wondered what clients would have to say about what really works for them and whether they would agree with what the expert trainers were saying. Knowing that I would be returning to work in the addictions field on completion of my graduate studies, I wanted this study to inform my own practice. I wanted to understand better what really matters in drug addiction recovery. I wanted to listen to both counsellors and clients, providing them with equal space as they explained what they think really mattered. As I asked them the question “what
works?”, I looked for similarities and divergences in their replies. I expected points of agreement to be a very strong indicators of what works and differences to be eye-openers for professionals practicing in the field.

Drug addiction is one of the hardest habits to break and relapse rates are high. Therefore it is essential for anyone working in the field to have a thorough understanding of the therapeutic dynamics and the roads that lead to recovery. In fact in the research and professional practice communities there is a constant push to develop and apply efficacious and evidence-based treatment approaches. However, it is equally important for counsellors to understand the clients’ experience and to examine practices and theoretical approaches in the light of the client’s experience. In so doing counsellors can more fully understand the needs of clients and attempt to address issues that are crucial for recovery to take place. Studies to determine efficacious treatment are extensive, studies asking for the perceptions of clients in addictions are budding, but studies comparing clients and counsellors’ perceptions are scant. This study will shed light on the degree of agreement between clients and counsellors about effective therapeutic interventions. The main implications will relate to counsellor training, practice and research in the area.

Definitions

Substance Use Disorder

The Substance-Related disorders in DSM-IV TR (2003) are divided into two basic groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance-Induced Disorders (including Substance Intoxication and Substance Withdrawal).

Substance abuse is considered as a maladaptive pattern of use leading to clinically significant impairment or distress, and is usually characterised by recurrent substance use
resulting in a failure to fulfill major role obligations; recurrent substance use in situations in
which it is physically hazardous; recurrent substance-related legal problems; and continued
substance use despite having persistent or recurrent social or interpersonal problems caused or
exacerbated by the effects of the substance.

On the other hand, substance dependence is a maladaptive pattern of use leading to
significant impairment or distress characterised by tolerance and withdrawal symptoms; the
substance being taken in larger amounts or over a longer period than intended; a persistent desire
or unsuccessful efforts to cut down or control substance use; a great deal of time spent in
activities necessary to obtain the substance; important social, occupational or recreational
activities are given up or reduced; and the substance is continued despite knowledge of having
persistent and recurrent physical or psychological problems that are likely caused or exacerbated
by the substance.

Substance dependence is what is usually referred to as drug addiction and in this proposal
will be used interchangeably. In the past, the criteria for dependence relied on the symptoms of
physiological symptoms of tolerance and withdrawal. However in the last version of DSM, there
is no need for physical symptoms for a client to meet the criteria of dependence. Psychological
dependence is regarded as equally important as physical dependence. This was done to capture
the younger population of substance dependant individuals. This has resulted in a recording of
higher rates of substance dependence since more substances qualified. On the other hand, since
clients with a lack of physical symptoms respond better to treatment, treatment outcome rates
have also improved.

Recovery

"Remember that recovery is a journey, not a destination. Where do you begin? With the
first, tiniest, shakiest step. A journey of a thousand miles begins with a single step.” (Wilson & Wilson, 1992, p. 283). This is the definition offered by a self-help book for people recovering from addiction. From this perspective recovery is seen as a process characterised with successes, relapses or lapses. While some clients manage to achieve abstinence others never do so. For clients who do manage to quit and maintain change, the current perspective is that three years of abstinence is commonly regarded as a stabilized recovery (Koski-Jannes & Turner, 1999).

**Personal Perspectives on Recovery**

This study is qualitative in nature and as a researcher I was the data-gathering instrument. I would like to take a moment to acknowledge personal attitudes or perspectives about recovery from addiction. Together with the previous literature, such views served as spectacles from which to understand the results of the study.

Through my academic background, training and work experience I have come to believe that substance abuse plays a very functional role in the user’s life. Be it for recreational purposes or as a form of self-medication, the person usually has valid reasons to turn to a substance. Some of the reasons may include, the need to fit in with drug using peers, the need to alienate oneself from a boring life, the excitement of going over the limits of permission or the need to hush the pains of abuse. However when the experimentation phase is over and the habit kicks in, the person’s life increasingly revolves around the substance. What starts off as a solution becomes an overbearing burden and an added problem to deal with.

When it comes to recovery I strongly subscribe to the bio-psycho-social model that suggests all three domains of the person’s life need to be addressed for recovery to take place. I believe that most important ingredients for change and recovery from drug addiction relate to the client, the counsellor and interplay of their relationship. The client needs to have: a strong
motivation for change; social support that contains the person’s efforts; and a reconnection with the self to understand what may have pushed him/her to seek substances, coupled with cognitive, emotional behavioural changes. On the other hand the counsellor, to start with, needs knowledge of the dynamics of addiction; a non-judgemental attitude toward the person and his/her motivation to seek the drug; and an ability to live with the tension of having a client that might still be harming him/herself with the substance while in counselling.

The clients’ and counsellor’s interactions is the third building block for recovery. Like any other counselling setting, a strong alliance in the relationship needs to be present for any change to take place. In such a relationship the clients have the permission to be themselves without the risk of being judged. This includes having the addiction acknowledged as an important part of their life. The user is not a bad person who has made bad mistakes but rather a valuable person who is rethinking his/her choices. Because a large majority of individuals dependant on drugs have a history of rejection and abuse it is imperative for the counselling relationship to be one of caring. This does not mean that the counsellor gives in to all the requested demands or that there is no space for challenging. It means that the counsellor’s right to challenge needs to be earned after the client understands that the counsellor genuinely appreciates him/her. In this relationship the clients are allowed to be temporarily dependent on the counselling relationship and the counsellor. They know that they can always fall back on the relationship at any point in of their journey towards recovery.

Overview

Following this introduction to this study, the following two chapters will lay the foundations for the carrying out of the study. Chapter two will review the current state of research with regard to client/counsellor perceptions of therapy, process of change in addiction
recovery and factors influencing that change, and current efficacious treatment interventions for
addictions. Chapter three will present and discuss the methodology used in the study, delineating
the rationale for methodological choices and describing details of procedures and method of
analysis. The results obtained from the interviews will be reported in chapter four. Chapter five
will contain the discussion of the category system developed in the study and a discussion of the
comparison between clients and counsellors. The concluding chapter, chapter six, will sum up
the study, present the implications and limitations of the study and end with suggestions for
further research.
CHAPTER 2
LITERATURE REVIEW

Introduction

This review is intended to provide a thorough background for the proposed study. Most of the reviewed studies will fall into two major categories: research areas directly related to drug addiction, and areas related to clients' and counsellors' perceptions of effective therapy. This review is divided into eight separate sections: three in the category of drug addiction, two in the category of client/counsellor perceptions and three sections combining these two categories. Section one provides a profile of drug using trends. Section two and three will include a review of the process of recovery from addiction, and efficacious treatments for substance abuse respectively. The fourth section will look into what clients alone have said on the therapeutic experience in both addiction counselling and other treatment fields, and the fifth section will review the comparisons between clients and their counsellors. The sixth will review the scarce literature on client/counsellor perceptions in the addictions field and the seventh section will look at the methodology that has been used to make comparisons between clients and counsellors. The chapter concludes with a section that summarizes the literature and ties it to the proposed study.

Profile of Drug Use Trends

Drug abuse is a global phenomenon. According to the World Drug Report (UN office on drugs and Crime, 2000), 134 countries and territories reported a drug abuse problem in the 1990s. Although cannabis is the most widely abused drug, heroin and cocaine have continued to be the most problematic substances. In terms of geographical regions, the main drugs for which treatment is required are opiates in Europe, Asia and Oceania; cocaine in North and South
America; amphetamine-type stimulants (ATS) in parts of East and South-East Asia; and cannabis in Africa. In general abuse trends show a stabilization or decline of opiates in the main consumer markets of Western Europe, and a decline of cocaine consumption in the United States. On the other hand, abuse levels are increasing in many drug transit countries. ATS abuse grew strongly in the 1990s, but began to show signs of stabilization in some of the main markets of Western Europe towards the end of the decade. In contrast ATS abuse has continued to grow in East and South-East Asia.

Drug Addiction and the Process of Recovery

Theory of Change

The dynamics of change and recovery from drug addiction need to be considered to fully understand the counselling experience for clients and counsellors working with this population. An understanding of such dynamics of change can serve as a guiding map for addictions counselling. An influential theory of clients’ readiness to change addictive behaviour such as chronic substance abuse is the Transtheoretical Model of change (Prochaska & Diclemente, 1982). This model contends that people’s willingness to change their addiction moves through identifiable stages: pre-contemplation, contemplation, action and maintenance. Furthermore, research on the stages of change model has indicated that different processes of change such as planning to quit, are associated with the various stages (DiClemente, Prochaska, Fairhurst, & Velicer 1991).

Following the establishment of this change-model researchers have looked into the context in which chronic substance abusers become ready for change. Cox and Klinger (1990) suggest that individuals with a substance abuse problem make a decision to change their behaviour pattern when they consider the positive emotional and behavioural consequences of
changing as overshadowing the negative ones. The individual will be motivated to change if he or she expects satisfaction in alternatives to using drugs, and does not expect intolerable distress as a result of quitting. Cox, Blount, Bair and Hasier (2000) have further established that when clients are highly motivated to change, (characterised by an emotional involvement in their goal pursuits, clients who expect strong satisfaction if they succeed and strong disappointment if they fail, expect to reach goals in the near future, expected strong chances of success and feel strongly committed) they are not only more determined in making changes but also tend not to deny problems.

Factors Influencing Recovery from Addiction - Research on Clients' Reasons for Change

The factors leading to change in addictive behaviours have been studied extensively among both clients who received treatment and those who did not. In a recent review, Blomqvist (1996) summarizes findings of such studies. Quitting drug use, for clients who do not seek treatment is sparked off by any or a combination of problems with health, family, work or finances, law, sudden frightening or humiliating experiences and maturing. For those, who do seek help, change in treatment is attributed to therapy techniques, confiding relationships, convincing rationale, safe and encouraging setting and direct feedback. Finally, change is maintained by the use of adequate coping techniques and the availability of social support for sobriety in the individual's environment (Koski-Jannes & Turner, 1999).

Recovery from drug addiction seems to result from a variety of factors and circumstances that interact together to help the individual move out of the vicious circle. There are some indications that clients addicted to different drugs may be motivated by change by different factors. Mc Bride et al (1994) found that cigarette smokers were more motivated by health concerns than marijuana and cocaine users. On the other hand, the latter two were more
motivated by a wish for self-control. Furthermore, cocaine users were more likely to be motivated by social influence than both marijuana and tobacco users. Such differences suggest that the motivational enhancement approaches may need to consider the specific substance.

Efficacious Treatments for Substance Abuse

Successful recovery from drug addiction is the result of an interplay of many favourable factors and circumstances. As pointed out in the previous section some individuals move out of addiction without turning for help from treatment services. However, for a good number of individuals, treatment plays a significant role in the recovery matrix. Three treatment approaches that are currently receiving considerable attention by researchers (Donovan, Kadden, DiClemente & Carroll, 2002) because of their track record include the 12-step model, cognitive behavioural therapy with an emphasis on relapse prevention and motivational enhancement therapy, a form of brief intervention. These three constitute the most popular treatment approaches with 95% of treatment facilities in North America following the 12-step model.

Although all three approaches have been found to be efficacious in controlling substance abuse, a major study has indicated that outcome seems to be independent of the form of treatment (McLellan, Alterman, Metzger, Grissom, Woody, Luborsky & O'Brien, 1994). In this study researchers used abstinence as a criterion for successful treatment outcome. They looked into methadone maintenance, inpatient and outpatient 12-step programmes and evaluated them for efficacy of reducing opiate, cocaine and alcohol dependence. These interventions were equally effective and were associated with reduction in substance dependence. They found recovery rates ranging from 30 to 70% averaging 50%. Clients who received treatment benefited and the benefit was not related to time in treatment. Brief interventions were equally effective. This finding emphasizes the need to understand the subjective experience of clients in treatment
and what constitutes the ingredients that are helpful in recovering from an addiction.

Mclellan et al. also evaluated the same three therapeutic approaches (methadone maintenance, inpatient and outpatient 12-step programmes) for efficacy of improving psychosocial adjustment. Psychosocial adjustment has a pivotal role in the recovery since poor levels of this adjustment at end of treatment were predictive of relapse to substance abuse. Type and amount of treatment received was in fact associated with improved psychosocial adjustment. The longer the treatment the better the outcome in psychosocial adjustment.

Factors Influencing Therapeutic Change

Certain client attributes have been found to enhance or adverse effect therapeutic change. Donovan, Kadden, DiClemente & Carroll, (2002) found that while motivational readiness enhanced treatment, network support for drinking and high alcohol involvement were all related to poor outcome. In dual diagnosis clients, psychiatric severity and sociopathy had a poor prognosis. Furthermore the less physiological symptoms the more people responded to treatment.

Clients' Perceptions of Effective Therapy

Research that looks into the lived experience of clients in counseling has proliferated in the last decade. This has happened in part as a response to a need to consider the clients' subjective experiences and a realization that models based on quantitative studies alone are limited because they do not capture the full complexity of how people change. As a result most of these studies are qualitative in nature. Examples of such research include studies of clients' perceptions of marital therapy (Bowman & Fine, 2000; Estrada & Holmes, 1999) and perceptions of adult clients who were abused as children (Dale, Allen & Measor, 1998).

Some studies that gave a voice to clients receiving services to control their addiction, have been attempted. Although more studies need to be carried out in order to build a more
complete picture, the current studies serve as a starting point. In an early study Orbitz (1975), studied 50 male alcoholics who were shown videos of directive and non-directive therapist counseling styles with the same clients. The non-directive technique was perceived by participants as more socially desirable. However when asked what style they would prefer, participants showed a strong inclination toward the directive technique. The authors do not provide enough details about the extent to which participants were involved in the two-month treatment programme. This would have shed some light as to whether such a preference would have been dependant on their level of involvement.

In a recent study, Kasarabada, Hser, Boles and Huang (2002), studied clients’ perceptions of their counselors’ and outcomes of drug treatment were considered. The main finding was that patients’ positive perceptions of their counselors were significantly associated with longer stay in treatment and better psychiatric functioning as measured by the Addiction Severity Index. This seems to confirm Miller, Hubble, and Duncan’s (1995) idea that for the development of rapport and consequently engagement, clients need to perceive the counsellors as empathic and non-judgemental.

Gender differences in perceptions of drug user treatment programme for eight male and eight female youthful offenders were studied by Hegamin, Anglin and Farabee (2001). With regards to help-seeking behaviours, the study supported previous studies indicating that females are more likely than males to recognize and seek treatment for psychiatric and emotional difficulties. With regards to treatment engagement, both males and females showed a desire for additional counselling. However females emphasized the need for it to be delivered by a counselor who is empathic and supportive.
Client vs. Counsellor Perceptions of What Works

Although the literature about client and counsellor congruence is inconclusive there are some indications that client and counsellor agreement can be advantageous. For instance, in Llewelyn’s (1988) study of general counselling effectiveness, more differences in perceptions where found when the outcome was poor. Furthermore the correct identification of clients’ concerns at intake was positively related to engagement in counselling (Tryon, 1986). Finally a mutual definition of a problem appears to facilitate agreement on change (Sirles, 1982).

An ingredient that has been very well established as an essential factor for any therapeutic work to be successful is the counselling relationship. The clients that seem to benefit most from counselling are those that are motivated, engaged and connected with their counsellor (Miller, Hubble & Duncan, 1995). Such motivation, engagement and connectedness are by and large the result of an alliance developed between client and counsellor. A positive rapport results when the therapist is empathic, genuine and respectful (Torrey, 1972, Rogers, 1965) factors that are closely linked to the Rogerian approach to counselling. However several studies have found that it is the clients’ ratings of the alliance, rather than the counsellors’ perceptions, that are highly correlated with outcome (Miller et al, 1995). This means that strong alliances are developed when clients perceive the counsellor as warm, trustworthy, non-judgemental and empathic. Therefore counsellors’ own evaluations of their success in building rapport are not enough. In this sense, “the most helpful alliance will develop when the therapist establishes a therapeutic environment that matches the clients’ definition of empathy, genuineness and respect” (Miller et al.,1995 p. 56)

Studies that have compared clients and their counsellors have been carried out in the following seven areas. Comparisons relating to; counselling relationship (Halstead, Brooks,
Goldberg, & Fish, 1990, Horn & Anchor, 1982, Kiesler & Watkins, 1989, Preschken & Johnson, 1997); counsellor behaviours (LaCrosse, 1977); practice issues (Manos, 1982, Sitkowski & Herron, 1991); perceptions of individual counselling programmes or approaches (Davies & Ralph 1998); personal characteristics (Dolinsky, Vaughan, Luber, Mellman & Roose, 1997, Herman, 1998, Martinez, 1991); problem and change (Hutchinson, Lee & Hutchinson, 1987, Sirles, 1982, Tryon, 1986) and factors related to therapeutic effectiveness (Cummings & Barak, 1995, Fuller & Hill, 1985, Rogers & McLeod, 1995). A mix of quantitative and qualitative approaches have been used, with the majority of studies adopting quantitative approaches. In this chapter, only the last category, i.e. comparisons on factors related to therapeutic effectiveness, will be reviewed since that is the focus of the proposed study. With regard to therapeutic effectiveness three quantitative studies and three qualitative studies have been found.

**Quantitative Studies**

Rogers and McLeod (1995) compared clients’ and counsellors’ perceptions of brief counselling intervention (six sessions) in an occupational setting. In their comparison, they asked 223 clients and their counsellors to rate the degree to which clients had benefited from counselling and the extent to which the number of sessions was adequate. They found fair agreement between clients and counsellors on their satisfaction of counselling outcome. The major difference related to the number of sessions. Clients were more satisfied with the number of sessions while counsellors tended to rate the number of sessions as inadequate. “Presumably, counsellors and clients operate different criteria for success, have different objectives for counselling, and different agendas (Rogers & McLeod, p.229).

In another study of short-term counselling, Cummings and Barak (1995) found agreement between clients and counsellors on the need for depth as an important factor for change. Seeing
positive results (positivity) was considered to be another important factor for clients but not for counsellors. This need for positivity was also found by Fuller and Hill (1985) in a study of a single session outcome. The discrepancies in this study centred around clients perceiving the need for reassurance and relief from problems as opposed to counsellors who considered insight as an important ingredient for change. Clients also perceived more support, focus and clarity, less self-control and resistance than counsellors had actually intended to provide. In this study the counselling dyads agreed on the importance of counsellors' imparting of information.

**Qualitative Studies**

Qualitative studies comparing counselling dyads support some of the findings from the above studies. Wark (1994) studied five pairs of therapists and couples. Results are remarkable in that stark differences appeared between clients and therapist. Six categories of helpful incidents from client participants were: positive results (similar to previous studies); the routine provided by structure; alternative perspectives offered by the therapist; non-directive style of the therapist; directive therapist; and focus on positives by the therapist. Four categories of helpful incidents from therapists were: signs of readiness for change; techniques for change; client interaction in session; and change outcome. Three categories of hindering incidents emerged from clients were no follow-through with assignments; therapist imposition and no resolution of problems. Two categories of hindering incidents from therapists were: therapist responsibility for change and not enough data gathering. The only area of agreement between clients and therapist was on the helpful incident of continuing evidence of change during therapy. The finding of such differences has many important implications for practice. It challenges counsellors to move out of their own worldview, give less emphasis on “doing therapy” and concentrate more on what is happening during the therapy session. The client-therapist relationship needs to be seen as a
partnership, rather than a giving and receiving liaison. Wark's greatest contribution was to examine the effectiveness of therapy with variables obtained from the clients' words and secondly to provide a sense of how different the experience could be perceived by clients and their therapists. She has laid the ground for the replication of the study applied to other areas such as the addictions field, where such a comparison has not as yet been carried out.

In Llewelyn's (1988) study of general counselling, personal contact was a point of agreement between both groups. The discrepancies were very similar to Cummings and Barak's finding. Clients emphasized problem solution, relief and reassurance while counsellors emphasized clients gaining emotional and cognitive insight as channels for change.

A final study that accentuates the differences between clients and counsellors was conducted by Metcalf and Thomas (1994) who studied six client/therapist dyads engaged in solution focused brief therapy. Clients perceived the role of the therapist as a mediator, friend, outsider, saviour, guide and sounding board. Counsellor behaviours found to be helpful were: counsellors saying what would work and counsellor suggestions. On the other hand therapists viewed their role as a consultant and behaviours they considered helpful for the clients were: asking scaling questions, paraphrasing, looking for strengths and resources, listening, not participating unless asked, giving ideas and highlighting competencies.

Comparing Clients and Counsellors in the Addiction Field

In the addictions field, five studies comparing clients and their counsellors on the following set factors were found: perceptions of relapse risk (Walton, Blow & Booth, 2000); perceptions of the environments of adolescent drug treatment residential and outpatient programs (Friedman, Glickman & Kovach, 1986); perceptions of treatment needs (Jordan, Roszell, Calsyn, and Chaney, 1985); agreement (congruence) among clients and counsellors at the beginning of
therapy and the treatment outcome of opiate-addicted clients (Nurco, Shaffer, Hanlon, Kinlock, Duszynski, & Stephenson, 1988); and finally perceptions of an adolescent substance abuse programme (Kaminer, Tarter, Bukstien & Kabene, 1992). Of the five studies the last two are most relevant for the proposed study.

Kaminer et al. evaluated the level of agreement between staff of an adolescent substance abuse treatment program and 98 clients (aged 13 to 18) regarding their perception of the efficacy of treatment modalities. Results indicated significant differences in perception value of three modalities: individual treatment contracting, therapeutic community meeting and educational counselling. Agreement was found on seven other variables: family therapy; self-help group; relapse prevention group; medications; vocational counselling; social skills group and chemical dependency education. Similar to studies in other fields, this indicates that in drug addiction treatment disparity between clients and counsellors may also exist. However since the picture is far from clear, more studies need to be carried in this field.

In an earlier study, Nurco et al., (1988), examined the relationship between the degree of agreement (congruence) among clients and counsellors at the beginning of therapy and the treatment outcome of opiate-addicted clients. The study included 897 drug-addicted individuals admitted to 25 separate drug treatment services in the US. They hypothesized that high congruence between clients’ and counsellors’ perceptions of the clients’ problems and the most efficacious ways to address them is positively related to successful treatment outcome. In their examination they classified addicted clients by ethnic group and gender. The study indicated that there was only one statistically significant (.2) association for Blacks and Hispanics especially females with these ethnic backgrounds. However, these associations are not clinically significant. Hispanics and Blacks in general showed the greatest relationship between congruence and
outcome. With regards to congruence on relative problem severity and outcome Hispanic and Black females showed significant relationships. With regards to congruence on appropriateness of services and outcome Hispanic males and Black females showed significant relationships. Finally significant correlations for Black males and females resulted when congruence on confidence in treatment and outcome were compared. For Whites, not only was a positive relationship absent, but significant relationships for Whites, although low, were found to be negative. Here one has to keep in mind that in the study whites were most severely addicted and had highest rates of exposure to past treatment. Very interestingly, "only client/counsellor congruence with respect to estimation of the likelihood of positive change (i.e. Confidence in Treatment) was related to outcome measures" (p. 51). Therefore when both client and counsellor thought that treatment would likely be successful there was an increased likelihood of positive change. Although significant, the relation was still rather weak. One important consideration in interpreting results is the way in which outcome was assessed. Six months after clients were admitted, counsellors rated the degree of improvement. This follow-up assessment seems to be most questionable. A recent study from a different addictions field namely - eating disorders (Geller, 2002) has showed that clinicians tend to over-rate the clients' readiness for change. Asking the clients to rate their outcome might have provided the study with a more accurate measure. Notwithstanding this limitation, the major contribution of this quantitative study was to establish that congruence at the beginning of treatment for drug addiction, as a single factor to predict treatment outcome seems to be of little value.

A study comparing client/counsellor perceptions of therapy and length of treatment (Horn et al., 1982) has suggested that congruence between clients and counsellors was higher at the end of long-term therapy. The study reviewed in this paper looked at congruence at the outset of
treatment. Congruence at this stage was not found to be very high. It would be interesting to look into congruence at the very end of treatment and explore whether that would be predictive of the maintenance of a drug free life-style.

Methodological Approaches Comparing Clients & Counsellors

The few studies from fields other than drug addiction that have identified factors that help and hinder the counselling process directly from clients and their counsellors have focused on critical incidents (Llewelyn, 1988; Wark, 1994). In Wark’s study, participants included five pairings of family therapists and couples. Therapists were in training at the doctoral level. Three interviews were carried out, after the same sessions for each couple and before the 10th session. The researcher wanted to explore the clients’ experience while they are in therapy. Wark used the Critical Incident Technique (Flanagan, 1954), an inductive method of analysis, to sort critical incidents into categories based on what clients and therapists had said.

Two possible limitations arise from this study. First, since therapists were still in training, one can question whether similar results would be gained if the therapists had been very experienced in the field. Secondly, the study focused exclusively on events occurring in the therapy sessions. An extension to this could have been the consideration of extra therapy events. Hill (1991) points out that extra therapy events can be both positive and negative, but do affect the therapy process. Thus not considering these events could have represented a partial picture of what helped clients to achieve problem resolution.

In Llewelyn’s study, 40 client and therapist pairs were interviewed after each session and asked to identify helpful and other important events (including unhelpful events). Therapists’ experience ranged from 2 to 20 years. She opted for a deductive method of analysis using pre-set categories of events as a filter to analyse events identified by participants.
As outlined earlier such studies have shed light on some discrepancy between clients and counsellors. However they contained some methodological limitations that the current study attempted to overcome. For instance, in Wark’s study, the use of therapists in training might have contributed to them concentrating more on techniques and perceiving them as important elements for therapeutic change. In Llewelyn’s study, unhelpful incidents were rarely reported because of an emphasis on helpful events during data collection. Furthermore, her use of fixed categories might have also restricted the development of other possible categories. An attempt was made to overcome such limitations.

Summary

Research looking into addictions counselling and support services have largely focused on evaluating the efficacy of such services or treatment approaches, with most studies concluding that they enhance treatment outcome. Cognitive behavioural, the 12-step model and motivational enhancement therapy have been established as some of the most prominent efficacious therapeutic approaches to address drug addiction. However, clients manage to control their addiction notwithstanding which form of treatment they receive. For this reason it is important to understand the processes of change that are operating when a client engages in a therapeutic relationship. Lily, Quirck, Rhodes and Stimson (1999) hold that “whilst there has been an emphasis on outcomes-based research, there has been a dearth of research examining the processes involved in the delivery of counselling and support services” (p. 268). As a result scant attention has been given to the experience of clients and their counsellors in relation to therapeutic processes such as the development and maintenance of the therapeutic alliance.

In fields other than drug addiction, studies have shown that discrepancies exist in the way clients and counsellors perceive the means by which the counselling experience was helpful in
achieving change. With the exception of one study that compared adolescent clients' and their counsellors' perceptions of a drug rehabilitation programme (Kaminer, Tarter, Bukstien & Kabene, 1992), a comparison between clients' and their counsellor's perceptions of helpful and unhelpful events in addictions counselling has not yet been attempted. The current study attempted to carry out this comparison in order to look at the lived experience of the counselling process of both clients and counsellors and to shed some light on the degree of agreement between clients and counsellors about effective therapeutic interventions.
CHAPTER 3
METHODOLOGY

Introduction

This chapter outlines the research methods adopted for the study to address the three research questions: What do clients and counsellors consider as helpful events in drug addiction counselling? What do clients and counsellors consider as hindrances in counselling? How similar are these perceptions for clients and their counsellors? The first part of this chapter will include an overview of the approaches chosen to address the research questions, namely, the Critical Incident Technique and Timeline Methodology. After that, methodological decisions regarding participants, settings, procedures and the method of analysis will be presented. The study received the Behavioural Research Ethics Board’s approval and all followed procedures were endorsed as ethically sound (see Appendix A for Ethics Certificate).

Critical Incident Technique

The Critical Incident Technique (Flanagan, 1954) was used as a means to identify helpful and hindering incidents or events in the therapy process from clients and their counsellors (the words incident and event will be used interchangeably). Originally developed in World War II to identify effective pilot performance, this method has been increasingly used in counselling research (Amundson & Borgen, 1987; Ellis, 1991, Lee & Cochran, 1997, McCormick, 1994, Wark, 1994, Young & Friesen, 1992). This method seemed to be the best approach to address the research questions for two main reasons. First it “is an exploratory qualitative method of research that has been shown both reliable and valid in generating a comprehensive and detailed description of a content domain” (Woolsey, 1986, p. 242). Secondly it has been repeatedly and successfully used to identify and provide detailed descriptions of events that hinder and help a
specified activity. Rather than testing pre-existing hypotheses, events will be allowed to emerge from the data in an inductive process.

No strict tests exist to decide sample size, however Flanagan recommends the gathering of incidents until redundancy is reached. More specifically redundancy or adequate coverage is achieved when the addition of 100 critical incidents to the sample adds only two or three critical behaviours. A heterogeneous participant pool is desirable to maximize critical incident diversity and strengthen the comprehensiveness of generated categories (Woolsey, 1986).

Timeline Methodology

Chell (1998) describes the timeline procedure as a chronological sequencing of events relevant to a particular theme, identified on a past-to-present continuum. Apart from the requirement that events are collated in temporal order as they occurred, the method allows for flexibility. The time-line on which events are positioned can be straight or depicted with highs and lows symbolically representing helpful and hindering moments over time.

This procedure complemented the critical incident technique and was chosen for its advantageous features. As described by Chell, the timeline makes possible analysis of events beyond the immediate context of an event; inter-event relationships can be explored; it delineates recurring themes and patterns; facilitates theory or framework development; and finally allows connections to appear between seemingly isolated events.

Participants

Thirteen individuals participated in the study. These included seven clients recovering from drug addiction and their addictions counsellors (six in all). Since this study was exploratory and generalization of the findings is not possible, a purposive sample was used. Tables 1 to 5,
presented further on in this chapter, outline the participants’ demographic data, drug addiction, recovery and treatment data. Pseudonyms have been used to protect the participants’ identities.

*Participation Criteria*

Five selection criteria were used to recruit client participants. First, all participants were adult individuals over the age of 19. In fact ages of the seven client participants ranged from 27 to 76, 46 being the average age (see table 1). Second, client participants had experienced a substance dependence (drug addiction) problem as defined by the DSM-IV TR: a maladaptive pattern of use leading to significant impairment or distress characterised by tolerance and withdrawal symptoms; the substance being taken in larger amounts or over a longer period than as intended; a persistent desire or unsuccessful efforts to cut down or control substance used; a great deal of time spent in activities necessary to obtain the substance; important social, occupational or recreational activities given up or reduced; and the continued drug use despite knowledge of persistent and recurrent physical or psychological problems that are caused or exacerbated by the substance. Based on the counsellors’ formal assessments all client participants met the criteria for substance dependence. The third criterion included clients who were actively engaged in an outpatient counselling relationship to overcome their drug addiction. The outpatient counselling had to be the main treatment of choice for participating clients. The duration of time involved in outpatient counselling for participants ranged from six months to five years four months. The average period of time connected to outpatient counselling was two years five months. Table 3 depicts detailed treatment information. The fourth criterion for client participants was that they experienced a successful outcome from counselling by reaching the maintenance stage of change. This stage is characterised by individuals who have been working to prevent relapse, are less tempted to relapse and are increasingly more confident that they can
continue their change (Prochaska & DiClemente, 1991). At the time of interview all client participants had been abstinent from any drug. The period of abstinence ranged from six months to four years, with an average of one year seven and a half months (see table 4). The final selection criterion involved recruiting participants who had ended their participation in counselling no longer than a year before being interviewed for the study. The time between the last counselling session and the research interview ranged from one month to a year, with an average of four months (see table 4). Since it is common for clients in the addictions field to keep receiving some aftercare support after termination, client-participants receiving such support were accepted for this study. In fact three client participants were in the after-care phase of treatment and four had completely ended their participation in counselling (see table 4).

Two selection criteria were used for counsellor-participants. First, participants had been working in the drug addiction field for a least one year. The years of work experience in this field ranged from two to 15 years with seven being the average (see table 5). The second criterion for counsellor participants was that they held a minimum of a masters level training in counselling psychology (see table 5).

Recruitment

Clients and counsellors were recruited from agencies offering outpatient addictions counselling and support services in British Columbia’s lower mainland (Canada). With the consent of agency management, dyads of counsellors and clients were approached separately and invited to participate by a third party, namely the researcher. At no point were clients asked to participate by their counsellors and neither were counsellors asked to participate by their management. This practice avoided any pressure for either clients or counsellors to participate in the study.
Prospective participants were invited to participate in the following manner: the researcher first carried out a ten-minute presentation of the research in staff meetings of addiction counsellors' teams, and distributed an invitation letter (see Appendix B). Interested counsellors could approach the researcher within the two weeks following the meeting. Counsellors who showed interest in participating were then asked to identify clients fitting the research criteria and to ask the identified client whether his/her contact information could be passed on to the researcher. When this was granted, the researcher approached the client individually by phone and sent an invitation letter (see Appendix B) if the prospective participant fit the criteria. Clients who replied to the invitation were forwarded a copy of the consent form (Appendix C). Upon their endorsement of the consent form clients were recruited. 11 agencies, and a total of 46 counsellors were approached. Of the 46 counsellors, 18 were interested to participate. Of those 18, eight counsellors could not identify clients fitting the criteria, four identified clients who eventually did not show interest to participate and six counsellors identified clients who were interested to participate. A pilot interview was carried out with the first client-counsellor dyad. The counsellor-participant who took part in the pilot-interview also identified a second client who agreed to participate. The counsellor was re-interviewed about the counselling experience with the second client he identified. Therefore, in total six counsellors identified seven clients who agreed to participate and 14 interviews were held.

The recruitment process aimed at attaining clients with a range of drug-using and treatment histories. Variability within the boundaries of the set five client-participants criteria was desired in order to have a heterogeneous participant pool from which to extract incidents. Likewise variability within the counsellor-participants was also considered an asset. What follows is an overview of client-participants' information relating to their addiction, treatment
and recovery from drug addiction, and a brief description of counsellor-participants in relation to their therapeutic approaches.

**Client Participants**

The five female and two male client participants were all adult, Caucasian individuals living in the Vancouver lower mainland area. A close inspection of table 1 shows the variability in ages, socio-economic status; education levels and employment background. On the other hand three similar trends could be observed. Participants tended to have some family history of drug addiction, the majority experienced some form of childhood, adolescent or adult abuse, and the majority were not involved in criminality.

In terms of their drug abuse and addiction histories, variability could be observed in the drug of choice (see table 2). With the exception of two clients, participants started experimenting with alcohol and drugs in their early to mid-teens. All were deeply entrenched in their addictions and had been struggling with one substance or another for a lengthy period of time prior to approaching the outpatient counselling service studied in this research. The drug abuse/addiction periods ranged from six to 20 years, averaging at 14.5 years. In these abuse/addiction periods clients were not necessarily using drugs over all the times. These periods were characterized by a series of using, abstaining and relapsing phases. Clients were not able to hold long-term abstinence during this time.

In relation to treatment, participants were deeply engaged in the experience as already noted by the long counselling period and the numerous amount of sessions received (see table 3). Five of seven participants had their sessions spread over two or three counselling clusters. Having separate clusters corresponded with periods of discontinued counselling due to a relapse
### Table 1

**Demographic Data of Client Participants**

<table>
<thead>
<tr>
<th></th>
<th>Ana</th>
<th>Bob</th>
<th>Clare</th>
<th>Doris</th>
<th>Alice</th>
<th>Philip</th>
<th>Gina</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>40</td>
<td>62</td>
<td>27</td>
<td>76</td>
<td>42</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Current marital status</strong></td>
<td>Common Law</td>
<td>Separated</td>
<td>Single</td>
<td>Widowed</td>
<td>Separated</td>
<td>Separated</td>
<td>Married</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
</tr>
<tr>
<td><strong>Current socio-economic status</strong></td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Grade 12</td>
<td>Some high school</td>
<td>College &amp; 1.5yrs of university</td>
<td>Grade 12</td>
<td>Grade 8 &amp; some technical school</td>
<td>Grade 8</td>
<td>Grade 12 &amp; some vocational school</td>
</tr>
<tr>
<td><strong>Current employment status</strong></td>
<td>Unemployed</td>
<td>On leave of absence</td>
<td>Office job</td>
<td>Pensioner</td>
<td>Unemployed for 10 years</td>
<td>Builder</td>
<td>Office job</td>
</tr>
<tr>
<td><strong>Employment history</strong></td>
<td>Unskilled jobs</td>
<td>Carpenter &amp; sales</td>
<td>Office work</td>
<td>Administrative jobs</td>
<td>Unskilled jobs</td>
<td>Trades</td>
<td>Office work</td>
</tr>
<tr>
<td><strong>Other mental health difficulties</strong></td>
<td>/</td>
<td>Depression</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>Depression</td>
</tr>
<tr>
<td>Past experience of abuse</td>
<td>Childhood sexual abuse; domestic violence</td>
<td>Adolescent sexual abuse</td>
<td>Domestic violence</td>
<td>/</td>
<td>Domestic violence</td>
<td>Childhood neglect</td>
<td>/</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------</td>
<td>------------------</td>
<td>---</td>
<td>------------------</td>
<td>------------------</td>
<td>---</td>
</tr>
<tr>
<td>Criminal Convictions</td>
<td>Fraud</td>
<td>Trafficking; break &amp; enter</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Family History of Addiction</td>
<td>Parents and 2 siblings</td>
<td>/</td>
<td>Mother; Sibling Step Father and Grandfather</td>
<td>Parents (excessive drinking)</td>
<td>Aunts, Uncles and Father</td>
<td>Biological Parents</td>
<td>/</td>
</tr>
</tbody>
</table>
Table 2

*Client Participants' Drug Abuse/Addiction History and Abstinence*

<table>
<thead>
<tr>
<th></th>
<th>Ana</th>
<th>Bob</th>
<th>Clare</th>
<th>Doris</th>
<th>Alice</th>
<th>Philip</th>
<th>Gina</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main substance used</strong></td>
<td>Cocaine; Alcohol;</td>
<td>Cocaine; heroin</td>
<td>Cocaine; Crystal Meth.</td>
<td>Alcohol</td>
<td>Cocaine</td>
<td>Alcohol</td>
<td>Alcohol, Marijuana</td>
</tr>
<tr>
<td><strong>Other substances used</strong></td>
<td>Anti-depressants</td>
<td>Marijuana; anti-depressants</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>Marijuana</td>
<td>Speed; anti-depressants</td>
</tr>
<tr>
<td><strong>Age at first use</strong></td>
<td>12 (alcohol, marijuana, mushrooms exp.); cocaine at 30</td>
<td>Early teens (alcohol exp.)</td>
<td>13 (exp.*)</td>
<td>55</td>
<td>31</td>
<td>13 (alcohol, marijuana exp.)</td>
<td>17 (exp.*)</td>
</tr>
<tr>
<td><strong>Period of drug abuse / addiction prior to outpatient counselling</strong></td>
<td>20 yrs</td>
<td>6 yrs **</td>
<td>17 yrs</td>
<td>20 yrs</td>
<td>10 yrs</td>
<td>20 yrs</td>
<td>8**</td>
</tr>
<tr>
<td><strong>Major relapses during outpatient counselling</strong></td>
<td>Series of relapses</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Time Abstinent at interview</strong></td>
<td>4 yrs</td>
<td>1 yr</td>
<td>1 yr 3 mths</td>
<td>11 mths</td>
<td>9.5 mths</td>
<td>3 yrs</td>
<td>6 mths</td>
</tr>
</tbody>
</table>

* exp. = experimentation  ** prior to this addiction phase clients had struggled with another addiction. Prior to the 6yrs Bob had experienced an alcohol addiction from which he had recovered. Similarly Gina had also struggled with alcoholism. Both had experienced a lengthy period of abstinence prior to progressing to another addiction or relapse.
Table 3

*Client Participants' Treatment Information*

<table>
<thead>
<tr>
<th></th>
<th>Ana</th>
<th>Bob</th>
<th>Clare</th>
<th>Doris</th>
<th>Alice</th>
<th>Philip</th>
<th>Gina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of outpatient counselling</td>
<td>5yrs</td>
<td>1yr 6mths *</td>
<td>1yr 9mths</td>
<td>5yrs 4mths</td>
<td>1 yr 4mths</td>
<td>1yr 5mths</td>
<td>6mths</td>
</tr>
<tr>
<td>Number of counselling clusters</td>
<td>3</td>
<td>1**</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total Number of sessions with outpatient counsellor</td>
<td>48</td>
<td>32**</td>
<td>47</td>
<td>33</td>
<td>12</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Other services accessed during outpatient counselling</td>
<td>Res (6 wks)</td>
<td>SRH; AA; NA</td>
<td>Res (6wks); AA; DP</td>
<td>Res (3mths)</td>
<td>AA</td>
<td>AA; Ed Sr. (8wks)</td>
<td></td>
</tr>
</tbody>
</table>

** 10 years earlier had client had another counselling experience with same counsellor to work on alcohol addiction

*** 10 years prior to this counselling cluster of 32 sessions the client worked with his counsellor on an alcohol addiction and received 30 sessions

*** DP: Day Programme  
Ed Sr: Education Series  
TWk: Therapeutic Workshops  
AA/NA: Alcoholics/Narcotics Anon

Res: Residential Treatment  
SG: Support Group  
SRH: Support Recovery House
### Table 3

**Client Participants' Treatment Information**

<table>
<thead>
<tr>
<th></th>
<th>Ana</th>
<th>Bob</th>
<th>Clare</th>
<th>Doris</th>
<th>Alice</th>
<th>Philip</th>
<th>Gina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of outpatient</td>
<td>5yrs</td>
<td>1yr 6mths*</td>
<td>1yr 9mths</td>
<td>5yrs 4mths</td>
<td>1yr 4mths</td>
<td>1yr 5mths</td>
<td>6mths</td>
</tr>
<tr>
<td>counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of counselling</td>
<td>3</td>
<td>1**</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>clusters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of</td>
<td>48</td>
<td>32**</td>
<td>47</td>
<td>33</td>
<td>12</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>sessions with outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>counsellor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services accessed</td>
<td>Res (6 wks)</td>
<td>SRH;</td>
<td>Res (6 wks);</td>
<td>AA;</td>
<td>Res (3mths)</td>
<td>AA</td>
<td>AA; Ed Sr.</td>
</tr>
<tr>
<td>during outpatient</td>
<td></td>
<td>AA; NA</td>
<td>AA;</td>
<td>TWk (5);</td>
<td>DP</td>
<td></td>
<td>(8wks)</td>
</tr>
<tr>
<td>counselling</td>
<td></td>
<td>DP; SG</td>
<td>SRH;</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** 10 years earlier had client had another counselling experience with same counsellor to work on alcohol addiction

*** 10 years prior to this counselling cluster of 32 sessions the client worked with his counsellor on an alcohol addiction and received 30 sessions

<table>
<thead>
<tr>
<th>Demographic Data of Counsellor Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td><strong>Drug addiction history</strong></td>
</tr>
<tr>
<td><strong>Years of work experience in addictions field</strong></td>
</tr>
<tr>
<td><strong>Training in Counselling Psychology</strong></td>
</tr>
<tr>
<td><strong>Main Theory Base and Therapeutic Approaches Used with respective client</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

(a) Family of origin Work (e) Cognitive therapy (b) Relapse Prevention (f) Psycho-education (c) Directive Style when called for (g) Attachment theory
or partial recovery. With no exception all participants also accessed some other service, secondary to the outpatient one. Five accessed support groups like Alcoholics Anonymous or Narcotics Anonymous; three completed a residential treatment programme; two completed a day programme; two accessed support recovery houses and two attended other therapeutic workshops or psychoeducational groups that were spread over a definite and short period of time. Table 3 presents basic details about the client participants’ outpatient counselling.

Client participants approached counselling differently. Three had very low motivation to make changes in their drug use at the start of counselling. The other four were on the higher end of the motivation continuum when they started (see table 4). Ana, Clare and Alice entered counselling with no real intention of quitting their drug use. Ana and Alice were court mandated to counselling as a condition to receive their children back after having been removed from them for child protection reasons. Clare had to seek counselling after being convicted of drug charges. Although she started being tired of living a chaotic life, like Ana and Alice she was actively using at the beginning and well into the counselling experience. Bob, Doris, Philip and Gina engaged in counselling voluntarily. All were confronted by extremely serious consequences of their drug use. Bob had the experience of reaching rock-bottom, “feeling physically, mentally, spiritually, financially bankrupt”. He had a desperate desire to move out of his chaotic and disrupted life. For Doris it was health and relationship difficulties that prompted her to seek help. First she had experienced substance-induced seizures and secondly she perceived the imminent danger of losing the relationship with her partner and daughter. Philip was also experiencing a deep-seated dissatisfaction with life. He was feeling very sad and at risk of suicide. Philip’s fear of dying was greater than the fear of facing his problems, and he sought counselling to support him in his move toward abstinence. Like Philip, Gina felt a strong need for help to sustain
abstinence. She felt consumed by the addiction, at imminent risk of losing her marriage and her work and feeling suicidal when not under the influence. Of the seven client participants Philip and Gina, entered counselling drug free and experienced no relapse throughout the entire counselling period.

_Counsellor Participants_

Since variability in the sample was desired, counsellors adhering and using different therapeutic approaches in their work with clients did not constitute a hindrance. Table 5 outlined the counsellor participants’ demographic information. The three male, and the three female addiction counsellors were all Caucasian individuals with ages ranging from 32 to 55, with an average age of 44 years. In terms of the therapeutic approaches and the theory base they adopted to work with their respective client, counsellors considered themselves eclectic. In his approach Andrew’s drew from family of origin and insight oriented therapies. He worked at gaining the client’s trust to then own the right to challenge and offer directions. He also used relapse prevention strategies. Barbara worked from a person-centered and cognitive therapy base. She used psycho-education and relapse prevention strategies when needed and was also directive at key moments. Karen approached her client using a biopsychosocial approach. She drew from Gestalt, body awareness and centring approaches. She accompanied her client in the client’s own self discovery and self-acceptance. Karen was particularly careful to match the client’s needs in the moment and also used psycho-education. Attachment theory was a base from which to understand her client. Deb used a supportive counselling approach, focused on meeting the client where the client was at and responding in ways very congruent to the client’s situation. She also used psycho-education when needed. Fred used person centered, cognitive, Satir model and interpersonal counselling approaches. Finally Gordon also used an integration of a variety of
approaches: person-centered, humanistic-existential approaches toward meaning making, and some narrative therapy type interventions/conversations in relation to recovery practices the client was engaging in. Gordon also provided psycho-education about the process of recovery from addictive substances. Table 5 included a summary of the approaches adopted by counsellor participants in this study.

Settings

Interviews with five counsellors took place in their offices and that with the other counsellor was held in an interview room at a community centre. The pilot interview with the client participant was held over the telephone due to geographic distance. Client participants were offered the option to have the interview at the addictions agency they frequented, their home or an interview room at the University of British Columbia, according to what they found most suitable. Three interviews with client participants took place at their addictions agency, two clients preferred to hold the interview at their home and one opted to hold the interview at the university.

Procedures

Pilot Interview

The interview was piloted with one counsellor-client dyad to ascertain the efficiency and effectiveness of the procedure and the questions asked. Due to its depth and relevance, data from the pilot interview was included in the analysis. The participants fully understood the scope of the questions asked and generally did not encounter difficulties in understanding the questions that were put forward to them during the interview.

Four adjustments to the interview procedure were made following feedback from the client and counsellor participants participating in the pilot interview. First, it was decided that
client demographics would be collected at the beginning of the interview rather than at the end. Asking demographic questions at the beginning served as a better introduction and orientation to the critical incident interview.

Secondly, an adjustment to the research time requested from participants in the invitation letter was changed. On the invitation letter and consent forms, the interview time participants were expected to dedicate for the research was changed from an hour and a quarter to an hour and a half. This proved to be a more realistic expectation of time requested from participants.

A third adjustment was made to the wording of one of the concluding questions, to make it more clear to participants. The corrected version of the question is the following: If you had to imagine a pie divided in 10 pieces - and this pie represents the experiences that helped you move out of addiction - how many pieces of the pie would be taken up by the outpatient counselling experience you were engaged in? What do the other pieces of the pie represent? Before this correction, the question was formulated as a scaling question asking participants to scale the importance of the outpatient counselling experience from one to ten. The corrected question was more suitable to gain the required data and more understandable by participants.

The last and most significant adjustment was the addition of critical incident questions relating to unhelpful events emerging from addiction counselling experiences that the client had prior to engaging in the outpatient counselling examined by the study. The pilot client-participant could not identify any hindering events emerging from the outpatient counselling experience. Because the focus of the study was on successful outcome, this was an expected scenario. However in the pilot interview, the client could identify significant and numerous hindering events from prior counselling experiences. Because of their relevance to the study, a question about hindering events emerging from other counselling experiences was included in the
interview guide. Later interviews with client participants demonstrated a similar trend in the identification of unhelpful events i.e. identifying hindering events from prior counselling experiences.

**Data Gathering**

Data was gathered in two steps. First, an individual face to face interview was conducted with seven dyads of drug and alcohol counsellors and their clients. With the participants’ consent this interview was tape-recorded. Secondly, when data from each interview was gathered, transcribed and analysed, participants were asked to review the data and invited for a second check-in interview to confirm the data’s accuracy. This second interview was used as one of the data validation procedures (discussed further in the data analysis section), and was carried out by phone or via-email. The first interviews were carried out between 27th October 2003 and 16th April 2004. The second interviews were held between the 29th July 2004 and the 30th October 2004.

As outlined in the participants section, participants were interviewed no longer than a year after the termination of counselling or during their aftercare. This decision was based upon the understanding that the more recent and direct observations are preferred over retrospective data (Flanagan, 1954). It allowed for the collection of both macro and micro level experiences. For each counselling dyad the interview with the client participant was carried out before that of the counsellor participant. This served as an extra reassurance for client participants that the confidentiality of what they had shared in their interview would be maintained.

On recruitment, participants were asked to prepare for the interview by thinking about helpful and hindering events in their counselling experience. Client participants were encouraged to make notes of such events and the chronological order in which they happened. Counsellor
participants were also encouraged to think of events and jot down notes prior to the interview. In addition counsellors were asked to fill out an interview preparation form (see Appendix D) requesting detailed information about the clients' outpatient counselling experience: starting and ending dates, counselling periods, counselling clusters, number of sessions, counselling approaches used and other related information. The preparation work that was requested of participants served as an aid throughout the interview session.

The Main Interview

Interviews were loosely structured and aimed at eliciting participants' helpful and hindering events in the outpatient counselling experience they had participated in. On average the first interview lasted one hour 20 minutes. Appendix E contains the client and counsellor versions of the interview guide. This interview was divided into two parts: the orientation and the critical incident interview. The orientation (approximately 15 minutes) served to: review the consent form, re-affirm the confidential nature of the interview and the participants' option to withdraw at any time during the interview; gather demographic data; gather background data about the participants' addiction; ask some introductory questions and explain further the critical incident interview procedures. It also provided a space for the researcher and participant to build rapport.

Demographic data was collected for the purposes of describing sample characteristics. Client participants' demographic data included: age, gender, race, educational background, current employment, employment background, marital status, socio-economic status, socio-economic status, other mental health difficulties, criminal convictions, past experience of abuse and family history of addiction. Demographic data collected from counsellors included age, gender, race, years of work experience in the addictions field, counselling training and drug
addiction history (i.e. whether they had experienced and drug addiction or not).

During the orientation phase of the interview client-participants were also asked for background information related to their addiction. This included: substance/s used, age at first use, length of addiction, time abstinent, treatment history, past relapses, reasons for seeking treatment and reasons for quitting.

At the end of the orientation phase, participants were asked introductory questions about their reasons for participating and their preparation for the interview. Counsellor participants were also asked how they identified the client participants. This information served to better understand and interpret the data.

In the second part of the interview (approximately one hour and a quarter), the critical incident interview was carried out. This interview aimed at eliciting helpful and hindering events in the outpatient counselling experience. Events were allowed to emerge in the interview and participants were not led into sharing about events related to particular areas of the counselling experience. Not guiding and leading participants in their sharing served to avoid any biases in the participants’ responses that might have been introduced by the researcher.

At the beginning of the critical incident interview, all participants were invited to draw a time-line of their counselling experience and mark approximate dates when counselling occurred, relapses, phases of discontinued counselling, and any other landmark information. The setting up of a timeline served two purposes. First, it helped participants focus on the experience and get embedded in it prior to start eliciting events. Secondly the time-line was set and ready to be used throughout the interview to pinpoint the time at which the mentioned events occurred. Once this was set, participants were asked to elicit events. The following is the client version of the questions asked:
1. Think back through your counselling experience. What happened that helped you make changes regarding your addiction? You may want to think of most helpful experiences followed by next most helpful. What is the first thing that comes to mind?

2. Where does this incident fit on the time-line representing the time between your first and last sessions?

3. What happened that could have hindered you in counselling? You may want to think of least helpful experiences followed by next least helpful. What is the first thing that comes to mind?

4. Where does this incident fit on the time-line?

5. If you had other counselling/treatment experiences apart from the counselling you had with your outpatient counsellor, what events were helpful in these other counselling experiences? What events were not helpful?

For each mentioned event participants were asked about what led up to the incident, what exactly the incident was and what were the after effects or outcome. Clarification questions were used to help participants articulate events clearly, e.g. what exactly happened that was helpful? How did you know that event was helpful? As the participants mentioned an incident, they were asked to place the incident on a time-line set up at the beginning of the critical incident interview.

The interview was concluded with some final questions. Apart from asking whether there was anything they wanted to add, participants were asked to weigh the significance of the outpatient counselling experience in relation to other experiences that might have been important in their recovery. All participants were invited to do this in the following manner. They were asked "If you had to imagine a pie divided in 10 pieces - and this pie represents the experiences
that helped you (client) move out of addiction - how many pieces of the pie would be taken up by the outpatient counselling experience that you (the client) were engaged in? What do the other pieces of the pie represent?" This question was also put forward to counsellor participants. The very last question asked participants about how they were feeling after the interview. This served as a safety question to check whether any participant was feeling distressed with anything that was said or occurred during the interview. In the eventuality of distress a back-up counsellor was available for debriefing. This intervention was never needed.

The Second Interview

Following transcription and analysis, participants were forwarded the results emerging from their interviews and re-contacted for a second check-in interview. In this interview participants were asked for feedback about their results. Participants had the opportunity to confirm or disconfirm the accuracy of the results, comment on the categorisation, and make any clarifications or changes necessary so that the results correctly represented their experience. Five of fourteen participants were not available for this second interview. In all, five client participants and four counsellor participants were interviewed. Eight of these interviews were carried out by telephone and one by e-mail. Telephone interviews lasted for an average of 17 minutes.

Data Analysis

Three main analyses were carried out: the analysis of critical incidents accompanied by seven validation procedures, the analysis of the time-line, and the analysis of the stated significance of the outpatient counselling experience.

Critical Incident Interview Analysis

Data from clients and counsellors was analysed separately. Events extracted from the
clients' interviews were then compared to the events extracted from the counsellors' interviews. Analysis of critical incident followed three general steps. Helpful and hindering incidents were extracted from the transcribed interviews. Secondly, incidents that were similar or appeared connected were grouped into helpful and hindering categories. Finally, categories underwent several procedures to test their trustworthiness. Generally, the analysis followed procedures set out by Flanagan (1954) but was also complemented by other procedures especially in testing reliability and validity of categories.

In the extraction of critical incidents, the study adopted Flanagan's (1954) criterion as to what constitutes a critical incident i.e. any observable human activity that was sufficiently complete in itself and allowed inferences and predictions to be made. Furthermore criteria for a critical incident to be extracted included the source of the event, what actually happened and the outcome of that incident (Woolsey, 1986). Any incidents that did not fit these criteria were excluded due to insufficient elaboration or clarity.

In the development of the category system a high level of specificity (Woolsey, 1986) was adopted. The level of specificity refers to the extent to which categories are broad and gathering a wide spread of incidents or highly specific. The high level of specificity was adopted to account for all the nuances related to similarities and differences between clients' and counsellors' perceptions.

Seven procedures were used to establish the trustworthiness of the category system generated by the researcher: a test of comprehensiveness; inter-sorter reliability; independent judgement of the actual interviewing style; the check-in with each individual participant; participation rate; independent expert assessment; and literature verification.

In an attempt to achieve comprehensiveness and adequate redundancy of incidents, the
analysis was carried out after each interview. Interviews from the first dyads were analysed and categories formed. The second dyad was then analysed using the base of categories developed from the analysis of the first dyad. New categories emerged when incidents did not fit previous categorisation. Such a process continued from one dyad to the next until all incidents were suitably placed in categories. The data from the seventh counselling dyad was used in the spirit of Andersson and Nilsson’s (1964) recommendation to test comprehensiveness by withholding 10% of the incidents from the initial categorisation process. Incidents from the last pair of participants were introduced once the categories had been formed.

An independent sorter was given a description of categories and asked to place a sample of 90 incidents (25%) under the appropriate category. The independent sorter was a graduate student in counselling psychology in her final year of the Masters degree. As recommended by Andersson and Nilsson, an inter-rater reliability of .75 was required for the final categories to be established. After this exercise was completed a feedback session with the independent sorter ensued to clarify any differences in the ratings.

The independent judgement of the actual interviewer style involved having an independent judge listen to the audio recordings of the interview to check that the interviewer was not asking any leading questions. The procedure was carried out throughout the data-gathering phase of the first three dyads including the dyad from the pilot study. This allowed for corrections in the interviewing style to be made early on in the data gathering phase.

The fourth validation procedure involved the check-in with participants. This corresponded to the second interview in the data gathering procedure outlined earlier. Each participant reviewed the incidents and categories into which his or her incidents had been placed. Participants were asked to comment, clarify and make any changes necessary to make the results
and accurate representation of what they shared during the main interview.

The next test of trustworthiness involved the examination of the participation rate. Participation rate is calculated by having the number of participants identifying the same incident in a particular category divided by the total number of participants. For example, if 50 out of 100 participants identify incidents in a particular category, the participation rate would be 50%. For this study, the minimum participation rate for an incident to be included in a category was set at 25% (Borgen & Amundson, 1984). This corresponds to two client participants out of a total to seven client participants or two counsellor participants out of a total of seven counsellor participants.

Expert assessment and literature verification were the last two procedures to test the soundness of categories. The expert assessment involved having an experienced addiction counselling specialist, and a client who underwent outpatient addictions counselling, comment on the generated categorisation and the observed similarities and differences between counsellors and clients. The addiction counselling specialist had 13 years of experience in this field, trained at the Masters level in Counselling Psychology and had taught courses related to addiction counselling related at college and university level. Considering the scant literature on the subjective experiences of clients and to a lesser degree of counsellors, and considering the lack of literature on their comparison such expert opinions provided valuable comments on the appropriateness of the categories. Finally the categories emerging from the study were contrasted with the literature. When agreement with the literature was observed confidence was placed in the category. When the category was not supported by the literature, that category was seen as needing further study.
**Time-Line Analysis**

On completion of the critical incident analysis, the analysis of the time-line was carried out. Specific counselling points mentioned by participants were first placed on a time-line. Secondly categories of events present on specific time-line points were grouped together under that time-line point. Participation-rate was the test of trustworthiness used for this analysis. Categories represented under a time-line point that did not include at least 40% of client participants or 40% of counsellor participants were excluded from the specific time-line point. This rigorous participation rate was used because of the wide spread of incidents over the whole counselling time-line.

**Analysis of the Significance of the Outpatient Counselling Experience**

As described in the procedures section of this chapter, at the end of the main interview participants were invited to weigh the significance of the outpatient counselling experience in comparison to other experiences that contributed to the clients’ recovery. The pie charts emerging from client and counsellor participants were averaged out separately and compared.

**Conclusion**

The Critical Incident Technique and the Time-Line Methodology served as appropriate and sound tools to gather helpful and hindering events from both client and counsellor participants. What follows is the presentation of the results gathered in this study using the above techniques. Background data and data around the significance of the counselling experience, the category system emerging from incidents, similarities and differences between clients’ and counsellors’ perceptions, and time-line data will be outlined.
CHAPTER 4

RESULTS

Introduction

This chapter will lay out the findings of this study emerging from the main interview, the secondary interview and the validation procedures. Background data providing a backdrop for the reading and interpretation of the rest of the results is presented first. Amongst other background data, this section also includes the analysis of the significance of the outpatient counselling experience within the wider context of recovery. Data from the critical incident interview will follow. This data will portray the categories of helpful and hindering events developed from the 371 events identified by participants. Results from the tests of trustworthiness of the data will also be presented. Finally, the analysis of the time-line will be provided.

Interview Background Data

*Reasons for Participating*

Reasons for participating for counsellor participants varied significantly from reasons offered by client participants. Tables six and seven outline the reasons offered by clients and their counsellors together with the number of participants mentioning the same reason. While counsellors did not agree on one main reason, the majority of client participants agreed on the motivation of participating in the study as a way of giving back.
<table>
<thead>
<tr>
<th>No. of Particip.</th>
<th>Reason for Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>An interest in the subject: Interest in success stories; in the comparison between clients and counsellors; interest in what works in counselling.</td>
</tr>
<tr>
<td>2</td>
<td>Knowledge of what a thesis involves and wanting to reciprocate the support found when counsellors carried out their own research.</td>
</tr>
<tr>
<td>2</td>
<td>Knowledge of the important role research plays and wanting to participate in the advancement of learning about addictions counselling.</td>
</tr>
<tr>
<td>2</td>
<td>Wanting to reflect about their counselling experience with the client.</td>
</tr>
<tr>
<td>2</td>
<td>Wanting to support the researcher</td>
</tr>
</tbody>
</table>
Table 7

*Client Participants’ Reasons for Participating*

<table>
<thead>
<tr>
<th>No. of Particip.</th>
<th>Reason for Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>A way of giving back. A wish to contribute for the benefit of other individuals struggling with addiction and a wish to contribute to counsellors working with such individuals.</td>
</tr>
<tr>
<td>3</td>
<td>Appreciation for the help received for the counsellor and counselling service (related to wanting to give back because a lot was received).</td>
</tr>
<tr>
<td>1</td>
<td>Considering the possibility of taking up counselling program - Interest to know what research involves.</td>
</tr>
<tr>
<td>1</td>
<td>Encouraged by the fact the counsellor introduced her to this research on success stories.</td>
</tr>
<tr>
<td>1</td>
<td>Interest in engaging in interesting experiences.</td>
</tr>
</tbody>
</table>

*Choice of Client Participant*

Counsellor participants were asked about how they identified the client participants that gave their permission to be approached by the researcher for the study. Table eight outlines the reasons provided by counsellor participants and the number of participants mentioning the specific reason.
Table 8

*Counsellor Participants' Reasons for Identifying Client Participants to Participate in the Study*

<table>
<thead>
<tr>
<th>No. of Particip.</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Client characteristics allowing full participation in research: clients that were verbal, articulate, insightful, available, self aware, intelligent, able to express self.</td>
</tr>
<tr>
<td>3</td>
<td>Awareness that clients' involvement in research interview would benefit them.</td>
</tr>
<tr>
<td>3</td>
<td>Someone counsellors connected with in a special, strong way and had a meaningful therapeutic relation with.</td>
</tr>
<tr>
<td>3</td>
<td>Client fit research criteria.</td>
</tr>
<tr>
<td>2</td>
<td>Client had previously expressed to counsellor an interest in giving back and involving self in activities that could help the field in some way.</td>
</tr>
<tr>
<td>1</td>
<td>Awareness that clients' participation in research would not harm them.</td>
</tr>
</tbody>
</table>

**Specialness of Counsellor**

During the data analysis of client-participant interviews it became strikingly evident that clients perceived their counsellors in a very special way. Comments expressing the specialness of their counsellors were coded and grouped under a non-critical incident category. This perception is especially relevant in understanding and interpreting results coming from these client participants. It indicates that clients participating in the study had experienced a very fulfilling counselling relationship. Four client-participants were represented in this category.

The specialness of the counsellor was reflected in the deep impact the counsellor had on
the client's life and his or her recovery, and in how the counsellor stood out when compared with other counsellors from past counselling experiences. Comments from each of the client participants represented in this category include the following: "N (counsellor) is a unique counsellor, from my point of view...he's got a quality that a lot of counsellors don't have, and I've shared my experience with other addicts that see counsellors, and they don't like them..."; "He is really, really good – not all clients have that...He wasn't just the counsellor, he was willing to go the distance"; "N(counsellor), she's just marvellous. I would recommend her to anyone... She is exceptionally good. She really, really is... N (counsellor) is absolutely superb. She is superb for me. I don't know how I would have gotten through without her and I was definitely one that never believed in counselling."; "(Chuckles ) I am extremely grateful because I'd still be floundering.. I'm sure, I'm sure I would still be floundering. And I'm sure that if it wasn't for N (Counsellor) I would still be floundering. Not that he's solely responsible for my recovery, by any means...I guess I put a lot in it too. God too. I think he put us both together. I think that he probably just gave me the counsellor that was the one that I needed to figure all this out. Because I've had other counsellors in the past who have done me no good at all."; "He is my hero. It's hard for me to be objective because it's all a process that I've had in dealing with addiction. I use the term unabashedly, I really mean it. N (counsellor) is really a hero of mine because I can't but believe that if it had not been him, my experience would have been different. I do believe on some intangible level of human existence, whatever that means, that N (counsellor) will be very, very special in my life. I am very grateful for the vocation he's chosen, for the time that he spent with me... If I was going to have anymore kids, they might be named N (counsellor).

Significance of the Outpatient Counselling Experience

At the end of the first interview participants were asked to weigh the importance that the
outpatient counselling experience had in relation to other experiences that contributed to their recovery. This weighting was done by the use of a pie chart. Other experiences that were mentioned related to the clients’ own will and contribution to the counselling process, social support, and help received from other services. Within the social support section of the chart, participants mentioned, support from family, friends and work. Within the help from other services section of the chart, participants included participation in residential treatment, joining a recovery house, AA and short term group counselling. On average client participants gave most weight to the counselling experience (63% of the chart). Second came the help from other service (17%), client’s will and contribution (11%) and social support from family, friends and work (9%). Although with a less strong weighting, counsellor participants also gave most importance to the counselling experience (45%), second came help from other service (27%), the clients’ will and contribution (24%) and finally social support (4%). Figure 1 portrays the pie chart for client participants and the one for counsellor participants.

Most striking differences appear in the weighting of the outpatient counselling experience and the client’s contribution. While clients tended to give a stronger weighting to the counselling experience when compared with their counsellors’ weightings, counsellors tended to weigh the role that clients’ will and contribution, more strongly. The difference in the counsellors’ perception of the clients’ role is more pronounced if one considers that two of the counsellors commented that when allotting percentages to the pie they failed to consider the client’s role. For a closer comparison of counselling dyads see figure 2 portraying the pie charts of each of the participants.
Figure 1

*Pie Charts of the Average Weighting of the Significance of the Outpatient Counselling Experience for Client and Counsellor Participants*

**Client Participants' Average Weighting**
- 63% Social Support
- 17% Client's Will & Contribution
- 11% Help from Other Service
- 9% Outpatient Counselling

**Counsellor Participants' Average Weighting**
- 45% Social Support
- 27% Client's Will & Contribution
- 24% Help from Other Service
- 4% Outpatient Counselling
Figure 2

Participants’ Individual Pie Charts - Weighting of the Significance of the Outpatient Counselling Experience

<table>
<thead>
<tr>
<th>Client Participants</th>
<th>Counsellor Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Dyad 1

Dyad 2

Dyad 3

- Client’s Will and Contribution
- Help from Other Service
- Outpatient Counselling
- Social Support
Dyad 4

Dyad 5

Dyad 6

Dyad 7

- Client’s Will and Contribution
- Help from Other Service
- Outpatient Counselling
- Social Support

Counsellor 3 and 5 did not consider client’s contribution in their pie.
Critical Incidents in Outpatient Drug Addiction Counselling

371 events were extracted from the fourteen interviews carried out with seven clients and their counsellors. 83% of these events were directly related to the outpatient counselling experience and 17% were not. Although participants were asked to reflect and mention events emerging from counselling with their addictions counsellor, participants were not censored from identifying events that within the context of the counselling experience were significant for their recovery. Thus the 17% of events not strictly related to the one-to-one counselling. Of these 17%, 9% were related to experiences outside the outpatient counselling (other therapeutic activities and social support) and 8% were related to client characteristics and/or experiences.

The grand majority of events were helpful, 88%, and 12% unhelpful. This ratio of helpful and hindering events was equally represented in the events that were strictly related to the outpatient counselling experience. Of the 371 incidents 202 were identified by client participants and 169 by counsellor participants.

Out of these events were developed 24 categories, 19 of which are helpful and four hindering. Within the areas strictly related to the outpatient counselling experience 15 categories of helpful events and five categories of hindering events were developed. The final four categories were all helpful categories and split equally between events related to experiences outside the outpatient counselling experience and the events related to client characteristics. 17 of the 371 events were placed in other categories that did not pass the participation rate test of trustworthiness of data. These events were considered idiosyncratic and were excluded from the category system developed in the study. These events are mentioned in the tests of trustworthiness section of this chapter. Table 9 presents a distribution of events, and the number of categories developed within each particular area of focus: the outpatient counselling
experience, events outside the outpatient experience and events related to the client. Idiosyncratic
events are excluded from this table.

10 subcategories for helpful events related to outpatient counselling and two
subcategories for helpful events related to the client were formed for further specificity and
deeper understanding of the respective categories.

What follows is presentation and description of the categories. Since the focus of this
study is outpatient drug addiction counselling, helpful and hindering categories directly related to
the outpatient counselling will be presented first. Helpful categories of events outside the
outpatient counselling and helpful categories of events related to client characteristics and
experiences will follow.

Helpful and Hindering Events in Outpatient Drug Addiction Counselling

14 helpful and five hindering categories were developed out of the incidents directly
related to the outpatient drug addiction counselling experience. 13 of the helpful categories and
two of the hindering categories were developed out of incidents mentioned by both client and
counsellor participants. On the other hand a helpful and a hindering category were developed
from incidents coming from clients alone, while the final helpful and the final hindering category
were developed out of incidents mentioned by counsellors alone. Tables 10,11,12,13 present the
helpful and hindering categories outlining the participation rates and the number of events per
category.

Categories of helpful events identified by both clients and counsellors (table 10) include:
Counsellor Validating Acceptance; Counsellor Directness/Challenges; Counsellor Consistent
Presence; Help in Understanding Self and Drug Use; Counsellor Pacing Self with Client;
Working on the Resolution of Personal Struggles; Counsellor Listening, Empathy and Mirroring;
Table 9  
*Distribution of Events and Categories*

<table>
<thead>
<tr>
<th>Categories of Events Identified by:</th>
<th>Events Related to Outpatient Drug Addiction Counselling</th>
<th>Events Outside Outpatient Counselling</th>
<th>Events Related to Client Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpfulness</td>
<td>Events</td>
<td>Categories</td>
<td>Events</td>
</tr>
<tr>
<td>Both Clients and Counsellors</td>
<td>264</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Clients Alone</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Counsellors Alone</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hindering</td>
<td>25</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Both Clients and Counsellor</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Clients Alone</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Counsellors Alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>20</td>
<td>31</td>
</tr>
</tbody>
</table>
Counsellor Help in Bridging Client with System; Counsellor Self-Disclosure; Counsellor Setting and Respecting Boundaries; Counsellor and Client Sharing Humour; Relapse Prevention Work; Counsellor-Client Sharing Attributes/Experiences. The category of helpful events identified by clients alone was Counsellor Expertise and that identified by counsellors alone was Counsellor Felt Sense of Strong Connection with Client (see Table 11).

Categories of hindering incidents identified by both clients and counsellors included: Blurred Boundaries and Boundary Related Unethical Behaviour; Client Forced/Pressured into treatment; and Lack of Counsellor Consistent Presence (see table 12). The category of hindering events identified by client alone was Addiction as the Sole Counselling Focus, and that identified by counsellors alone was Counsellor Not Pacing Self with Client (see table 13). It is important to note at 71% (or 22 of the 31 events) of events represented in categories of hindering events emerged from counselling experiences other than the outpatient counselling experience that was examined in this study.

For greater specificity and understanding four of helpful categories were further subdivided into subcategories. These were all categories on which clients and counsellors agreed. Category one, Counsellor Validating Acceptance, was subdivided into four subcategories: Counsellor Non-Judgemental Acceptance; Counsellor Validation; Counsellor Normalisation and Encouragement for the Future; and Expressions of Genuine Care/Concern for the Client. Within category two, Counsellor Directness/Challenges emerged two sub-categories: Recommendations Regarding Treatment/Therapeutic Activities and Counsellor Challenges/Invitation for Openness to Challenge Self. Within category six, Working on the Resolution of Personal Struggles, emerged sub-categories: Working on Solutions for Specific Personal Struggles and Corrective Emotional Experiences with Counsellor Contributing to the Resolution of Personal Issues.
Table 10

Categories of Helpful Incidents Related to the Outpatient Counselling Experience Identified by Both Clients and Counsellors

| Category | Clients | | | Counsellors | | |
|----------|---------|------------|-------|------------|-------|
|          | Participation Rate* | No. of Events | | Participation Rate* | No. of Events | |
| 1        | Counsellor Validating Acceptance (4 subcategories) | 7 | 38 | 6 | 27 |
| 2        | Counsellor Directness/Challenges (2 subcategories) | 7 | 20 | 7 | 17 |
| 3        | Counsellor Consistent Presence (availability, flexibility and stability) | 6 | 19 | 6 | 14 |
| 4        | **Help in Understanding Self and Drug Use** | 6 | 15 | 4 | 9 |
| 5        | Counsellor Pacing Self with Client | 6 | 11 | 4 | 12 |
| 6        | Working on the Resolution of Personal Struggles (2 subcategories) | 5 | 8 | 6 | 14 |
| 7        | **Counsellor Listening, Empathy and Mirroring** | 4 | 7 | 7 | 10 |
| 8        | Counsellor Help in Bridging Client with System (2 subcategories) | 3 | 4 | 5 | 7 |
| 9        | Counsellor Self-Disclosure | 3 | 4 | 2 | 3 |
| 10       | Counsellor Setting and Respecting Boundaries | 3 | 3 | 3 | 5 |
| 11       | Counsellor and Client Sharing Humour | 2 | 2 | 4 | 4 |
| 12       | Relapse Prevention Work | 2 | 2 | 2 | 4 |
| 13       | Counsellor-Client Complementing Attributes, Experiences | 1 | 3 | 2 | 2 |
| **Total** | 136 | | | 128 | |
Table 11

*Categories of Helpful Incidents Related to the Outpatient Counselling Experience Not Identified by Both Clients and Counsellors*

<table>
<thead>
<tr>
<th>Category</th>
<th>Clients</th>
<th></th>
<th>Counsellors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation Rate*</td>
<td>No. of Events</td>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>14 Counsellor Expertise</td>
<td>2</td>
<td>2</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>15 Counsellor Felt Sense of Strong Connection with Client</td>
<td>/</td>
<td>/</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7.
Table 12

*CATEGORIES OF HINDERING INCIDENTS RELATED TO THE OUTPATIENT COUNSELLING EXPERIENCE IDENTIFIED BY BOTH CLIENTS AND COUNSELLORS*

<table>
<thead>
<tr>
<th>Clients</th>
<th>Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>1 Blurred Boundaries and Boundary-Related Unethical Behaviour</td>
<td>1</td>
</tr>
<tr>
<td>Events in this Category Arising from a Service Other than Outpatient Counselling</td>
<td>2</td>
</tr>
<tr>
<td>2 Client Forced/Pressed into Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Events in this Category Arising from a Service Other than Outpatient Counselling</td>
<td>3</td>
</tr>
<tr>
<td>3 Lack of Counsellor Consistent Presence</td>
<td>2</td>
</tr>
<tr>
<td>Events in this Category Arising from a Service Other than Outpatient Counselling</td>
<td></td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7.

Table 13

*CATEGORIES OF HINDERING EVENTS RELATED TO THE OUTPATIENT COUNSELLING EXPERIENCE NOT IDENTIFIED BY BOTH CLIENTS AND COUNSELLORS*

<table>
<thead>
<tr>
<th>Clients</th>
<th>Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>4 Addiction as the Sole Counselling Focus</td>
<td>/</td>
</tr>
<tr>
<td>Events in this Category Arising from a Service Other than Outpatient Counselling</td>
<td>2</td>
</tr>
<tr>
<td>5 Counsellor Not Pacing Self with Client's Needs</td>
<td>/</td>
</tr>
<tr>
<td>Events in this Category Arising from a Service Other than Outpatient Counselling</td>
<td>/</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7.
Within category eight, Counsellor Help in Bridging Client with System emerged two subcategories: Help in Accessing Service and Counsellor Advocacy and Help for Client to Understand the System. Table 14 outlines these sub-categories, the number of events per subcategory and corresponding participation rates.

*Differences in Clients’ and Counsellors’ Perceptions of Helpful and Hindering Events in Outpatient Counselling*

Differences in the perceptions of helpful and hindering events between client and counsellors emerge from three levels of analysis. First are differences apparent in categories emerging from events identified by clients alone and those identified by counsellors alone. These were identified in the previous section. The second set of differences appears on closer observation of the emphasis placed on a category that was identified by both clients and counsellors. The third set of differences emerged when categories on which client and counsellors agreed were rank ordered according to participation rate and number of events. The differences emerging from the latter two levels of analysis are presented here.

Upon close examination of tables 10 and 14, differences in emphasis placed on some categories and subcategories, by clients and counsellors, appear. A difference in emphasis was established when: a group (either clients or counsellors) had 40% (or more), the events related to a specific category than the other group; and/ or the participation rate for the same category for clients and counsellor varied by three participants. Categories or subcategories with events mentioned more frequently by clients included: Category four, Help in Understanding Self and Drug use (client events - 15; counsellor events - 9); Subcategory 1.2, Counsellor Validation (client events - 17; counsellor events - 4). Categories or subcategories of events mentioned more frequently by counsellors included: Category 7, Counsellor Listening, Empathy and Mirroring
Table 14

Sub-Categories of Helpful Incidents Related to the Outpatient Counselling Experiences

<table>
<thead>
<tr>
<th>Sub-Categories</th>
<th>Clients</th>
<th>Counsellors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation Rate*</td>
<td>No. of Events</td>
<td>Participation Rate*</td>
</tr>
<tr>
<td>1. Counsellor Validating Acceptance</td>
<td>6</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>1.1 Counsellor's Non-Judgmental Acceptance</td>
<td>5</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>1.2 <strong>Counsellor Validation</strong></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Counsellor Normalisation and Encouragement for the Future</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Expressions of Genuine Care/Concern for the Client</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Counsellor Directness/Challenges</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Recommendations Regarding Treatment/Therapeutic Activities</td>
<td>5</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Counsellor Challenges / Invitation for Openness to Challenge Self</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6. Working on the Resolution of Personal Struggles</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6.1 <strong>Working on Solutions for Specific Personal Struggles</strong></td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>8. Counsellor Help in Bridging Client with System</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>8.1 Help with Accessing Service</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7
** Bold type denotes a difference in emphasis between client and counsellor participant
(participation rate [PR] counsellors - 7; PR clients - 4); Subcategory 6.1, Working on Solutions for Specific Personal Struggles (counsellor events – 12; PR counsellors – 6; client events – 5; PR clients – 3).

A final set of differences between clients and counsellor perceptions of helpful and hindering incidents in outpatient drug addictions counselling can be observed from a rank ordering of categories, for clients and counsellors, according to participation rate and number of incidents per category. This was done for helpful categories identified by both clients and counsellors (see table 15). From this table one can note that only two categories were in the same rank for clients and counsellors. These were category 10, Counsellor Setting and Respecting Boundaries and category 13, Counsellor-Client complementing Attributes, Experiences. Most of the categories differed by a rank or two. Category 9, Counsellor Self-Disclosure differed by three ranks. Two most prominent differences appear. First, category four, Help in Understanding Self and Drug Use was four ranks higher for clients and category seven, Counsellor Listening, Empathy and Mirroring, was five ranks higher for counsellors. What follows are descriptions of each of the categories identified in this section.

Description of Categories of Helpful Events Related to Outpatient Drug Addiction Counselling

Helpful Category 1: Counsellor Validating Acceptance. This category contains events in which counsellors expressed to clients how valuable they are as human persons, how worthy they are to receive care and how their limitations, negative actions or decisions do not taint their value as a human person. This category is further explained by the four subcategories present in it: Counsellor’s Non-Judgemental Acceptance; Counsellor Validation; Counsellor Normalisation and Encouragement for the future and Expressions of Genuine Concern/Care for the Client
### Table 15

Comparison of Rank Ordering of Categories of Helpful Incidents Related to the Outpatient Counselling Experience Identified by Both Client and Counsellor Participants. Rank Ordering According to Participation Rate and Number of Incidents.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Category Rank Order – Clients</th>
<th>PR</th>
<th>Category Rank Order – Counsellor</th>
<th>PR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Counsellor Validating Acceptance</td>
<td>7</td>
<td>Counsellor Directness/Challenges</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>Counsellor Directness/Challenges</td>
<td>7</td>
<td>Counsellor Listening, Empathy and Mirroring</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Counsellor Consistent Presence</td>
<td>6</td>
<td>Counsellor Validating Acceptance</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Help in Understanding Self and Drug Use</td>
<td>6</td>
<td>Counsellor Consistent Presence</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Counsellor Pacing Self with Client</td>
<td>6</td>
<td>Working on the Resolution of Personal Struggles</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>Working on the Resolution of Personal Struggles</td>
<td>5</td>
<td>Counsellor Help in Bridging Client with System</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Counsellor Listening, Empathy and Mirroring</td>
<td>4</td>
<td>Counsellor Pacing Self with Client</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Counsellor Help in Bridging Client with System</td>
<td>3</td>
<td>Help in Understanding Self and Drug Use</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Counsellor Self-Disclosure</td>
<td>3</td>
<td>Counsellor and Client Sharing Humour</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>Counsellor Setting and Respecting Boundaries</td>
<td>3</td>
<td>Counsellor Setting and Respecting Boundaries</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Counsellor and Client Sharing Humour</td>
<td>2</td>
<td>Relapse Prevention Work</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Relapse Prevention Work</td>
<td>2</td>
<td>Counsellor Self-Disclosure</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>Counsellor-Client Complementing Attributes, Experiences</td>
<td>1</td>
<td>Counsellor-Client Complementing Attributes, Experiences</td>
<td>2</td>
</tr>
</tbody>
</table>

* Categories with equal ranking  
**Bold type** denotes a difference of 4 or 5 ranks between clients' and counsellors' rank ordering
Subcategory 1.1: Counsellor's Non-Judgmental Acceptance. Counsellors expressed acceptance toward their clients while refraining from passing judgment. As a result clients felt accepted as persons. This feeling of acceptance as a person was particularly significant when clients self-disclosed thoughts and actions they felt ashamed about, or when they shared about their shortcomings. Gina shared of her deep shame about not being mentally and emotionally present for her children over the span of time she was using drugs. Doris shared how she felt fully responsible for her partner's distancing and how she was to take full blame. At her initial counselling phases Clare shared with her counsellor how she was not committed to quitting drugs and was still actively using. At some central point in the counselling period Ana started the session by sharing that she had a lapse and used cocaine after months of staying away from the drug.

Counsellors responded to these disclosures with a lack of judgment. This was particularly significant because clients had histories of being looked down upon and blamed for their drug using habits. In fact the counsellors' responses to such disclosures were very opposite to responses the clients had received when they shared similar limitations with other people. Counsellors expressed acceptance both verbally and non-verbally. Counsellors used words like "that's Ok that that happened (referring to slip), but we can make sure it doesn't happen again, we can try our darnest to prevent it from happening again"; "That's OK, it's happened, it's gone, it's past, let's move forward"; "you're a person too... you've made a mistake but you're not a mistake... you can move forward". When a client shared that she was not ready to quit, contrary to her expectation the counsellor told her that it was Ok and that she could work with that. Other examples include counsellors who asked the clients what they thought about their own action rather than negatively judging it; counsellors who expressed no expectations about how the
clients should be or act. Nonverbally acceptance was expressed by a counsellor who accepted to see a client when she was not fully fit for it (under some influence of a substance) and by another counsellor who accepted to see the client after a time of lost contact or relapse without looking down upon her.

This acceptance had three very powerful effects on clients. First and foremost, clients felt that they were persons rather than addicts. Second, rather than feeling guilt ridden and discouraged, clients felt hopeful about not being alone in their struggle and knowing that with the help of their counsellor they could overcome their struggles - "You kind of felt that she was always on your side." Finally, clients increased their trust and felt safe with their counsellors. One of the clients shared how her initial disclosures served to test the trust she could place in her counsellor. Once the counsellor did not judge her or put her down she felt safe to disclose more. Another client expressed how "Those (negative actions) were very difficult things for me to admit... I did feel that I could admit anything. He made it a very safe thing to do... I told him things that had never been spoken out loud before and that I had difficulty admitting even to myself... So by showing me that he did not judge me a bad person, he allowed me to be free to openly express some of those things."

Subcategory 1.2: Counsellor Validation. Counsellors affirmed the client's qualities, feelings, actions or decisions. This affirmation was very powerful when clients themselves or other professionals were questioning the value of the clients' action. Validation brought about clients' increased self worth, a feeling of being respected and a reassurance that they were moving in the right direction. Validation tended to occur in six scenarios.

Counsellors offered validation for client's who were downplaying or questioning the value of what they had done. In the initial counselling phases, a client was able to maintain
abstinence for six days. She was looking down on herself and upon the fact that she could hold abstinence only this far. The counsellor reframed this experience more positively telling her that six days was a significant amount of time considering the amount of time she had been using drugs prior to this drug-free period. Another counsellor acknowledged the deep value of the care that client had shown toward his disabled brother and elderly parents. This care had been a major stressor in his life. This client was focusing on how bad he was to start using drugs during this time. Alternatively the counsellor focused and acknowledged the importance of his contribution to his family.

Counsellors also offered validation when clients were upset about the way they were treated in another service. Bob shared with his counsellor how he was upset about being forced to share about very personal experiences while at a support recovery house. He was confused about whether he was right in thinking that his sharing would have been appropriate. His counsellor responded by stating that he was right in thinking and feeling that way and that it was too early in his recovery to be asked to do that.

In a third scenario validation occurred when clients wanted to take up a therapeutic programme or accept medication (or conversely when they did not want to commit to a programme) but were pressured by peers/others to do otherwise. One client was being looked down upon from some support group peers for taking prescribed antidepressant medication. He was told that he couldn’t consider himself ‘clean’ if he was using this medication. The counsellor supported the client in using this medication. The client felt immensely reassured that he was on the right track.

Counsellors also validated the clients’ doubts or hesitations about something that was taking place in counselling: After a counsellor asked his client a very difficult question, the client...
was very hesitant to answer. The counsellor acknowledged that it was indeed a difficult question and that it is understandable for her to be afraid. The client felt much respected by his validation. Client, “He never made me feel like I was a drug addict for one. He never made me feel like I was stupid. He validated all the feelings I had, like being afraid to answer the question. He never forced me to answer, he never stood over and berated me and said answer this question! He validated why I might not want to answer it and he reaffirmed why I should answer it.” During the initial counselling phase another counsellor validated the questions a client was posing regarding confidentiality. This client was in the process of having some court proceedings and confidentiality was a real concern for her.

In a fifth scenario counsellors expressed how valuable the clients were and validated their strengths, progress and positive change. A client knew how important she was for her counsellor when he remembered the names of her children and other details the client had shared in previous sessions. Two counsellors validated their clients’ contribution to the counselling process.

Finally, counsellors validated the subjective emotional experience of their clients. When a client shared about her deep shame and about the loss of time she could have used otherwise, the counsellor did not “sugar coat” his client’s feeling. He validated her experience acknowledging the feelings rather than trying to distort them. This allowed the client to acknowledge these feelings – an important step to find resolution of her shame and to make amends.

Subcategory 1.3: Counsellor Normalisation and Encouragement for the Future.
Counsellors normalised behaviours and events, clients were feeling very distressed about. They expressed to clients that their actions, feelings, and thoughts around a particular event were to be
expected. Normalisation was frequently directed toward drug using patterns, lapses, relapses, and symptoms of drug use or withdrawals. Normalisation for reactions to challenging experiences (eg past abuse) was also offered. With these normalisations the counsellors “did not feed into” the clients’ negative self-perceptions. Clients did not feel flawed in some serious way. Bob had encountered many people who were "quite surprised" when they learned that he was using crack at in his elderly age. The counsellor understood that his situation was a regular progression of addiction and "simply a symptom". When the counsellor communicated this to him the client felt reassured. Client, “So I was no longer considered a bit of a freak”.

Subcategory 1.4: Expressions of Genuine Care/Concern for the Client. Counsellors expressed genuine caring and genuine concern for the clients’ well being. This was expressed verbally or non-verbally in session, or through actions outside the counselling room. Examples of non-verbal expressions include caring mannerisms and appropriate hugs. Verbally, counsellors expressed care by warm greetings and the beginning and end of sessions and by saying how important it was for them that the client was alive. Examples of action-based expression of care/concern include counsellors phoning clients during a period when client lost touch and accompanying a client during significant moments (e.g. court hearing). As in the other subcategories, these expressions instilled worth and value in the clients. At the initial phases clients became convinced that their counsellor was going to really stand by them. These expressions fostered the clients’ trust in their counsellors.

Helpful Category 2: Counsellor Directness/Challenges. Counsellors were directive in their challenging and in putting forward recommendations or ideas for clients to take up. They challenged by presenting or inviting clients to consider a position that the clients were either shying away from or would have not considered otherwise. Counsellors were direct in presenting
positions (views about the client's thoughts, feelings and behaviours) and put forward recommendations at times. A deeper description is found in the following two subcategories.

Subcategory 2.1: Recommendations Regarding Treatment/Therapeutic Activities. During the course of counselling, counsellors presented direct therapeutic recommendations to clients. Recommendations ranged from those related to the outpatient counselling experience (e.g.: reading self-help books, writing letters, recommendations in resolving a personal issue) to recommendations of therapeutic activities outside the outpatient experience (joining a residential treatment programme; attending a group, changing an AA group). Recommendations also varied in their intensity, ranging from strong opinions about what the client should do to tentative proposals. Most fell within the strong opinion side of this continuum.

Subcategory 2.2: Counsellor Challenges / Invitation for Openness to Challenge Self. During the course of counselling, counsellors directly challenged the client's thoughts, actions and decisions or invited them to be open and challenge themselves. Counsellor's challenged: by sharing honest thoughts and feelings about the client's actions/decisions/thoughts; by questioning or pin-pointing inconsistencies in the client's disclosures; by presenting a different position or view, for the client to consider; by directly asking them whether they were ready to give up behaviours; and by directly asking clients to be concrete. One client expressed how "The counsellor didn't put up with crap... he was honest with me. You know, he wouldn't just listen and say aha, aha. He'd say 'oh I don't think so (laughs), you're not telling the truth.' He was rigorously honest with me."

Counsellors invited clients to be open and challenge themselves by: inviting clients to come back to a topic they were running away from; inviting them to consider a different position; inviting discussions they would have not brought up themselves.
Challenges were acceptable when the clients had established trust in their counsellor. Although at times challenges were not necessarily pleasurable, these challenges helped clients move forward. One client expressed how "Between the middle and last third (of the counselling period) he started showing me things that I didn't realise. He has listening to the things that you've told him in the past and relating them to the questions he asks you, to find about consistencies and inconsistencies. Not to find out whether you are lying to him... just to see how your life has gone. He would point things out. I would be talking to him nice and normally about inconsequential things and he'd go 'Ha ha! that doesn't fit with what you've said before.' The inconsistencies the counsellor pinpointed related to the client's childhood life. Initially this had a strong, somewhat upsetting impact on the client, "So when he's pointing things out to me that are totally blowing me away, I'm leaving the office and I'm going 'OK I understand what just happened, but I need to go self-sabotage (use drugs) for a while because I don't like what just happened, and I'm afraid to go back to learn more'. So I would be consciously aware of the fact that I was self-sabotaging because of something that I had learned, that had happened in my childhood. So I was consciously self-sabotaging but I was still always coming back to N (counsellor) because I wanted to learn more about why I self-sabotage in the first place... There was times when I did not want to go back to him because I knew that I would learn something else that would shatter whatever my illusion was and I didn't want to learn anything else because eventually it started coming after every session. After every counselling session with N (counsellor) I'd learn something else. A lot of it became overwhelming for me because once the flood gates were open, I guess, the pieces of the puzzle started slamming down and I wouldn't want to go back to N (Counsellor) because he was so good at it that I knew that there's going to be another revelation that I wasn't necessarily wanting to hear (laughs)... It was scary... a lot of
the time I wanted to run away from it but I never once said 'Oh this is not helping at all'. Never once did I say that this is much bs... Even though I was learning things I didn't want to learn or even though my perception of things were shattered and all of a sudden things are not the way that I had thought them to be... in my nice normal life... So that's why I started trusting... that's why I decided to just go for broke with N (couns)... I decided to throw all the eggs in one basket.

Helpful Category 3: Counsellor Consistent Presence. Counsellors were present for the client both generally over an extended period of time (long term stability, commitment and consistency), and when the need arose in immediate situations (short-term availability and flexibility).

Counsellors were a stable presence for clients. They were both committed to work with the client till the need was there and consistent (or reliable) in their presence and presentation. Commitment was expressed by counsellors who did not have a strict number of sessions they could offer, and counsellors who maintained contact with the clients when they were undergoing some other form of treatment (e.g. residential treatment or recovery house). The latter scenario turned out to be very important for Bob. While at the recovery house the client experienced a negative experience from the staff that almost brought about a relapse. Because he had stayed in touch with his counsellor, he could share this with her and gain her support to assert himself with the management of the recovery house. Most importantly commitment was expressed when counsellors could see the client after a period of discontinued counselling because of relapse, or partial recovery. Five of the clients who experienced relapse during the counselling phase were able to reconnect with the same counsellor that was seeing them earlier. In one situation the gap between counselling phases was of 10 years. When the reconnection occurred, a positive and
trusting rapport was already present. This allowed for deeper counselling work to happen sooner since client and counsellor did not need to dedicate time to develop the counselling relationship. The main outcome of this long-term commitment was that clients knew they could count on their counsellors. One client expressed how, "To me counselling is more effective when I became willing to open up myself, because I felt comfortable that the counsellor wasn't going anywhere, that we were gonna to do this, and he was going to be there... He was committed to stick and stay". Consistency was expressed by counsellors whose behaviour and presentation were consistent from session to session; and counsellors who kept appointments with the client consistently.

In the short-term counsellors made themselves available in response to clients' immediate needs. They allowed themselves to be flexible and be present for the client outside the boundaries of the fixed counselling session. This flexible availability was expressed when: counsellors were available to see client’s shortly after they sought help and were in crisis; counsellors who accepted to see the client after they had terminated; counsellors who were reachable by phone outside the fixed session. Three of the client participants accentuated the experience of receiving an immediate response soon after they phoned in for help. They were given and appointment for an intake session within a week of calling. This gave them hope that help was at hand. Equally important was the fact that help arrived at a crisis point that had moved them to do something about their addiction. The immediate response did not allow clients to change their opinion on the immediacy of the need for help.

Helpful Category 4: Help in Understanding Self and Drug Use. Counsellors helped clients understand themselves and understand themselves in relation to their drug use. The understanding and self-awareness that took place, helped clients move toward resolution of
personal issues. In helping clients understand themselves counsellors: used techniques to help clients understand problematic aspects of their personality, feelings they experienced, beliefs about themselves, or disruptive relationships in their past or present. One client understood how, "Coming from a dysfunctional family... I was used to the abnormal. I thought the dramatic was normal for me. The actual calm stability felt very uncomfortable for me. So I had to overcome that because when life got too boring, I used, I needed, I created my own havoc, because I was used to drama". Another client understood the source of the long conflicted history with her sister and most importantly understood why her sister resented her. The client understood how the family history had affected her sister's attitude and behaviour towards her.

In helping clients understand themselves in relation to their drug use, counsellors: helped clients identify triggers for their use; helped clients identify past, family of origin or present influences/contributors to their drug use.

By understanding themselves and their drug use clients started to gain control on their lives and their drug use. By identifying triggers and influences on their drug use, clients knew which situations were to be avoided to prevent relapse. They also identified the issues they needed to work on and somewhat set an agenda for their counselling. Another outcome was that the awareness started to bring resolution. The client who understood her sister's antagonism toward her, was no longer affected by it. This client stopped needing to jump into drinking after being verbally attacked by her sister. She learned to think and not give too much weight to her sister's comments or try to read too much into them.

Helpful Category 5: Counsellor Pacing Self with Client. Counsellors were sensitive to client's individual needs and made a conscious effort to be on the same page as their client. This was expressed by checking-in with clients about their needs rather than assuming they knew
what the clients needed. Counsellors checked in with clients on how they could be of help and asked them for feedback about what was helping. This was done by checking in whether they were understanding clients correctly; offering clients, options about their treatment; responding in tailor-made ways to client's individual need; suggesting therapeutic options that fit the client’s needs; considering and adopting therapeutic activities that matched the client’s learning style; and allowing the space for client to set the agenda and share whatever was of concern at the moment. Some examples include a counsellor who adopted the client’s style of using lists to remember what she was going to work on during that week. The same counsellor checked in with the client about whether she was correct in her feedback to the client. This counsellor also checked-in with her client when the latter told her about the accomplishment of attending ten support group meetings. The counsellor did not assume that the client experienced this as a success. She first asked her how she experienced the accomplishment and than congratulated her once the client confirmed that this was a success for her. A client shared how she told her counsellor that her main motivation for counselling was to bring her children back. The counsellor responded by saying that that would also be his agenda. At the end of the intake session another counsellor informed the client that she could ask to be seen by another counsellor if she preferred to have a counsellor closer to "her station in life". Two of the counsellors also asked their clients for feedback about the counselling experience at different points of the counselling period.

Helpful Category 6: Working on the Resolution of Personal Struggles. Counsellors worked on solutions for personal struggles and resolutions of personal issues. This took the form of a hands-on task, counsellor and client worked on or an experiential process in which the interpersonal relating brought about resolution. These events are further described in the
subcategories: Working on Solution for Specific Personal Struggles and Corrective Emotional Experiences with Counsellor Contributing to the Resolution of Personal Issues.

Subcategory 6.1: Working on Solutions for Specific Personal Struggles. Counsellors worked with clients on solutions for specific personal struggles. Once a clear difficulty/challenge, clients experienced in their personal lives was identified, counsellors worked with clients on resolving it. Counsellors and clients worked on daily-living problems such as organising debt, gaining a driving license back and on personal issues such as planning a ritual for departed partner, or finding metaphors for the client’s preferred way of being to keep in mind during her day. Counsellors used psycho-education and modelling for clients’ learning of new ways of being; and counsellors offered a space for clients to practice what they were learning e.g. practicing assertiveness and appropriate ways of giving feedback.

Subcategory 6.2: Corrective Emotional Experiences with Counsellor Contributing to Resolution of Personal Issues. In general all counsellors acted in caring ways. In some situations, because of particular counsellor characteristics, the caring expressed by these counsellors allowed the clients to experience healthy and loving human relationships they had never experienced. Such experiences were very strong and significant when clients experienced transference relations with their counsellors. One example of the above scenario was when a male counsellor respected boundaries and did not act on a female client’s indirect sexual invitations. By doing so, the counsellor acted in a very different way than other male individuals in the client’s life. This questioned the client’s mistrust of men. A second example involved another client who received acknowledgment of very positive deeds he had done with his family, by a female counsellor. Throughout his life this client had struggled to gain approval from women in his life. He had experienced his mother as “perfectionistic… having no room for
alternative ways to do things.” This female counsellor’s validation meant a lot for him, “Here was finally a female person that was giving me an ‘atta boy’ and giving me an acknowledgement that I have all my life tried to get”.

Helpful Category 7: Counsellor Listening, Empathy and Mirroring. Counsellors listened to the client when they were disclosing personal material. Listening took the form of physical attending, and the more advanced forms of listening: empathy (the listening and reflecting back to the client the feeling behind what the clients had just shared); advanced empathy (reflecting back to the client a deeper meaning) and mirroring (the reflecting back to the client what was shared to function as a bouncing board for the client’s ideas). These forms of listening were accompanied by the absence of non-listening forms of communication. As they listened counsellors refrained from giving interpretations, judging, or interrupting silences. These forms of listening were very much welcomed by clients when they were sharing very personal, emotional experiences. A counsellor listened as a client shared about the “desperate state” (total isolation, suicidal thoughts) the client was in. This facilitated his need to “unload”, something that was very much needed for his recovery to progress. Client, "And I think the greatest thing of all at that moment, was the fact that N (name of counsellor) was listening... she just let me pour it all out". The same client shared how the counsellor acknowledged the painful experiences the client went through by communicating back to him what she was listening to. Client, "she was probably the first one to really acknowledge how painful this whole process had been" "she acknowledged the loss and gave me permission to feel sad about that", "nobody up to that point or the other counsellors I'd seen had really had a sense of how, uh, how difficult that had been".

The counsellors’ listening gave clients the permission to share and experience feelings they might have tried to subdue and helped clients feel understood. The reflective part of
empathy, and mirroring allowed clients to understand themselves and their situation better. As an example, a counsellor reflected back to the client what he heard his client say and tentatively shared a deeper meaning. He reflected things back to her suggesting a possible enhanced meaning that got her to think at a deeper level - the client shared how she would take up causes and become combative to the point of "losing balance" - how this had cost her and how she would like to avoid taking up roles at work that put her in a combative role. The counsellor reflected back to her saying, "Sounds like you've recognized this has been a lifelong pattern, that there's something that's drawn you into those roles, something about social justice and being there for the underdog and having compassion for people who might not have a voice, and yet it sounds like you would like to find a way to not get into battles with that, just stay true to your values and to live your values without feeling like your own internal sense of balance is being threatened. Sounds like it's a case of trying to figure that out, how to stay true to your convictions and your mission in life without falling into this combative way of being."

Helpful Category 8: Counsellor Help in Bridging Client with System. Counsellors acted in ways to help bridge the client with other systems (social services; legal; health services etc). This bridging took the form of helping clients in accessing services and advocating for clients when they encountered some blockage. These events are further explained the two subcategories below.

Subcategory 8.1: Help with Accessing Service. When clients were in need of specialised services other than the outpatient counselling, counsellors helped clients access these services. This help took the form of exploring and presenting options to clients, informing clients about services they can access, making referral phone-calls for clients to access a service and helping them in accessing funds to pay for the needed service.
Subcategory 8.2: Counsellor Advocacy & Help for Client to Understand the System.

Counsellors intervened in support of clients who were alone or disadvantaged as they asserted themselves with some form of authority. They also explained how the 'system' worked to empower them as they faced other professionals. This advocacy took several forms. Some examples include: a counsellor phoning staff of another service in which the client was being disrespected; a counsellor writing a letter of support for the client to gain her driver's license back; a counsellor explaining the client's situation to the insurer; a counsellor supporting the client in refusing to sign a consent form that allowed the social worker to access personal information about her addictions counselling.

Helpful Category 9: Counsellor Self-Disclosure. Counsellors used appropriate self-disclosures. This category encompasses events in which counsellors shared personal information of any depth. Disclosures ranged from light disclosures about daily living events to deeper self disclosures about personal experiences similar to those of the clients. Most of the disclosures were on the lighter side. Such disclosures are not understood in the traditional sense of a deep disclosure of intimate information but rather as the sharing of no risk information from the counsellors' lives to express their humanity. Examples of this are derived from three of the counsellors who shared little pieces of their lives: After a session, a client asked her counsellor some general personal questions e.g. whether he was married. The counsellor shared with her that he was and that he had a young child, and showed her the picture of his child. On another occasion, around Halloween, the counsellor shared how he had taken his child trick or treating. Another counsellor responded to the client’s question “how are you?” with a brief but genuine self-disclosure about how she was feeling. This happened at the beginning of the session before client and counsellor engaged in conversation regarding the client's issues. At times she would
express that she was "feeling great". At other times she might have expressed how she was "feeling tired because her car broke down on the way to work". The lighter disclosures portrayed the counsellor's humanity. Clients could see the human side of their counsellor. Clients also felt they could relate better because the counsellors were approachable and non-threatening. One client stated, “he (the counsellor) didn't come across as ‘too clinical’. Clients also felt trusted when counsellors disclosed some little information, and this further enhanced rapport.

When the counsellors self-disclosed more revealing information, this was done in the context of sharing an experience similar to that of the client. One client was struggling with communicating in appropriate ways. The counsellor shared about the difficulties she encountered earlier on in her life and what she had found helpful. Such disclosures both helped clients perceive their counsellors as equal human beings and helped them develop alternative ways of being.

Helpful Category 10: Counsellor Setting and Respecting Boundaries. Counsellors explained boundaries around the counselling – confidentiality, sessions offered, missing sessions. A counsellor explained to the client that she was going to be offered eight weeks of counselling (a session a week) and that after this period counselling could be extended if the need arose. In another situation when a client was missing sessions in a row, the counsellor non-judgementally communicated to the client her wish to be called if the client was not going to turn up. When counsellors explained boundaries, clients could know “where they stand” in relation to the counselling experience. While setting boundaries counsellors also respected the clients' personal boundaries. Examples of this include, not over functioning or care-taking clients, not responding to indirect sexual invitations.
Helpful Category 11: Counsellor-Client Complementing Attributes, Experiences.

Counsellors and clients had complementing attributes and/or experiences. On one hand clients and counsellors shared qualities or experiences. For example, a client and counsellor who were of same gender; a client and a counsellor who found similar things humorous or a client and a counsellor who had a very lively character. On the other hand, some clients and counsellors had qualities and experiences that complemented each other in ways that brought them closer. Examples of this include a counsellor who had many similar qualities to the client’s mother or a client who found it easier to disclose a traumatic past event because the counsellor was of opposite gender. These similarities or complimenting attributes generally made the full engagement in the counselling experience easier.

Helpful Category 12: Counsellor and Client Sharing Humour. Counsellors and clients shared humour. They laughed or chuckled together about clients’ bizarre past experiences, elements in counselling experiences, and other events or things they both found humorous. On one occasion, a client shared amusing incidents from the days she used drugs. She shared how she ended up going to work bald after shaving her head for the fun of it while at a party. The counsellor laughed heartily to the point of tearing. Another counsellor laughed with his counsellor about issues they had dealt with seriously in previous sessions. At other times humour was initiated by counsellors.

The sharing of humour had numerous outcomes. Through this humour clients perceived counsellors as fellow human beings. Secondly, a client felt acknowledged by the counsellor’s appreciation of his humour. Most importantly the sharing of humour served as a connecting element. For the client who shared bizarre experiences from the time she was actively using drugs, it was important that the counsellor laughed. As painful as some of these experiences
were, when the client shared these events, she meant for them to be funny. The counsellor's laughter enhanced the connection between them. Client, "That also was an illustration for me that he was really listening to me, that he wasn't just taking a history, maintaining eye contact just for the sake of it. But he was truly listening because to understand the essence of the humour you have to hear the story. It was great, really important." Early on in counselling this laughter served as a connecting bridge: This client got the impression that the counsellor did not indulge in alcohol or drugs. The counsellor, a straight person, sharing laughter with the client, who at that point perceived herself as a "druggie", meant that he was not judging her. On the contrary it communicated that he valued her and the relationship they were developing. Another outcome of laughter was that it served to "lighten things up" and to "release negative energy."

Some of the outcomes of the sharing of laughter were more important for counsellors. The client's ability to laugh at him/herself and at his/her problems indicated a sign of healing. Counsellor, "This is particularly significant in terms of addictions, because the realities are usually very grim and horrific and it is usually difficult to get to a point to laugh about oneself."

For counsellors, the experience of sharing laughter was a sign that they had a strong therapeutic alliance and that counsellors could further in-depth counselling work. Counsellors took this as a sign that clients were "willing to be more vulnerable" and that counsellors could be more personal, more challenging. Thus further work could be carried out.

Helpful Category 13: Relapse Prevention Work. Counsellors helped clients set up a relapse prevention plan. This took the form of helping clients identifying risk factors/situations that could result in relapse and plan strategies to address such risk factors. Counsellors also discussed re-entry issues with clients. One counsellor gave the client a reminder to dispose of any paraphernalia in the house before entering residential detoxification. Another counsellor
helped the client identify high-risk situations and strategies to deal with them. Specifically the client was at highest risk when she felt criticised or rejected. This would upset her and she would drink. Considering the client's history of slips and two major relapses, this was helpful in order to prevent high risk situations or triggers and consequently prevent her from resorting to alcohol.

Helpful Category 14: Counsellor Expertise. This is a category emerging from events mentioned by clients alone. Clients had the knowledge of being in the hands of a specialist. Either because of the information that was given to them about their counsellor or from noticing their counsellor behave in a professional manner, clients had the experience of feeling in the hands of a professional. This had a significant outcome for clients. Client, "I trusted that she knew what I was talking about, that she didn't have to have tons of background... she knew addiction, she knew addicts. There wasn't anything that I could tell her... there wasn't anything that has happened to me, or that I could tell her, that she hadn't already heard". "She was tuned into the addiction". "I had the sense of 'I can let go now', I can let go the control, I can let go fighting this, because... (N counsellor) has got this in hand. N (Counsellor) knows what's best for me." Another client experienced this in the following manner, "I felt like I was in the hands of a professional. I felt like, the caregiver who was with me knows what he was doing." This feeling of being in good hands gave her "faith" in the process. Client, "It gave me continuing confidence that not only had I made the decision to stop, but that I was going to learn things and tips and processes... (that would bring about success in recovery).

Helpful Category 15: Counsellor Felt Sense of Strong Connection with Client. This is a category emerging from events identified by counsellors alone. After the initial contacts, in which clients disclosed about their situation/story, two counsellors felt a strong connection with the client. The felt they could join with them very easily. In one of these situations, the client
came to counselling, attended two sessions and then lost contact with the counsellor for four months before reconnecting. In those first two sessions the client shared her story. As the counsellor listened to the tragic events that had transpired in the client's childhood, she was deeply moved by the client's story and felt a very strong connection with her. The counsellor had experienced a very loving environment in her life. The connection or resonance with the client sprouted from the counsellor's understanding of how awfully difficult it must have been not to experience that. The deeply felt connection moved the counsellor to be there for the client in a very special way, to be for her a very strong supportive presence for her throughout and also support her through the "bigger community and net of people" the counsellor was in contact with.

Description of Categories of Hindering Events Related to Outpatient Drug Addiction

Counselling

Hindering Category 1. Blurred Boundaries and Boundary-Related Unethical Behaviour

(Events mainly from counselling experiences other than the outpatient counselling). Counsellors acted in ways that blurred client-counsellor boundaries or even unethically crossed such boundaries. Examples of this ranged from indulging in long friendly discussions with no therapeutic aim; offering the client the option of meeting at a cafeteria if the client wanted; to a counsellor who overwhelmed the client with his very personal burdensome self disclosures; asking a client to do manual labour work for them; and a counsellor who took up a job with his client. It is important to note that the unethical incidents mentioned by clients happened in counselling experiences outside the one examined in this study.

The negative impacts of such incidents were various and serious. Some clients felt that by opening up the relationship outside counselling would place expectations on them, a position that
is very different from the counselling relationship. For another client, the unethical incident led to a full-blown relapse. After five months of abstinence (three months from leaving the support recovery house) one of the counsellors from the recovery house, asked the client to do a manual labour job at her home. The client was anxious to please and because it was his counsellor who was asking, it was difficult to refuse. He was placed in a vulnerable position. Because of the work, the client had missed some of his regular meetings and some of his visits to his brother, something he felt bad about. On the evening he got paid, he was “feeling hungry, angry, lonely and tired... HALT”. This led to a relapse that lasted a month. For another client the unethical incident lead to very stressful and uncomfortable situation. This client engaged in counselling with an unprofessional counsellor. The counsellor “crossed lines that I believe he shouldn't have crossed." The client was feeling sorry for his counsellor, and going against his gut feeling, the client offered his counsellor a job. The counsellor took up a manual labour job for the client. In this situation the client had a supervisory role over his counsellor. This created a dual relationship scenario that placed the client in conflict between his supervisory role and his client role. In his work for the client, the counsellor was showing a lack of commitment. Because of the situation the client was in, the client found it difficult to confront him. After this incident the client dropped contact with the counsellor and terminated counselling. Client, "When the clients are hiring the counsellors to do other kinds of work, that's bad too. That really, really turned out awful. I hired the guy (the non-professional counsellor)... and it was a disaster. Not a good idea! Don't cross those lines! It really put a bad a taste in my mouth. I haven't talked to him since... His entire human side came out. A side that I thought I could trust. Because of the relationship that we developed I couldn't really say, 'Why didn't you show up today? How come you're not here (on time)'. I wasn't being the boss that I was supposed to be. On a job site you cannot do that.
You have to take charge. I take charge. And if you're not going to take charge with him, well then everybody else is watchin you: How come he gets special treatment? It just breaks everything, It falls apart."

Hindering Category 2. Client Forced/Pressured into Treatment. (Events mainly from counselling experiences other than the outpatient counselling). Counsellors pushed clients into behaviours/actions/ideas/feelings they did not want. The pushing ranged from placing verbal pressure that made the client uncomfortable to being verbally forceful, leaving the client with no option other than complying or forcefully freeing themselves of the situation. Examples include a client who was not yet committed to quit using drugs and was asked to sign a contract of quitting or not receive the service; a client pressured to share about his abuse; a client who was feeling disturbed in a group and ordered to stay when he expressed his wish to move out.

The more forceful counsellors were, the more serious the outcome. A client who was pressured to share about his past experience of abuse while at a recovery house, ended up at high risk of relapsing. At a support group, group members placed indirect pressure on a client to stop his prescribed antidepressant medication. They looked down on him because he was still "hooked on something". This medication had helped the client tremendously in finding stability in his life and to engage in counselling. Stopping the medication would have had serious consequences.

Hindering Category 3: Lack of Counsellor Consistent Presence. (Events mainly from counselling experiences other than the outpatient counselling). This is the reverse of the helpful category Counsellor Consistent Presence. Counsellors who not present for the client for the extended period of time needed for recovery. Ana experienced a frequent shuffling in her counsellor with the result that she was feeling uncomfortable sharing her story over and over
again, "It was hard enough to start out, to go see a counsellor and be really rigorously honest...and you tell them so much and then all of a sudden you tell another person so much, and then, oh now to another, and you're not really getting anywhere. You're always starting at the beginning... It made me feel that I was just another statistic. I was just another name, in a file... We couldn't get any grounding because I just get started feeling comfortable and bang I was switched". One of the counsellors mentioned how periods of diminished counsellor-presence lead to an increased vulnerability to relapse. Bob had his counselling terminated after a set amount of five sessions leaving him full of unfinished businesses. This client had been assigned to a company counsellor before engaging with the outpatient addictions counsellors. The first of two of the five sessions focused on family history and the addiction background. On the third session the counsellor informed the client that they only had two more sessions left. At a time when the client was still actively using, five sessions were surely not enough to address the complexity of the client's difficulties. The client felt that they had "barely scratched the surface".

Hindering Category 4: Addiction as the Sole Counselling Focus. (All events from counselling experiences other than the outpatient counselling). This category was developed from events identified by clients alone. In these incidents counsellors focused counselling solely on the dynamics of the addiction - describing the clients’ drug abuse pattern and planning or working on ways of controlling the addiction, without considering other aspects of the client’s past and present life. Clients felt that their counsellors were missing important chunks of their lives and that they were getting nowhere. By focusing simply on the addiction, one of the clients felt that his counsellor could only perceive him as an addict.

Hindering Category 5: Counsellor Not Pacing Self with Client's Needs. This category was developed out of events identified by counsellors alone. Counsellors identified events in
which they ‘missed the boat’. They either presented an idea or a treatment recommendation with the wrong timing or kept back from intervening when needed. Examples include a counsellor recommending a client to join a therapeutic workshop at a time she was moving house and a counsellor who kept back from moving on to new topics at a time when the client was ready to move on. On such occasions clients either disengaged from counselling or diminished their engagement.

Helpful Events Outside the Outpatient Counselling Experience

Two helpful categories were developed out of the incidents not directly related or outside the outpatient drug addiction counselling experience. These two categories developed from both clients’ and counsellors’ incidents. They are titled Therapeutic Activities Accompanying Outpatient Counselling and Social Support. Tables 16 presents these two helpful categories outlining the participation rates and the number of events per category. Their descriptions follow below.

Helpful Category 1: Therapeutic Activities Accompanying Outpatient Counselling.

Together with outpatient counselling as the main treatment plan, clients participated in other treatment/therapeutic activities. Clients attended therapeutic workshops, psycho-educational groups; joined AA or NA, carried out a residential treatment programme, a day programme and/or joined support recovery houses. Clients who carried out a residential programme (ranging from a month to three months) or carried out some short-term therapeutic workshops furthered their therapeutic work. Unless clients joined a residential programme, clients kept regular contact with their counsellor. Those who attended a residential programme reconnected with their outpatient counsellor when the programme was over. A client who joined a support recovery house found in it a supportive and safe place away from drug using peers. Clients who attended a
### Table 16

**Categories of Helpful Incidents Outside Outpatient Counselling Experience Identified by both Clients and Counsellors**

<table>
<thead>
<tr>
<th>Categories of Helpful Incidents</th>
<th>Clients</th>
<th></th>
<th>Counsellors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation Rate*</td>
<td>No. of Events</td>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>1 Therapeutic Activities</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Accompanying Outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Social Support</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7
support group, usually did so over an extended period of time. In these groups they found continued support.

Helpful Category 2: Social Support. Clients experienced support from peers, family members, and their employers. Peer support was received from organised settings such as AA, NA or other therapeutic groups and/or from peers in informal settings such as friends and church members. Peer support was expressed in many forms: having a group of people leading drug-free lives, to relate to; encouragement at difficult times; and support for clients’ decision to follow and maintain treatment. Clare attended NA "to stay in contact with people that are clean" and are living "a healthy lifestyle". In her support group Doris shared about a challenge she was facing whilst supporting her daughter through financial stress. Group members expressed to her how great it was for her to be going through that stress without resorting to alcohol, "well, if you're not drinking over all that, you kind of got it under control!" The client felt very supported and validated by the group. Such comments coming from people who “had been there” (who struggled with addiction) was very meaningful for the client. She felt very understood. Client, "They know how hard it is or how easy it would be to pick up a glass. Because they went through it they really understand. It really does help".

Clients experienced support from family members during and after the counselling period. At times clients asked family members to support them in specific ways during their struggles in maintaining a drug free life. As an example, Gina was aware of her ability to deceive someone into thinking that she was not using drugs. As she started counselling, the client invited her husband to challenge her or call on her if ever he sensed any lying or inconsistencies in what she was saying. By doing so the client was exposing her ability to deceive to someone she could count on.
For a client who had still maintained her job during her active addiction, support from the employer was particularly significant. Gina was allowed three months off work to be able to focus solely on her recovery. She was also allowed to return to work at her own pace. This support greatly facilitated her recovery. As she worked on herself she did not need to attend to work-related challenges and concerns. Client, "For me personally being able to book out of the workplace was again a huge critical success factor for me because it allowed me to take full advantage of what I was learning in the therapeutic process and so I didn't have to deal with work as well. It was one less thing."

Helpful Events Related to Client Characteristics/Experiences

Two helpful categories were developed out of the incidents related to client characteristics and/or experiences. These categories emerged out of incidents mentioned by both client and counsellor participants. They were titled Client Motivation and Client Experiencing Progress/Success and Counselling Effectiveness. Table 17 presents these helpful categories outlining the participation rates and the number of events per category.

For a greater specificity and understanding, Category 1, Client Motivation was further subdivided into two subcategories: Client Confronted with Serious Consequences of Continued Drug Use (Reaching Rock Bottom) and Client Decision, Will and Commitment to Change. Table 18 presents these subcategories, outlining the participation rates and the number of events per category.

Within this section of helpful events related to client characteristics/experiences a strong difference between clients and counsellors is apparent within Category 1, Client Motivation. The differences appears in the stronger emphasis placed on this category by client participants. The participation rate for clients is seven while that for counsellors is four. Furthermore clients
Table 17

Categories of Helpful Incidents Related to Client Characteristics/Experiences Identified by Both Client and Counsellor Participants

<table>
<thead>
<tr>
<th>Categories</th>
<th>Clients</th>
<th></th>
<th>Counsellors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation Rate*</td>
<td>No. of Events</td>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>1  Client Motivation</td>
<td>7</td>
<td>13</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2  Client Experiencing Progress/Success and Counselling Effectiveness</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7

** Bold type denotes a difference in emphasis between client and counsellor participant

Table 18

Sub-Categories of Helpful Incidents Related to Client Characteristics/Experiences Identified by Both Clients and Counsellors

<table>
<thead>
<tr>
<th>Sub-Categories</th>
<th>Clients</th>
<th></th>
<th>Counsellors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participation Rate*</td>
<td>No. of Events</td>
<td>Participation Rate*</td>
<td>No. of Events</td>
</tr>
<tr>
<td>1.1 H Client Confronted with Serious Consequences of Continued Drug Use (Reaching Rock Bottom)</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1.2 H Client Decision, Will and Commitment to Change</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7

** Bold type denotes a difference in emphasis between client and counsellor participant
identified 13 events within this category while counsellors identified only five. This difference is similarly represented in the two subcategories. What follows is a description of these categories.

Helpful Category 1: Client Motivation. Clients were motivated to change. They had the awareness of the need to change coupled with the will to take positive action to bring about change. This category is further explained by its two subcategories: Client Confronted with Serious Consequences of Continued Drug Use and Client Decision, Will and Commitment to Change.

Subcategory 1.1: Client Confronted with Serious Consequences of Continued Drug Use (Reaching Rock Bottom). Confronted by very serious consequences of their drug use and abuse, clients felt compelled to seek help to address their drug abuse problem. Consequences faced, related to health, work, money, self-concept and relations with significant others. After a critical incident of being found in a coma, following a relapse, a client sought the counsellor's help on her own will. For Bob it was his employers terminating financial support that brought him to the point of rock bottom, "Well I was very very disappointed, disillusioned, disassociated and, just kind of at the same time, there was a part of me that thought this has to be part of the process of reaching a bottom. It was good, although I didn't feel that at the time. I had anger of course and a part of my denial was that I was alone in my difficulty... I'm financially, I guess we could say, I'm mentally, emotionally, financially, and spiritually bankrupt at that point". After a period of heavy use, Doris's behaviour had deteriorated. Her daughter was upset with her, the client was feeling ashamed of herself, and she was not speaking with her partner. The client found herself in a very "bad" situation and decided to enter residential detox. Losing the respect of the only daughter she felt very close to, and having her partner, who she was very fond of, distance himself, made her realise that she had too much to lose.
Subcategory 1.2: Client Decision, Will and Commitment to Change. Clients made a decision and experienced a strong determination to change. This was reflected in the clients’ commitment in persevering with counselling, the client’s openness to share and address difficult issues in their personal lives, the clients’ honesty in sessions and the clients’ openness to be challenged. Ana, Alice and Philip, all kept attending counselling even when counselling was unnerving because they were being challenged. On the other hand, in her intake session Gina invited her counsellor to challenge her or call on her if ever he sensed any lying or inconsistencies in what she was saying. In particular she invited him to challenge her if he thought she was using, "I know how good I am at snowing someone who really cares for me and one of the things that N (couns) and I discussed on the very first day on the intake session when he talked with me about my needs... I invited him to, and said that it was really important, just knowing myself, that if he ever he thought I was lying or sensed inconsistencies, that he... challenge me on them.... me stating that I was open to that, probably allowed for a slightly less sensitive approach for his part."

Helpful Category 2: Client Experiencing Progress/Success and Counselling Effectiveness. Clients experienced the benefits of attending counselling and maintaining a substance-free life. They were further encouraged by observing progress in handling challenging situations in their personal lives. This was particularly significant when they handled situations that in the past would have compelled them to turn to drugs. For Doris not to resort to drinking when she was stressed by her daughter’s serious financial problems was of great encouragement. Being able to cope without drinking made her “feel wonderful” and “proud” of herself. For Philip, the experience of a positive past counselling experience prompted him to seek further counselling when the need arose.
Tests of Trustworthiness of Data

Test of Comprehensiveness

In an attempt to achieve comprehensiveness and adequate redundancy of categories, data analysis was carried out after each interview. Interviews from the first client-counsellor dyad were analysed and categories formed. The second dyad was then analysed using the category system developed from the analysis of the first dyad. New categories emerged when incidents did not fit previous categorisation. Such a process continued from one dyad to the next until all incidents were suitably placed in categories. Table 19 shows the number of new categories introduced with each dyadic analysis. Redundancy for client participants was achieved by the sixth participant. When all events from the sixth participant were plotted into the category system developed by then, no new categories emerged. Redundancy for counsellor participants was achieved by the seventh counsellor participant. Close observation of table 19 shows how the majority of categories had emerged out of the first and second dyad.

The data from the seventh counselling dyad were used in the spirit of Andersson and Nilsson's (1964) recommendation to test comprehensiveness by withholding 10% of the incidents from the initial categorisation process. The seventh client participant identified 34 incidents and the seventh counsellor participants identified 32, totalling to 66 events. The 66 events correspond to 18% of the grand total number of events. This is well above the 10% criterion recommended by Andersson and Nilsson. As shown in table 19 events emerging from the seventh dyad did indeed fit the category system. This is indicative of a sound and comprehensive category system.
Table 19

Redundancy of Incidents for Client and Counsellor Participants

<table>
<thead>
<tr>
<th>Client Participant</th>
<th>No. of New Categories (Clients) *</th>
<th>Counsellor Participant</th>
<th>No. of New Categories (Counsellors) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

* Includes Categories, Subcategories and Idiosyncratic Categories

Inter-Sorter Reliability

Upon the development of the category system, an independent sorter attempted to replicate the sorting of the critical incidents into the established categories and subcategories. Across all categories, the sorter successfully sorted 83% of the critical incidents into their appropriate categories. This result falls within the bounds of Andersson and Nilsson's (1964) recommendation of reaching 75% to 85% agreement. It demonstrates that, generally, the critical incidents are conceptually reliable or trustworthy indicators of their respective categories and subcategories.

Independent Judgment of Interviewing Style

An independent judge listened to the audio-recording of the first three dyads (six...
interviews) to check that the interviewer did not ask participants any leading questions. The independent judge identified three interviewer statements and/or questions that could have been leading. All three were identified in interview with the second client participant. The independent judge did not find any other leading questions in the following three interviews he listened to. The very small number of leading questions is considered as a positive result indicating that the data emerging from the study truly represents participants’ unbiased perceptions. Abstracts from the parts of the transcripts in which the interviewer could have been leading are portrayed below. The leading questions/statements are italicised.

Participant: But in the class where the focus is not an insult, it’s just information, you can take it, and you can do with it what you want. If you don’t care you can say, screw it I don’t care. If you want to change the way that people...

Interviewer: behave towards you?

Participant: yeah, or the impression that they get of you, or the vibe that they get from you, then you can do something about it. You have the opportunity, you have some information, you can make some changes, but...

---

Participant: Like in the beginning she said that I’m here for you, you know, you’re not alone. And I say, no I don’t know... like... I can’t get a hold of you day or night, I can’t come to your house and say I need a place to stay (laughs), like, I didn’t understand that at all.

Interviewer: Do I understand that because of (ehm), these events, where she came to give you her number, do you see that, is that the connection?

Participant: Mhm. That’s part of it...(continued with clarification)
Participant: It made me happy that she said that, 'cause, like, ok, this is a good question to ask and she’s happy to answer it.’ It made me feel better about, like, that there wasn’t anything to hide here and she was gonna tell me what was really up, you know, cause I could just pretend that that didn’t really exist and be worried about it the whole time....But yeah, in that instance I was able to, and that kind of allowed me...

Interviewer: ...to be clear about.

Participant: Another thing she said that

Check-in Interview

After each participant reviewed the incidents and categories into which his or her incidents had been placed, the check-in interview was conducted. Participants were asked to comment, clarify and make any changes necessary to make the results a more accurate representation of what they shared during the main interview. Generally, participants expressed strong satisfaction about the accuracy of their results. Three types of changes were made: clarification of incidents that were not clearly expressed; changes of an incident from one category to another, and occasionally the identification of a new event. Table 20 lists the number and type of changes in the results following these interviews with 9 of the 14 participants. The other five participants were not available for the second interview.

Participation Rate

For this study, the minimum participation rate for an incident to be included in a category was set at 25%. This corresponded to two client participants out of a total to seven client participants or two counsellor participants out of a total of seven counsellor participants. Categories that met this criterion were included in the category system developed in this study.
Table 20

**Number and Type of Changes to Data from Check-In Interview**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Clarification/Correction of an Incident</th>
<th>Change in the Category of an Incident</th>
<th>Identification of a New Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client 1</td>
<td>4</td>
<td>/</td>
<td>3</td>
</tr>
<tr>
<td>Client 3</td>
<td>2</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Client 4</td>
<td>2</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Client 6</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Client 7</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor 1</td>
<td>1</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor 2</td>
<td>6</td>
<td>1</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor 3</td>
<td>9</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor 5</td>
<td>/</td>
<td>1</td>
<td>/</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

17 of the 371 incidents were placed into 12 categories that did not pass the participation rate test of trustworthiness of data. 14 of the 17 incidents were of a hindering nature. These categories included one or more incidents identified by only one client and/or one counsellor. Such incidents and corresponding categories were considered idiosyncratic and were excluded from the category system developed in the study. Tables 21 and 22 list these incidents and categories.
### Table 21

*Helpful Idiosyncratic Incidents and Corresponding Categories*

<table>
<thead>
<tr>
<th>Category</th>
<th>Critical Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor/Service</td>
<td>Counsellor CI*: Client's partner attended counselling.</td>
</tr>
<tr>
<td>Involvement of Significant Others</td>
<td>Counsellor CI: Counsellor saw the client and his partner for a session.</td>
</tr>
<tr>
<td>Service Co-ordination</td>
<td>Client CI**: The client was seeing two counsellors at the same time and the counsellors decided that the client was to work with only one of them.</td>
</tr>
<tr>
<td>Client Liking of Counsellor</td>
<td>Counsellor CI: Client attracted/developed liking toward counsellor.</td>
</tr>
</tbody>
</table>

* Critical Incident identified by Counsellor
** Critical Incident identified by Client
Table 22

*Hindering Idiosyncratic Incidents and Corresponding Categories*

<table>
<thead>
<tr>
<th>Category</th>
<th>Critical Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client-Counsellor</td>
<td>Client CI: Client in manual labour clothing had session in a sophisticated office with a counsellor wearing sophisticated clothing.</td>
</tr>
<tr>
<td>Differences/Mismatch (other service*)</td>
<td>Client CI: Counsellor of opposite gender and considerably younger than client.</td>
</tr>
<tr>
<td>Client’s Needs (other service)</td>
<td>Client CI: Client shared about stress provoking issues in counselling, and was alone to deal with these issues when he went back home.</td>
</tr>
<tr>
<td></td>
<td>Client CI: Client was asked to self disclose his main reason for need of recovery and was then told that what he shared could not be dealt with.</td>
</tr>
<tr>
<td>Counsellor Lack of Preparation for Session (other service)</td>
<td>Client CI: Counsellor who had replaced previous counsellor said to client that she had not seen client's file yet.</td>
</tr>
<tr>
<td>Over Counselling (other service)</td>
<td>Client CI: Client was mandated to see two different counsellors at the same time.</td>
</tr>
<tr>
<td>Counsellor Incorrect Assessment</td>
<td>Counsellor CI: Counsellor did not detect client continued drug use in initial counselling phase.</td>
</tr>
<tr>
<td>Client High Expectations</td>
<td>Client CI: Prior to attending a therapeutic workshop, client</td>
</tr>
<tr>
<td>Event Category</td>
<td>Client Description</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Client Shame</td>
<td>Client CI: Client held very high expectations about its outcome.</td>
</tr>
<tr>
<td>Client CI: Client felt shame about not making progress.</td>
<td></td>
</tr>
<tr>
<td>Counsellor CI: Client felt shame about his drug use when back to counselling after a long time away.</td>
<td></td>
</tr>
<tr>
<td>Client Lack of Openness and Continued Drug Use During Counselling</td>
<td>Client CI: Client was not willing to be open and share</td>
</tr>
<tr>
<td>Cash Flow During Initial Recovery Phase</td>
<td>Counsellor CI: Client received insurance money in one lump.</td>
</tr>
</tbody>
</table>

* other service: Events in this category arising from a service other than outpatient counselling.

**Independent Expert Assessment**

A drug addiction counselling specialist gave his feedback on the generated categorisation and the observed similarities and differences between counsellors and clients. According to the drug addiction counselling specialist, the category system generally fit into the current understanding of addictions counselling. It also resonated with his own personal experiences as an addictions counsellor: “Most of your categories (and the relative strength of your categories) are congruent with what I would expect.... Categories arrived at have a familiarity about them”.

Amidst the general consensual response, some surprising or unexpected results were pinpointed. The low participation rate for Helpful Category 14: Counsellor Expertise was somewhat unexpected. In the expert’s experience “a fair number of clients indicate that one reason they
came to professional addictions counselling services is because of their perception that they will receive counselling from skilled counsellors.” Secondly, although somewhat unexpected, an encouraging element was the fact that despite clients had experienced a significant number of boundary-related unethical behaviour in previous counselling experiences and therefore initial lack of success, these individuals were willing to undertake counselling again.

**Literature Verification**

Categories emerging from the study were contrasted with current literature. When agreement with the literature was observed greater confidence was placed in the specific category. Alternatively a category that was not supported by the literature was considered as needing further study. Only four categories of all 24 categories emerging in this study did not feature in the reviewed literature. This was considered as a positive indication that confidence can generally be placed in the category system. A comparison of the categories with the literature is presented in Chapter 5.

**Time-Line**

Participants pinpointed the approximate time at which a particular event occurred throughout the counselling period. Five time-line points and one generic phase were identified. These included: Initial Phase for clients initiating counselling with low motivation; Initial Phase for clients with high motivation; Working Phase; After Relapse / Period of Discontinued Counselling Phase; and Ending Phase. The generic phase was named Entire Period. The Initial Phase included the clients’ first approach to receive the service, their first session, and the sessions required for clients to engage and connect with their counsellor. The Working Phase was that in which most of the counselling work occurred. The After Relapse / Period of Discontinued Counselling Phase occurred at different points in time for different client
participants. For some it occurred closer to the initial phase and for others it occurred after a good part of the counselling work had occurred. For purposes of clarity, this phase was temporarily placed after the Working Phase. During this phase clients returned to counselling after a period of discontinued counselling either because of a relapse or partial recovery. The fifth phase was the Ending Phase, characterised by a consolidation of previous counselling work and termination work. It is also included aftercare work. The generic phase, Entire Period gathered events that could not really be allocated to a single time-line point because such events were repeated across the whole counselling experience.

Because of a wide spread of helpful incidents across the time-line a very rigorous participation rate of 40% was used for the helpful categories. This was done to capture the categories of events that were really important. Not using the rigorous 40% participation rate would have resulted in many of the categories represented in all time-line points. The 40% participation rate was not necessary for the hindering categories. Thus the 25% participation rate was maintained for hindering categories.

The time-line for categories of helpful incidents emerging from the outpatient addictions counselling is presented in Table 23 on pages 120 and 121. It includes incidents identified both by clients and counsellors. Categories are presented with their corresponding participation rates and number of events. Within the Initial Phase for clients with low motivation, clients and counsellors agreed on Counsellor Directness/Challenges and Counsellor Validating Acceptance. Categories identified by counsellors alone included Counsellor Listening, Empathy and Mirroring; Counsellor Pacing Self with Client; and Counsellor and Client Sharing Humour. For the time-line point Initial Phase for clients with high motivation, clients and counsellors agreed on Counsellor Validating Acceptance. Clients alone identified Counsellor Consistent Presence;
Counsellor Pacing Self with Client; Counsellor and Client Sharing Humour, and Counsellor Expertise. Counsellors alone identified Counsellor Listening, Empathy and Mirroring. Within the Working Phase, clients and counsellors agreed on Help in Understanding Self and Drug Use; and Counsellor Directness/Challenges. Clients alone mentioned Counsellor Validating Acceptance, while counsellors alone mentioned Working on the Resolution of Personal Struggles and Counsellor Help in Bridging Client with System. In the After Relapse / Period of Discontinued Counselling Phase clients alone identified Counsellor Consistent Presence and counsellors alone identified Counsellor Validating Acceptance. Within the ending phase is one category identified by counsellors alone, Counsellor Validating Acceptance. Six categories are present in the generic phase of Entire Period. Four were identified by both clients and counsellors and two by clients alone. The first four were Counsellor Validating Acceptance; Counsellor Consistent Presence; Counsellor Pacing Self with Client and Counsellor Listening, Empathy and Mirroring. The two categories identified by clients alone were Working on the Resolution of Personal Struggles and Counsellor Directness/Challenges.

Incidents emerging outside the outpatient counselling experience and incidents related to client experiences or characteristics were also placed on the timeline during the interviews. Three categories met the participation rate criterion (see table 24). Client Motivation featured in the Initial Phase for clients with high motivation and in the After Relapse/Period of Discontinued Counselling Phase. In both these phases, this category was for clients alone. The category, Therapeutic Activities Accompanying Outpatient Counselling featured in the Working Phase for both clients and counsellors. Finally the category Social Support emerged within the Entire Period segment of the timeline for clients alone.
<table>
<thead>
<tr>
<th>Time-Line: Categories of Helpful Incidents Related to the Outpatient Drug Addiction Counselling Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Phase:</strong></td>
</tr>
<tr>
<td>Client Low Motivation*</td>
</tr>
<tr>
<td>Counsellor Directness/Challenges</td>
</tr>
<tr>
<td>Couns. – PR: 3 CI: 5</td>
</tr>
<tr>
<td>Counsellor Validating Acceptance</td>
</tr>
<tr>
<td>Clients – PR: 3 CI: 5</td>
</tr>
<tr>
<td>Couns. – PR: 2 CI: 4</td>
</tr>
<tr>
<td>Counsellor Listening, Empathy and Mirroring</td>
</tr>
<tr>
<td>Couns. – PR: 3 CI: 3</td>
</tr>
<tr>
<td>Counsellor Pacing Self with Client</td>
</tr>
<tr>
<td>Clients – PR: 2 CI: 3</td>
</tr>
<tr>
<td>Counsellor Consistent Presence</td>
</tr>
<tr>
<td>Couns. – PR: 2 CI: 2</td>
</tr>
<tr>
<td>Counsellor Setting and Respecting Boundaries</td>
</tr>
<tr>
<td>Couns. – PR: 2 CI: 2</td>
</tr>
<tr>
<td>Counsellor and Client Sharing Humour</td>
</tr>
<tr>
<td>Couns. – PR: 2 CI: 2</td>
</tr>
<tr>
<td>PR = Participation Rate</td>
</tr>
<tr>
<td>CI = Critical Incidents</td>
</tr>
<tr>
<td>Couns. = Counsellors</td>
</tr>
<tr>
<td>* N (Clients) = 3</td>
</tr>
<tr>
<td>N (Counsellors) = 3</td>
</tr>
<tr>
<td>** N (Clients) = 4</td>
</tr>
<tr>
<td>N (Counsellors) = 4</td>
</tr>
<tr>
<td>† N (Clients) = 7</td>
</tr>
<tr>
<td>N (Counsellors) = 7</td>
</tr>
</tbody>
</table>
Table 23 continued

<table>
<thead>
<tr>
<th>Counsellor Service</th>
<th>Entire Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor Validating Acceptance</td>
<td>Clients – PR: 7 CI: 12  Couns. – PR: 5 CI: 7</td>
</tr>
<tr>
<td>Counsellor Consistent Presence</td>
<td>Clients – PR: 4 CI: 7  Couns. – PR: 3 CI: 5</td>
</tr>
<tr>
<td>Counsellor Pacing Self with Client</td>
<td>Clients – PR: 3 CI: 3  Couns. – PR: 3 CI: 9</td>
</tr>
<tr>
<td>Counsellor Listening, Empathy and Mirroring</td>
<td>Clients – PR: 3 CI: 3  Couns. – PR: 3 CI: 4</td>
</tr>
<tr>
<td>Working on the Resolution of Personal Struggles</td>
<td>Clients – PR: 3 CI: 4</td>
</tr>
<tr>
<td>Counsellor Directness/Challenges</td>
<td>Clients – PR: 3 CI: 3</td>
</tr>
</tbody>
</table>

* Total number of participants represented in that category. Maximum number of client participants or counsellor participants is 7
Table 24

**Time-Line: Categories of Helpful Incidents Related to Client Characteristics/Experiences and Incidents Outside the Outpatient Drug Addiction Counselling Experience**

<table>
<thead>
<tr>
<th>Initial Phase:</th>
<th>Initial Phase:</th>
<th>Working Phase</th>
<th>After Relapse / Period of Discontinued Counselling Phase</th>
<th>Ending Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Low Motivation</td>
<td>Client High Motivation</td>
<td>Therapeutic Activities</td>
<td>Client Motivation</td>
<td>/</td>
</tr>
<tr>
<td>/</td>
<td>Client Motivation</td>
<td>Accompanying Outpatient Counselling</td>
<td>Clients – PR: 3  CI: 4</td>
<td>/</td>
</tr>
<tr>
<td>Clients – PR: 3  CI: 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entire Period: Social Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients – PR: 2  CI: 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 25

*Time-Line: Categories of Hindering Incidents Related to the Outpatient Drug Addiction Counselling Experience*

<table>
<thead>
<tr>
<th>Initial Phase: Initial Phase: Working Phase</th>
<th>After Relapse / Period of Discontinued Counselling Phase</th>
<th>Ending Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Low Motivation</td>
<td>Client Forced/Pressured into Treatment</td>
<td>Blurred Boundaries and Boundary-Related Unethical Behaviour</td>
</tr>
<tr>
<td>Clients – PR: 2 CI: 2</td>
<td>Clients – PR: 2 CI: 4</td>
<td>Clients – PR: 2 CI: 2</td>
</tr>
<tr>
<td></td>
<td>Counsellor Not Pacing</td>
<td>Couns. – PR: 2 CI: 2</td>
</tr>
<tr>
<td></td>
<td>Self with Client’s Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Couns. – PR: 2 CI: 2</em></td>
<td></td>
</tr>
</tbody>
</table>

Entire Period: Addiction as the Sole Counselling Focus **Clients – PR: 2 CI: 2**
Four categories of hindering events within the outpatient counselling experience also met the participation rate criterion and were placed on the time-line (table 25). The category Client Forced/Pressured into Treatment featured in the clients' experience within the Initial Phase for clients with high motivation, and in the Working Phase. Counsellor Not Pacing Self with Client's Need featured in the Working Phase of the timeline for counsellors alone. Blurred Boundaries and Boundary-Related Unethical Behaviour featured in the experience of both clients and counsellors in the Ending Phase. Finally Addiction as the Sole Counselling Focus, a category identified by clients alone was allocated to the Entire Period segment of the timeline.

Conclusion

This chapter outlined the results of the study. Background data, data about the significance of the outpatient counselling experience, the category system of helpful and hindering events, results from the tests of trustworthiness of data and data from the time-line analysis were all outlined and described. The high level of specificity adopted in the generation of categories allowed for an in-depth understanding of the outpatient drug addiction experience and made possible the identification of all nuances in similarities and differences of perceptions between clients and counsellors. In the next chapter all these results will be discussed in the light of current literature.
CHAPTER 5

DISCUSSION

In this chapter results will be discussed in the light of previous and current literature. An attempt will be made to draw conclusions about similarities and differences in perceptions of clients and counsellors about drug addiction counselling. The chapter will open with a reflection about the data’s strong inclination toward helpful categories. The category system and the timeline developed in this study will then be discussed and contrasted with literature. This constitutes the final validation check of the results of the study. The main focus of this study was the comparison between clients and counsellors regarding what helped and hindered in addiction counselling. Therefore, the main and in-depth discussion will be dedicated to contrasting clients’ and counsellors’ similarities and differences emerging from this study, with those from other studies. Differences and similarities in the perceptions of events and the importance of the counselling experience will be discussed. Sample characteristics and background data will be used as an interpretative filter as possible conclusions are extracted. A reflection about the trustworthiness of data will conclude the chapter.

Understanding the Focus on Helpful Critical Incidents

A glance at the distribution of critical incidents (table 9 in the results chapter) immediately reveals the stark difference in the number of helpful incidents as compared with hindering ones. 88% of all incidents were of a helpful nature. In an attempt to understand this general trend in the results of this study, it is particularly important to keep in mind salient sample characteristics. Noteworthy characteristics are the successful nature of clients’ experiences and the special regard that both clients and counsellors had for each other and for their counselling relationship.
The most prominent commonality among client participants was that of achieving success. This success was two-pronged: the success in their recovery from addiction; and general success in the outpatient counselling experience. This success is particularly significant when one considers the long periods of time, clients were exacerbated by the substances used, the presence of family history of drug addiction, the presence of traumatic experiences of abuse in the most of the client participants’ childhood, adolescent or adult lives and the very early experimentation with alcohol or drugs for most of the participants - all factors that make recovery a very challenging feat. As expected at the outset of the study, clients experiencing success were less prone and able to identify hindering events.

Clients not only experienced counselling successfully but also seemed to consider the counselling relationship as a peak experience that would further make the identification of hindering results difficult. A striking characteristic indicative of a peak experience is the special regard that both clients and counsellors held for each other and for the counselling experience. This was manifested in the clients’ and counsellors’ comments. Four of seven clients commented on their counsellors’ specialness and uniqueness (direct comments viewed in results chapter). On the other hand when counsellors explained how they identified the clients during recruitment, three of six explained that they identified someone to whom they connected with in a special, strong way and had a meaningful therapeutic relation with. The specialness of the counselling relationship was also manifested in the clients’ and counsellors genuine difficulty in identifying hindering events within their counselling experience. When client participants were asked to identify hindering events emerging from their outpatient counselling experience, all commented about how difficult that was and how they just couldn’t think of anything. In fact cli
throughout the interview. Some counsellors commented about how if they had to be interviewed about other clients they would have had no problem finding hindering incidents in their counselling, however in the specific experience examined by the study they could not. Considering these indications, the category system developed in this study could have possibly captured a very special counselling experience. Together with the successful nature of the counselling experience, participants' special regard for the counselling relationship may be possible reasons for the majority of incidents pertaining to helpful categories.

Prior to discussing the category system and the time-line emerging from this study a further comment on the interplay between clients' positive perceptions of their counsellors and successful outcome, is noteworthy. Kasarabada et al. (2002) found that patients' positive perceptions of their counsellor were significantly associated with longer stay in treatment and better psychiatric functioning as measured by the Addiction Severity Index. This is entirely congruent with the experience of client participants in this study.

Helpful and Hindering Events in the Outpatient Drug Addiction Counselling Experience

The great majority of categories emerging in this study replicate previous findings. Table 26 lists the categories of helpful incidents emerging from this study together with corresponding studies that identified similar categories. Table 27 contains a similar list for categories of hindering incidents. With reference to the literature verification test of trustworthiness, it can be safely argued that confidence can be placed in most of the categories identified in this study since most are well supported in the literature. Of the 19 categories of helpful events, only two categories did not feature in the reviewed studies within or outside the addiction field. Of the five hindering categories, two categories did not feature within the reviewed studies. What follows is a discussion of the category system. Some salient points of agreement between categories in this
study and those of previous studies, together with points of disagreement will be discussed further.

Table 26

*Literature Verification List – Categories of Helpful Critical Incidents*

<table>
<thead>
<tr>
<th>Category Emerging from the Study</th>
<th>Category also featuring in the Literature</th>
</tr>
</thead>
</table>
| Counsellor Listening, Empathy and Mirroring | Rogers (1965)  
Torrey (1972)  
Metcalf and Thomas (1994)  
Miller, Hubble & Duncan (1995)  
Blomqvist (1996)  
Hanna, Hanna & Keys (1999)  
Hegamin, Anglin & Farabee (2001)  |
| Counsellor Validating Acceptance | Rogers (1965)  
Fuller and Hill (1985)  
Wark (1994)  
Metcalf and Thomas (1994)  
Miller, Hubble & Duncan (1995)  
Bedi, Davis & Arvay (2004)  |
| Client Motivation | Cox & Klinger (1990)  
Wark (1994)  
Blomqvist (1996)  
Kadden (1996)  
Miller and Rollnick (2002)  
| Counsellor Consistent Presence | Llewelyn (1988)  
Wark (1994)  
Mcelellan, Alterman, Metzger, Grissom, Woody, Luborsky & O’Brien (1994)  
Hegamin, Anglin & Farabee (2001)  |
| Counsellor Directness/Challenges | Orbitz, (1975)  
Fuller and Hill (1985)  
Wark (1994)  
Metcalf and Thomas (1994)  |
<table>
<thead>
<tr>
<th>Topic</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working on the Resolution of Personal Struggles</td>
<td>Fuller and Hill (1985)</td>
</tr>
<tr>
<td></td>
<td>Kaminer, Tarter, Bukstien &amp; Kabene, (1992)</td>
</tr>
<tr>
<td></td>
<td>Wark (1994)</td>
</tr>
<tr>
<td></td>
<td>Cummings and Barak (1995)</td>
</tr>
<tr>
<td>Client Experiencing Progress/Success and Counselling Effectiveness</td>
<td>Fuller and Hill (1985)</td>
</tr>
<tr>
<td></td>
<td>Llewelyn (1988)</td>
</tr>
<tr>
<td></td>
<td>Wark (1994)</td>
</tr>
<tr>
<td></td>
<td>Cummings and Barak (1995)</td>
</tr>
<tr>
<td>Help in Understanding Self and Drug Use</td>
<td>Fuller and Hill (1985)</td>
</tr>
<tr>
<td></td>
<td>Llewelyn (1988)</td>
</tr>
<tr>
<td></td>
<td>Cummings and Barak (1995)</td>
</tr>
<tr>
<td>Counsellor Setting and Respecting Boundaries</td>
<td>Torrey (1972)</td>
</tr>
<tr>
<td></td>
<td>Kaminer, Tarter, Bukstien &amp; Kabene, (1992)</td>
</tr>
<tr>
<td></td>
<td>Bedi, Davis &amp; Arvay (2004)</td>
</tr>
<tr>
<td>Counsellor Expertise</td>
<td>Miller, Hubble &amp; Duncan (1995)</td>
</tr>
<tr>
<td></td>
<td>Wark (1994)</td>
</tr>
<tr>
<td></td>
<td>Kasarabada, Hser, Boles &amp; Huang (2002)</td>
</tr>
<tr>
<td>Counsellor Pacing Self with Client</td>
<td>Metcalf and Thomas (1994)</td>
</tr>
<tr>
<td></td>
<td>Bedi, Davis &amp; Arvay (2004)</td>
</tr>
<tr>
<td>Counsellor and Client Sharing Humour</td>
<td>Bedi, Davis &amp; Arvay (2004)</td>
</tr>
<tr>
<td>Counsellor-Client Complementing Attributes, Experiences</td>
<td>Bedi, Davis &amp; Arvay (2004)</td>
</tr>
<tr>
<td>Therapeutic Activities Accompanying Outpatient Counselling</td>
<td>Kaminer, Tarter, Bukstien &amp; Kabene, (1992)</td>
</tr>
<tr>
<td>Social Support</td>
<td>Koski-Jannes &amp; Turner, 1999</td>
</tr>
<tr>
<td>Counsellor Help in Bridging Client with System (2 subcategories)</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor Felt Sense of Strong Connection with Client</td>
<td>/</td>
</tr>
</tbody>
</table>
Table 27

*Literature Verification List – Categories of Hindering Critical Incidents*

<table>
<thead>
<tr>
<th>Category Emerging from the Study</th>
<th>Category also Featuring in the Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Forced/Pressured into Treatment</td>
<td>Wark (1994)</td>
</tr>
<tr>
<td>Lack of Counsellor Consistent Presence</td>
<td>Wark (1994)</td>
</tr>
<tr>
<td>Addiction as the Sole Counselling Focus</td>
<td>Wark (1994)</td>
</tr>
<tr>
<td>Blurred Boundaries and Boundary-Related Unethical Behaviour</td>
<td>/</td>
</tr>
<tr>
<td>Counsellor Not Pacing Self with Client's Needs</td>
<td>/</td>
</tr>
</tbody>
</table>

Some areas of agreement between categories in this study and previous research are worthy of special attention because of their relevance and implications for addictions counselling practice. The three categories that featured most in previous and current literature were Counsellor Listening, Empathy and Mirroring; Counsellor Validating Acceptance; and Client Motivation. The first two of these categories are analogous to two of the three pillars of the Rogerian counselling approach, empathy and unconditional positive regard. This underlines the special role that this humanistic approach might play in the addictions field. As reported by clients in this study, during their experience of substance dependence, clients were judged, looked down upon and labelled. As a result being listened to, accepted and considered a human being rather than as a drug addict took on a very special meaning. These results highlight and acknowledge the centre-stage role that the person centred approach plays in the addictions field. These three categories most featured in other studies also affirm the role of the motivational enhancement approach, highly used in drug addiction counselling. This approach is based on
principles of non-judgmental listening and questioning to help clients weigh the advantages and disadvantages of their drug use and in so doing enhance their motivation to change – a factor that featured highly in both this study and the literature.

A second salient feature of the results is the presence of several categories that have been linked to the development and maintenance of a strong therapeutic alliance: Counsellor Listening, Empathy and Mirroring; Counsellor Validating Acceptance; Counsellor Consistent Presence; Counsellor Setting and Respecting Boundaries; Counsellor Pacing Self with Client; Counsellor and Client Sharing Humour; Counsellor Self-Disclosure; Counsellor-Client Complementing Attributes, Experiences; and Client Expertise. All these categories featured in other studies and accentuate the well established norm that a strong therapeutic alliance or a strong counselling relationship are both a strong component of counselling work and a crucial step for any other counselling work to be carried out.

Another intriguing finding is the coexistence of the category Counsellor Validating Acceptance and that of Counsellor Directness/Challenges. These two categories identify events that tend to be at opposite ends of the client acceptance continuum. These categories featured as the top two categories for clients, and enjoyed a 100% participation rate (seven of seven client participants mentioning incidents falling in this category). For counsellors, Counsellor Directness/Challenges was a top category with 100% participation rate and Counsellor Validating Acceptance ranked second with 86% participation rate (six of seven participants). Wark’s study of family counselling also found a similar co-existence. These two categories received considerable and somewhat equal value. A closer examination of how these two categories feature in the timeline possibly reveals a possible link between them. Amongst other time-line points, the category Counsellor Validating Acceptance featured in both the initial
counselling phases for clients with high and low motivation. Alternatively Counsellor Directness/Challenges featured strongly only in the initial counselling phases of clients with low motivation. This may initially seem surprising as one may expect that clients with a low motivation to change might refuse challenges. However within the initial phase time-line point for clients with low motivation, the category Counsellor Directness/Challenges was accompanied by another six categories. All six categories are associated with the development of rapport and acceptance. Therefore the directness and challenging that clients with low motivation were confronted with at the beginning was done in the context of counsellor acceptance and rapport building. As a result challenges might have been acceptable because clients’ knew that their counsellors had a basic acceptance of them as human persons. This is congruent with Egan’s (1994) conception that for challenging to be beneficial, counsellors have to first gain the right to challenge i.e. a challenge that is presented when the relationship is established is more likely to be accepted by its recipient.

A fourth significant finding is the importance that client participants placed on the category Client Motivation. Incidents from all client participants are represented in this category (ie 100% participation rate). Blomqvist (1996) found that clients who do not seek treatment were motivated to quit using by any combination of problems with health, family, work or finances, law, sudden frightening or humiliating experiences and maturing. Alternatively, for those who did seek treatment, change was attributed to therapy techniques, confiding relationships, convincing rationale, safe and encouraging setting and direct feedback. The category Client Motivation to Change for the clients in the study contained incidents related to clients being confronted with the serious consequences of their drug use. These were consequences similar to those identified by Blomqvist for individuals who quit drug use without seeking treatment. This
finding challenges Blomqvist conception that individuals who seek treatment attribute their change solely to factors other than facing serious consequences for their drug use.

Two helpful categories and two hindering categories did not feature in the reviewed literature. An attempt will be made to identify possible reasons for this. The two helpful categories were Counsellor Help in Bridging Client with System and Counsellor Felt Sense of Strong Connection with client. In relation to the former, this category could possibly be tightly related to the outpatient nature of this counselling experience and therefore idiosyncratic of the service structure. This category includes incidents related to referring clients to other services they can access, and counsellor advocacy. Unlike clients who engage in residential treatment as their main treatment plan, clients who are attempting recovery with the aid of outpatient counselling are faced with the task of working harder to engage with other important services such as connecting with support groups or therapeutic workshops. Therefore the need for counsellors to support clients in accessing these services and to advocate for them when they face difficulties becomes relevant and necessary. The other helpful category Counsellor Felt Sense of Strong Connection with Client is not a central category (participation rate: 29% or two of seven counsellors), and includes incidents identified by counsellors alone. The incidents pertaining to this category have nuances of what psychodynamic oriented scholars might frame as experiences of positive counter transference. Viewed from this perspective this category does not stand alone as a new unconsidered idea.

The two hindering categories that did not feature in the reviewed studies were Blurred Boundaries and Boundary-Related Unethical Behaviour; and Counsellor Not Pacing Self with Client. Blurred boundaries and Boundary-Related Unethical Behaviour have been found to have unequivocal harmful effects on clients. This harm is highly visible in the events mentioned in
this study. It reflects the darker side of very intense counselling relationships. Such hindering events did not feature in studies of other counselling contexts such as general counselling (Llewelyn, 1988), family counselling (Wark, 1994) or brief counselling (Metcalf & Thomas, 1994). Counselling periods extending over long periods of time, and intense counselling relationships might place clients afflicted with substance dependence or abuse at a higher risk of boundary related hindering, or rather harmful events. A close observation at the time-line shows that the boundary related hindering events tended to occur in the ending phase of the counselling experience i.e. after the relationship was developed. This is to be considered as a high-risk time-line point. The second hindering category not featured the reviewed studies was Counsellor Not Pacing Self with Client. Although not featured in other studies, this category is the direct opposite of the helpful category Counsellor Pacing Self with Clients, and therefore somewhat accounted for in the literature about helpful therapeutic factors.

Outpatient Drug Addiction Counselling Time-Line

Reference has already been made to some categories and their place within the drug addictions time-line. More salient features of this time-line and the categories represented within it will be discussed in this section. A starting point for the discussion of the time-line is the actual length of time in which clients were engaged in counselling. Generally, in this study, clients were connected to their outpatient counsellors over long stretches of time ranging from six months to five years four months, with an average of two years five months. Participating clients experienced a successful outcome. This is consistent with Mclellan et al.’s (1994) study showing that the longer the treatment the better the outcome in psychosocial adjustment – an essential protective factor against relapse.
Miller and Rollnick (2002), the main proponents of motivational enhancement therapy have identified different therapeutic strategies that lend themselves to different stages of change that clients are in during their recovery. In a similar fashion, some individual categories were represented differently across the time-line pertaining to this study. This points at the role that different therapeutic strategies or approaches play at different time-line points. A general progression observed in the therapeutic work as carried out throughout the time-line of this study seems to follow five main steps: the development of rapport; expressions of understanding/compassion and the enhancement of the clients motivation; the understanding and addressing of personal struggles within the outpatient counselling supported by other therapeutic activities; and the continued and validating support thereafter to sustain change. This progression is congruent with Miller and Rollnick’s understanding of the different approaches/strategies to be used a different phases of change.

It is interesting to note that when the rigorous criterion of 40% participation rate was used to identify categories represented within the different time-line points for helpful categories, a greater number of categories within the initial phases emerged. The number of categories diminished consistently toward the ending phase. This might be indicative of the centrality that the initial phase might play in the addictions counselling experience. Other studies have also identified the central role of the initial counselling phases and first contacts (Bedi, Davis & Arvay, 2004).

A final reflection on the time-line relates to the presence of the category social support throughout the entire counselling period. This is consistent with the well-established role that social and peer support plays in the recovery from addiction. This finding is consistent with
Koski-Jannes and Tunner's (1999) finding that change is supported and maintained in part by the availability of social support

Similarities and Differences in Clients’ and Counsellor’s Perceptions of Outpatient Drug Addiction Counselling

The main value of studies comparing clients’ and counsellors’ perceptions of various elements related to the therapeutic process has been the uncovering of various discrepancies between the two parties (Fuller & Hill, 1985, Wark, 1994, Metcalf & Thomas, 1994). The results of this study generally differ from those of such studies that have found stark differences between clients’ and counsellors perceptions. Of all 24 categories emerging in this study, clients and counsellor generally agreed on 17; disagreed on another 4; and placed a different emphasis on 3. This corresponds to a general agreement of two thirds of the categories. The addiction counselling specialist who carried out the expert assessment of results commented that it was comforting to see the high congruence between clients and counsellors. In an attempt to understand this congruence, studies that have found fair agreement between the two parties, together with salient sample characteristics will be considered. Note-worthy sample characteristics are clients who experienced a successful outcome, counsellors who were more prone to check-in with their client and long-term therapy. These may have served as necessary conditions for this congruence to emerge.

A main reason for the high levels of congruence between clients and counsellors in this study can be explained by Llewelyn’s (1988) study of general counselling effectiveness. In Llewelyn’s study more differences in perceptions where found when outcome was poor. Successful outcome is core to the counselling experience that the current study examined. All clients within the study experienced success in their recovery and in the counselling experience.
Congruence between clients’ and counsellors’ perceptions thus might both be a measure of successful counselling and a contributor to success. Another reason for the high levels of congruence might be found in counsellor participant characteristics. Participating counsellors’ might have held an awareness of the importance of checking in with their clients. In their reasons for participating three of six counsellors stated that in part they accepted to participate because of their interest in the subject: an interest in success stories, in the comparison between clients and counsellors and an interest in what works in counselling. Interest in the subject might also be indicative of knowledge and awareness of the significance of clients’ perceptions in predicting success. This might have led participating counsellors to check in more frequently with their clients about what was helpful and hindering. In fact a helpful category Counsellor Pacing Self with Client and hindering category Counsellor Not Pacing Self with Client was identified in this study. This is a clear sign that counsellors did indeed actively seek the client’s feedback about what was helpful and unhelpful for them. This is reflected in incidents in which counsellors asked their clients about their needs, and asked them to assess the effectiveness of their counselling experience. Several studies have found that it is the clients’ ratings of the alliance, rather than the counsellors’ perceptions, that are highly correlated with outcome (Miller, Hubble & Duncan, 1995). Counsellors’ own evaluations of their success in building rapport are not enough. If counsellor participants actively sought the client’s feedback they might have been in a better position to understand the client’s evaluations of success. In this way counsellors might have been able to keep in tune with their clients’ needs throughout the counselling periods. This contributed to success and in turn to high levels of congruence between the two parties.

A final reason explaining the high congruence is possibly uncovered by Horn et al’s (1982) finding that congruence between clients and counsellor is higher at the end of long-term
therapy. The counselling experiences for clients in this study can surely be considered long term therapy because of the lengthy counselling periods that clients were engaged in. This reason for congruence might be closely related to the previous reason for congruence i.e. successful outcome. Clients maintaining their engagement in counselling over a long period of time might possibly be another sign that these clients perceived counselling as a successful and effective experience.

Amongst the high levels of agreement in categories identified by both clients and counsellors are some differences that are noteworthy. The most striking differences relate to a different emphasis placed on category Help in Understanding Self and Drug Use and sub-category Working on Solutions for Specific Personal Struggles. Both category and subcategory emerged from incidents identified by both clients and counsellors. However the former was emphasized strongly by clients while the latter was emphasised by counsellors. Clients emphasized the understanding and self-awareness as a step towards resolution of personal issues. By understanding themselves and their drug use clients started to gain control over their lives and their drug use. By identifying triggers and influences on their drug use, clients knew which situations were to be avoided to prevent relapse. They also identified the issues they needed to work on and somewhat set an agenda for their counselling. Another outcome was that the awareness started to bring resolution. Conversely, counsellors focused on the hands-on resolution of personal struggles. Once a clear difficulty/challenge clients experienced in their personal lives was identified, counsellors worked with clients on resolving it. Counsellors worked with clients on daily-living problems and on personal issues. Counsellors used psycho-education and modelling for clients' learning of new ways of being; and counsellors offered a space for clients to practice what they were learning e.g. practicing assertiveness and appropriate
ways of giving feedback. This difference in emphasis is important because previous studies (Fuller & Hill, 1985, Llewelyn, 1988) indicated that it is counsellors rather than clients who tend to focus on insight as a helpful ingredient for therapeutic change. This difference between clients in this study and those of other studies might be explained by the nature of the problem of drug addiction. For clients who struggled with addiction for years, getting to the bottom of the reasons for turning to a particular drug might be a significant step towards the resolution of personal struggles and consequently to increased control of the drug.

Other important differences in emphasis relate to the sub-category Counsellor Validation and Client Motivation, both emphasized strongly by client participants and not as much by counsellor participants. (The category Client Motivation is discussed elsewhere). Based on clients’ reports counsellors validated clients repeatedly. However counsellors did not mention validating events as often as clients did. As noted earlier, the validation for clients afflicted with addiction takes on special significance since they are usually heavily labelled. This difference in the emphasis on validation strongly asserts the need for counsellors not to take their validation of clients for granted.

Another surprising difference is the category Counsellor Listening, Empathy and Mirroring emphasized slightly more by counsellor participants. This might also be understood by clients taking the counsellors’ listening for granted since the categories that where featured more importantly for clients necessitated listening by the counsellor participants.

Apart from differences in emphasis between clients and counsellors, obvious differences exist within the helpful category identified by clients alone (Counsellor Expertise) and that by counsellors alone (Counsellor Felt Sense of Strong Connection with Client); and the hindering category identified by clients alone (Addiction as the Sole Counselling focus) and that identified
by counsellors alone (Counsellor Not Pacing self with Client’s Needs). As noted by the
addictions specialist who carried out the expert assessment of the data, the lack of identification
of Counsellor Expertise by counsellors is somewhat surprising because a fair number of clients
indicate that one reason they access a particular service is because of they will receive assistance
from skilled counsellors. The identification of Addiction as the Sole Counselling Focus by
clients alone is understandable. The incidents gathered in this category emerged from
counselling experiences other than the one with the counsellors interviewed in this study.
Because such events did not happen with the counsellors interviewed in this study it is
understandable counsellors would have not identified such incidents. The Categories Felt Sense
of Strong Connection with Client and Counsellor Not Pacing Self with Client’s Needs are
discussed elsewhere. What follows is a discussion of the comparison between clients and
counsellors with respect to previous literature on comparative studies.

*Similarities and Differences in the Perception of Helpful and Hindering Events*

As noted in the literature review very few studies comparing clients’ and counsellors’
perceptions of therapeutic effectiveness were found. In this section the similarities and
differences emerging from the study will be contrasted with these few studies that have carried
out client and counsellor comparisons of helpful and hindering elements within counselling. As
already noted in the previous section, high agreement on categories has been found between
client and counsellors in this study. Since similar studies have generally found more
disagreement between clients and counsellors only a few similarities between the results of this
study and previous ones could be identified. These will be outlined first.

The agreement between clients and counsellors in the category Working on the
Resolution of Personal Struggles was also found by Fuller and Hill (1985) and Cummings and
Barak (1995). Similarly, agreement on the sub-category Recommendations Regarding Treatment/Therapeutic Activities was also found in the Metcalf and Thomas's (1994) study. Interestingly the only similarity between clients and counsellors in Wark's (1994) study, that of continuing evidence of change during therapy was also replicated in this study.

Some categories on which clients and counsellors agreed in the study, did not find the same agreement in previous studies. In Wark's study (1994) clients alone mentioned the routine provided by structure; alternative perspectives offered by therapist; non-directive style of therapist; directive therapist; and a focus on positive by the therapist. These categories seem to correspond with the categories of this study: Counsellor Consistent Presence; Counsellor Directness/Challenges; Counsellor Pacing Self with Client; and Counsellor Validating Acceptance – categories on which clients and counsellors agreed in the current study. In a similar fashion, adolescent clients alone in Kaminer, Tarter, Bukstien and Kabene's (1992) study identified individual treatment contracting. This factor overlaps with the category Counsellor Setting and Respecting Boundaries. In my study this category emerged from incidents identified by both clients and counsellors.

A major disagreement between the current study and previous ones relates to the category Client Experiencing Progress/Success and Counselling Effectiveness identified by both clients and counsellors. In three studies comparing clients and counsellors, similar categories were identified by clients alone: Seeing positive results (Cummings & Barak, 1995); Clients perceiving relief from problems (Fuller & Hill, 1985); and Problem solution (Llewelyn, 1988).

These differences between the current study and previous ones may be understood in the light of the discussion presented in the previous section explaining possible reasons for the high agreement between clients and counsellors in the study. One other difference in the comparison
of clients and counsellors between the current study and previous literature could be understood as follows.

In Fuller and Hill’s study of single session outcome, counsellors alone considered insight as an important ingredient for change. Similarly in Llewelyn’s study of general counselling, counsellors alone mentioned gaining emotional and cognitive insight as helpful categories. In the current study insight was emphasised by clients. The category Help in Understanding Self and Drug Use emerged from incidents identified by both clients and counsellors. However this was one of those categories that was strongly emphasized by clients alone. As discussed earlier, for clients who struggled with addiction for years, getting to the bottom of the reasons for turning to a particular drug was a significant step towards the resolution of personal struggles and consequently to increased control of the drug toward total abstinence.

Similarities and Differences in the Perception of the Significance of the Counselling Experience

Previous studies examining helpful and hindering events within a specific treatment program, counselling approach or counselling area of focus, have generally failed to acknowledge or factor-in the role of extra-therapy events. In this study, the consideration and measurement of extra therapy factors revealed very important differences in clients’ and counsellors’ perceptions. Results from the clients’ and counsellors’ weighting of the significance of the counselling experience by the use of pie charts revealed a major difference: While clients tended to give a stronger weighting to the counselling experience when compared with their counsellors, counsellors tended to weigh the role that clients’ will and contribution had, more strongly. The difference in the counsellors’ perception of the clients’ role is more pronounced if one considers that two of the counsellors commented that when allotting percentages to the pie they failed to consider the client’s role. Clients attributing greater significance to the counselling
experience than counsellors, is consistent with Schedin’s (2003) finding about clients’ and counsellors’ perceptions of career counselling. In his study, clients perceived greater interpersonal closeness to their counsellor than counsellors did to their clients. This might indicate that clients’ live the counselling experience and relationship with greater intensity than counsellors many tend to do. This has ramifications for the great trust clients may vest in their counsellors and consequently the power that counsellors’ responses and interventions might have. The intensity of a constructive intervention can be replicated by destructive interventions such as those identified within the Blurred Boundaries and Boundary Related Unethical Behaviour Category.

Trustworthiness of Data

The seven validation procedures were carried out to test the trustworthiness of the category system generated by the researcher. All seven procedures, the test of comprehensiveness; inter-sorter reliability; independent judgement of the actual interviewing style; the check-in with each individual participant; participation rate; independent expert assessment; and literature verification provided very strong results. The strong results in all of the tests of trustworthiness of data indicate that considerable trust can be placed in the category system and that results are highly relevant.

Conclusion

In this chapter results were discussed in the light of previous and current literature. General agreement between clients and counsellors was observed in this study. The agreement was explained in terms of the special characteristics of the sample and the successful nature of the counselling experience. Amidst this general agreement some interesting differences were uncovered. Generally the category system and time-line fit well within current literature while
the general congruence in the comparison between clients and counsellors challenged some developing notions about disparities between the two parties. The soundness of the category system as deemed by the results of tests of trustworthiness augurs well for the identification of the study's implications for counselling practice, counsellor training, theory, research and policy. Such implications will be identified in the following chapter, as will limitations and ideas for future research.
CHAPTER 6
CONCLUSION

Using the Critical Incident Technique and the Time-Line Methodology this study attempted to identify clients' and counsellor's perceptions of helpful and hindering events in the outpatient drug addiction counselling experience and to identify similarities and differences between the two groups. In this concluding chapter major findings will be summarised and major implications highlighted. Implications related to theory, addictions counselling practice, counsellor training; policy and research will be identified. Limitations of the study will be noted to help the reader weigh the study's implications. Finally suggestions for future research sprouting from the study will be noted. The chapter will open with a reflection about the relevance and value of the study.

Relevance of the Study

The study examined the counselling experiences of clients who experienced successful addiction counselling and experienced success in their recovery from addiction. The experience of a successful outcome becomes particularly salient when one considers the low success rates reported by research in this field. Recruiting participants fitting the research criteria was a tremendous task spread over six months of continuous contacts. Although several counsellors were interested, only a few could identify clients who fit the research criteria. This may be a reflection of the low success rates in clients struggling with addiction reported in the literature. Consequently the sample of client participants in this study may belong to a very unique group of individuals who achieve control over their addiction.

The value of this study may be understood within the context of this reality. Because of low success rates, understanding what constitutes a successful experience is of paramount
importance in trying to replicate success with other clients. Because the study focused on success stories, results of the study may therefore be particularly salient.

The results about these experiences of success are especially relevant considering the research indicating that outcome in addiction treatment seems to be independent of the form or type of treatment (Mclellan, Alterman, Metzger, Grissom, Woody, Luborsky & O’Brien, 1994). This has emphasized the need to understand the elements that are helpful in addiction counselling. This study attempted to do this, taking in consideration the perspectives of both clients and counsellors. The separate consideration of clients’ and counsellors’ perspectives had the added benefit of identifying points of disagreement. Because it is clients’ perceptions of the counselling experience that tend to predict success, being able to understand differences between clients and counsellors becomes especially relevant. Practitioners may be alerted about areas they might have otherwise disregarded or taken for granted.

A further value of the study is the consideration of extra therapy events, something that was not attempted in studies comparing clients and counsellors or studies focusing on specific forms of treatment. This contributed to a fuller picture of the outpatient counselling experience.

The focus on success, the clear identification of helpful and hindering events, the separate consideration for clients and counsellors, and the consideration of extra-therapy factors capture a counselling experience that practitioners, researchers and policy makers may be interested to understand in an attempt to replicate it with other clients. The sound results from the tests of trustworthiness of data increases the faith in the results and the implications arising from results.

Major Findings

371 events were extracted from the fourteen interviews carried out with seven clients and their counsellors. 83% of these events were directly related to the outpatient counselling, 9%
were related to experiences outside the outpatient counselling (other therapeutic activities and social support) and 8% were related to client characteristics and/or experiences. The grand majority of events were helpful, 88%, while 12% were hindering. Out of these events were developed 24 categories, 19 of which are helpful and four hindering. The hindering categories were developed mainly from hindering events identified in counselling experiences other than the one that was examined in this study.

Clients and counsellors agreed on two thirds of the categories. The helpful categories emerging from incidents mentioned by both were Counsellor Validating Acceptance; Counsellor Directness/Challenges; Counsellor Consistent Presence; Counsellor Pacing Self with Client; Working on the Resolution of Personal Struggles; Counsellor Help in Bridging Client with System; Counsellor Self-Disclosure; Counsellor Setting and Respecting Boundaries; Counsellor and Client Sharing humour; Relapse Prevention Work; Counsellor-Client Sharing Attributes/Experiences; Therapeutic Activities Accompanying Outpatient Counselling; Social Support; and Client Experiencing Progress/Success and Counselling Effectiveness.

The hindering categories emerging from incidents mentioned by both clients and counsellors were Blurred Boundaries and Boundary-Related Unethical Behaviour; Client Forced/Pressured into Treatment; and Lack of Counsellor Consistent Presence.

Disagreement between clients and counsellors was observed in two ways. In categories that were strongly emphasised by one of the two parties, or in categories that developed from incidents identified by either clients or counsellors alone. Disagreement in emphasis was also observed at the sub-category level.

Helpful categories emphasized by clients alone were Help in Understanding Self and Drug Use and Client Motivation. A helpful subcategory highly emphasized by clients was
Counsellor Validation. A helpful category of incidents identified by clients alone was Counsellor Expertise and a hindering category identified by clients alone was Addiction as the Sole Counselling Focus.

A helpful category emphasized by counsellors alone was Counsellor Listening, Empathy and Mirroring. One helpful subcategory emphasized by counsellors was Working on Solutions for Specific Personal Struggles. Another helpful category of events identified by counsellors alone was Counsellor Felt Sense of Strong Connection with Client. The Hindering category emphasised by counsellors was Counsellor Not Pacing Self with Clients Needs.

Another major difference between clients and counsellors related to their perceptions of the significance of the counselling experience. While clients tended to place greater value in the role that the counselling experience played in their recovery, when compared with their counsellors, counsellors tended to give a greater value to the clients’ will, motivation and contribution to the counselling process.

Theoretical Implications

The study extended the research on comparison of counselling dyads to a field in which such comparisons have been scarcely attempted namely the drug addiction field. Together with individual studies that have found higher levels of agreement between clients and counsellors, the study challenges the notion that clients and counsellors tend to disagree in their perception of counselling effectiveness. Furthermore the study identified factors that can contribute to increased agreement between the two parties. A positive counselling outcome, a counselling experience that stretches over a long period of time, counsellors who are more prone to check-in with their clients about counselling effectiveness, are all factors that increased the likelihood of client and counsellor congruence.
Notwithstanding the possibility for increased agreement between clients and counsellors, the existence of differences in perceptions needs to be acknowledged. In this study of very successful counselling experiences characterised by clients and counsellors who perceived the counselling relationship and their counselling partner as very special, some differences still emerged. As much as counsellors established an empathic connection with their clients and paced themselves with them, there still existed areas in which they might not have been on the same page of their clients.

Implications for Counselling Practice

Implications for addiction counselling practice emerge mainly from the differences in perceptions, particularly the areas in which counsellors failed to agree with clients. Three major implications arise from this area of disagreement. Another three implications arise from the results in general.

Clients emphasized the role of the help they received to understand themselves and their drug use. On a similar plane they were hindered when addiction was the sole focus of the counselling sessions. For clients who struggle with addiction over long stretches of time, and for whom drug use is a form of self-medication, getting to the bottom of root causes may have special value. The awareness of these root causes is a step toward resolution in and of itself. Counsellors in the study focused more on the finding and working on solutions for personal struggles. However the clients focus on the need for awareness suggests a need for counsellors not to rush into responding and working on solutions but rather allowing the required time for clients to reach an awareness of the influences and triggers of their addiction.

Clients unequivocally emphasized the significance of experiencing validation from their counsellors (subcategory: Counsellor Validation). This was an area that counsellors gave
considerably less attention to. Counsellors in the study might have taken this area for granted. However clients’ perceptions of its significance show a need for the role of validation to be taken very seriously. Validation for clients who may experience harsh labelling such as addict, junkie, or crack head, has enormous power. The counsellors’ affirmation of the client’s qualities, feelings, actions or decisions can increase self worth, engender a feeling of being respected and valued and a reassurance that the client is moving in the right direction. Such validation might be especially called for when clients themselves or other professionals question the value of the clients’ actions or decisions.

Counsellors in the study underestimated the role and value that their expertise played in the clients’ recovery. Clients who experienced their counsellors as experts or who learned about their counsellors expertise, tended to place more faith in the counselling experience and as a result experienced increased motivation to invest in counselling. Clients may actually benefit if counsellors do not shy away from acknowledging their expertise. This could be done formally or informally during sessions. Counsellors may communicate to their clients their years of experience and the level of their training specialisation.

A fourth implication relates to the role that the person-centered approach might play in addictions counselling. The 12-Step, Cognitive Behavioural Therapy and Motivational Enhancement Therapies have been considered the most prominent approaches to address substance abuse and dependence. The person-centered counselling approach may have been unacknowledged. However the significant overlap between categories in this study and the main tenets of the Rogerian counselling approach underlines the importance of this approach in drug addiction counselling.

A fifth implication emerges from the interplay of categories in the time-line. The role of
the counsellors' validation for the clients has already been noted. When placed in the context of counselling progression over time, such validation does not rule out the role and need of a healthy dose of challenging and directness. Clients who entered counselling with low motivation to change, seemed to progress when the validation, and rapport building interactions were accompanied by expert recommendations, challenges or invitations for clients to challenge themselves.

A final implication and possibly the most crucial one, emerges from a factor that might have led to the high level of congruence between clients and counsellors in this study – namely the counsellors tendency to check in with their clients about the effectiveness of the counselling experience. This was manifested in the identification of the helpful category Counsellor Pacing Self with Client and the hindering category Counsellor Not Pacing Self with Clients' Needs. Similar to other studies that have compared clients and counsellors, this study underscores the need for counsellors to check in with their clients more deliberately during counselling sessions. Such practice creates a stronger therapeutic alliance, allows counsellors to fully understand clients’ needs and to respond to them in tailor-made ways. Previous studies that did not find congruence alerted counsellors and strongly urged them to check in with clients. This study communicates the same urge, out of knowledge of the clear benefit inherent in this practice.

Implications for Counsellor Training

In the same fashion that this study alerts counsellors in practise, it alerts counsellors in training to examine counselling practices and theoretical approaches in the light of the clients’ subjective experience. The use of the Critical Incident Technique allowed for the identification of observable occurrences. The categories developed in the study were created from incidents that were described using observable, behavioural terms. Counsellors in training can find such
categories and incidents helpful in grasping what the outpatient drug addictions counselling is about. Each category can correspond to a training area and incidents within each category can offer very vivid examples of how particular skills, techniques, approaches, communications, or actions can be put into practice. Counselling instructors should orient their training on categories featuring highly in the clients’ experience.

Implications for Policy

At present, changes in policy addressing the drug problem in Vancouver are taking place. A four pillar approach (City of Vancouver, 2000) adopted by the city of Vancouver to deal with the drug problem, considers treatment together with prevention, enforcement and harm reduction as a major channel for change in this area. The understanding of the ways in which clients succeed to control their addiction may suggest ways to improve programs and services (Prosavac & Carey, 2003). A simple review of treatment characteristics of client participants (table 3 in the methodology chapter) offers straightforward implications for the organisation of outpatient drug addiction services. The duration of the outpatient counselling, the number of counselling clusters and the number of sessions received in the outpatient setting and other services accessed by clients who experienced a successful outcome, are all indicative of a considerable investment of time and energy delivered by counsellor participants in the study. The average duration of the counselling relationship was two years five months, with an average of 28 sessions. In the context of these treatment characteristics the results of the study point at four major implications for policy regarding the structuring of addiction counselling services.

The counsellors’ consistent presence throughout the entire counselling period played a very crucial role in the clients’ recovery. This speaks to the central role of the counselling relationship. When the service is structured in a way that allows a client to reconnect with the
same counsellor after a period of discontinued counselling, clients take less time to re-engage. Because the relationship would have already been developed, clients move more quickly to deeper counselling work, and their recovery is accelerated. Such an arrangement is not only beneficial for the clients but also fosters the service’s efficiency.

Another implication closely linked to the counsellors’ consistent presences relates to the length of time over which counselling was offered and the extensive number of sessions offered to client participants. Some services are developing very strict guidelines around the number of sessions that a client can be offered. Although some clients may be helped effectively within such boundaries, other clients may end up feeling pressured to ‘recover’ in a set number of sessions. Others may have the counselling service terminated prematurely leaving them with feeling unfinished, or alone with very raw feelings. Especially for clients who lived through traumatic life-experiences, and require longer term counselling, the strict guidelines around what they are offered may prove to be detrimental.

Client participants in the study spoke about the significance of the prompt response to their call for help. When clients were given intake appointments close to their call for help, they felt hope that help was near and hope that they were not going to be alone in facing their struggles. Conversely, other clients spoke of incidents in which a long period of time had passed since they called in for help. On some occasions these clients had overcome the crisis point and lost their motivation to do something about their addiction. Such incidents question the use of waiting lists as measures to control service costs.

The hindering events identified in this study generally happened in services other than the ones examined by this study. Such incidents speak to the lack of professionalism in some of the agencies offering addictions counselling. This is alarming when one considers the serious
unethical practices that client participants identified in this study, and suggests the need for legislation about standards for practice in the field. Policy makers may consider the need for structures that aid clients to access and choose services and counsellors that can effectively help them.

A final implication for policy relates to the employment of drug and alcohol counsellors. Clients in the study repeatedly mentioned a common myth within the drug user subculture that only counsellors who had their own addiction experience can truly understand and help someone in their recovery. None of the counsellors in this study had a personal experience of drug addiction and some clients reported the unique benefits of knowing that their counsellors were addiction specialists. Without devaluing that role that individuals who had personal addiction experiences can play in supporting others in recovery, this study affirms the need for competent counsellors with high levels of training.

Implications for Research

The study’s methodology and results also have implication for research. The first of these relates to the time at which critical incidents are collected. Literature about the critical incident technique states that the more recent and direct observations of an event, the better the quality of data (Flanagan, 1954). In this study the time between the last counselling session and the research interview ranged from one month to a year, with an average of four months. Although incidents where collected not as close to the actual counselling experience as recommended, the gap between the experience and the collection of events did not seem to hinder participants from identifying and fully describing specific incidents. The centrality of the counselling experience in the clients’ life might have counterbalanced the possible loss of details due to the gap between
the counselling experience and the interview. This might suggest that in the study of peak experiences a wider gap between the experience and the collection of incidents is permissible.

A second implication for research relates to effectiveness of the use of pie charts to examine a particular experience within the wider context in which it happens. In this study, participants were asked to weigh the significance of the outpatient counselling experience in the context of other experiences that contributed to the clients’ recovery, using a ten-piece pie chart. This proved to be a very straightforward way to assess the significance of the counselling experience within a wider context. Because of the helpful or hindering role that extra therapy events can play in the clients healing process (Hill, 1991), measuring such events is of paramount importance. The use of the pie chart is one method that can be used in this measurement.

A third and final implication relates to the analysis of critical incidents. As participants described incidents, they were specifically asked about what led up to the incident, what the incident entailed and what the observed outcome was. In this study, the developed categories were based on the observed incident rather than on its outcome. However alternative analyses could be carried out. Some incidents had multiple outcomes. On the other hand different incidents achieved the same outcome. This study analysed the incidents alone, however a mutual analysis of incidents and outcomes could also be carried out.

Limitations of the Study

Four possible limitations arise from sample characteristics and two relate to the tests of trustworthiness of data. The study provided a full description of helpful incidents within the outpatient drug addictions counselling. On the other hand it was not as efficient in providing an exhaustive picture of hindering events. This bias toward helpful incidents was expected because
of the study's focus on success stories. The inclusion of hindering events from other counselling experiences was an attempt to shed light on possible hindering areas. However a fuller picture of hindering events can be achieved by a study with a focus on unsuccessful experiences.

Clients in the sample were all Caucasian. This is an area in which variability in the sample related to race was not achieved. As a consequence results from the study may not reflect the experience of other racial groups.

A third limitation within the sample characteristics relates to the stability in the clients' recovery. Current literature indicates that three or more years of abstinence is usually indicative of a full recovery. In this study, the average length of abstinence at the time of the interview was one year seven months. The study focused on clients who experienced a successful counselling experience and a successful outcome in their recovery. The decision not to interview participants with lengthy periods of abstinence was motivated by a need to capture descriptive details about events occurring in the counselling experience. Notwithstanding, this methodological decision the possibility of relapse for some of the client participants, although not probable, is possible.

A fourth limitation could possibly be related to a slight bias in the counselling approaches adopted by counsellor participants. Two small commonalities appeared amongst these approaches. Three of six counsellors used the person centred approach amongst other approaches and four counsellors stated that they used psychoeducation at some point in the counselling experience (see Table 5 in Chapter 3). This could be indicative of a slight bias towards the person centred approach and the use of psychoeducation. A high level of variability was generally observed in counsellors' approaches and counsellors who acknowledged the use of the person-centred approach did not use it exclusively. This high level of variability may have counter-balanced the effects of this slight bias.
With regard to limitations related to the tests of trustworthiness of data, two limitations need to be noted. The first related to the check-in interview. Nine of 14 check-in interviews were carried out. Consequently the second interview with the other five participants was not conducted. Results form the check-in interview may therefore be incomplete. Notwithstanding this incompleteness, the positive results from the check-in interviews with the nine participants is indicative of a general trend that the data extracted from each interview tended to be a very accurate reflection of what participants shared during the interview.

The second limitation related to trustworthiness tests is linked with the test of comprehensiveness. While redundancy for categories identified by counsellors was achieved by the fifth interview, the redundancy of categories identified by clients occurred at the seventh. This is generally a positive result. At the same time one is left with the question of whether this redundancy would have also been observed if data from yet another interview would have been introduced to the data set.

Suggestions for Future Research

Some suggestions for future research relate to the replication of the study with the aim of strengthening the category system developed in this study. Another suggestion relates to an idea of a study that sprouts from the process that participants when through during this study.

A series of replication studies could be carried out to strengthen the category system developed in this study. A similar study with more participants would be helpful to affirm or discard categories identified in this study. Replication studies applied to specific client groups such as clients from racial groups other than white, or clients pertaining to particular age brackets could also be carried out. Such studies could shed light on possible differences or points of convergence with the current study. In this study participants ranged from ages 27 to 76. Some
participants from specific age brackets identified some age-specific incidents. One example is
derived from Bob’s experience when he spoke about how people had looked down upon him
because he was using crack at and elderly age and how his counsellor’s normalization had
special significance. Such an example points at the unique role that the clients’ age might play in
the overall recovery and counselling experience. The variety in client characteristics in this study
contributed to a richness in the category system. Of equal importance might be studies dedicated
to the comparison of counsellors and clients in specific age groups: teenage, young adult, middle
age and elderly. A final replication study could be carried out to examine the experiences of
clients who did not have a successful counselling experience. Such a study might be in a better
position to extract hindering events and thus achieve a fuller understanding of hindering events
in outpatient drug addiction counselling.

Another idea of future research sprouts from the current study. It might be interesting to
explore the effects for clients participating in a study about successful stories. One client
participant commented that her participation in the study was for her a form of relapse
prevention. Another commented about the gratification he felt about participating in a study
about successful stories. When asked about their reasons for participating, five of seven clients
replied that their participation was a way of giving back and contributing to others. Three of six
counsellors identified clients for participation in the study upon the awareness that the clients’
involvement in research might benefit them. Because of these apparent benefits, it might be
worth understanding the experience of being interviewed about a successful counselling story.
Such a study could explore the full experience of being interviewed and also the reading of the
results by the participants. Possible research questions could be: What is the effect of being
interviewed about a personal successful story? What effect does it have for clients to read the
results about their own successful story?

Conclusion

In this study a qualitative comparison of clients’ and counsellors’ perceptions of helpful and hindering events in drug addiction counselling was carried out. The study extended the current body of research by attempting to understand similarities and differences in perceptions of counselling dyads within a counselling area in which such a comparison had not been carried out. General agreement between clients and counsellors was observed in this study. The agreement was explained in terms of the special characteristics of the sample and the successful nature of the counselling experience. Although some interesting differences were uncovered, the general congruence in the comparison between clients and counsellors challenged some developing notions about disparities between the two parties. The soundness of the category system as deemed by the results of tests of trustworthiness indicates that general faith can be placed in the results and their implications.

The striking emphasis on helpful critical incidents is a reflection of the successful nature of the counselling experiences examined in this study. The study achieved an in-depth understanding of what is critical in the journey towards recovery from drug addiction through the help of outpatient counselling. Hindering elements may not have been fully understood however the study has the potential of equipping counsellors with the practices that contribute to success. The separate consideration of clients’ and counsellors’ perceptions can further help counsellors examine their counselling practices and theoretical approaches in the light of the clients’ subjective experience. As noted by an anonymous writer, the road to success is always under construction. I am hopeful that this study did indeed serve as reliable construction material for the extension of this road toward successful outpatient counselling for clients struggling with
substance abuse and dependence.
REFERENCES


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APPENDIX A

ETHICS CERTIFICATE
APPENDIX B

LETTER OF INITIAL CONTACT – CLIENT AND COUNSELLOR VERSIONS
APPENDIX C
SUBJECT CONSENT FORM – CLIENT AND COUNSELLOR VERSIONS
in a way that properly reflects your experience. This can be done by meeting a second time for approximately 45 minutes or by phone.

3. If you accept to participate you will be kindly asked to grant me and your counsellor, the permission to talk about your counselling experience.

The total time requested from you is two hours and a half over a period of about two months.

**Potential Risks or Benefits:**

No direct risks are anticipated as a result of the study. You may find participation in the study satisfying since your contribution may benefit future clients.

**Confidentiality:**

Your identity will be kept strictly confidential. A pseudonym will be used instead of your real name in the transcripts and in any communication of results. Any other names, places, dates or identifying information will also be changed to ensure your anonymity. Transcripts will be identified only by a code number and will be kept locked in a filing cabinet in the researcher's office. Any computer file containing data from your interview will be password protected.

**Compensation:**

In order to compensate for the costs of transportation each participant will be reimbursed with the sum of up to $10.

**Contact for information about the study:**

If you have any questions or concerns with respect to this study, you may contact Dr William Borgen or Mr Anthony Gatt at the numbers listed above.

**Contact for concerns about your rights as a participant:**

If you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.
Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without consequences of any kind.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

__________________________  _________________________
Signature of Participant        Date

__________________________
Printed Name of Participant signing above

Thanks for accepting to participate in this study. Your contribution is deeply valued.
3. If you accept to participate you will be kindly asked to grant me and your client, the permission to talk about your counselling experience with that client.

The total time requested from you is two hours and a half over a period of about two months.

**Potential Risks or Benefits:**

No direct risks are anticipated as a result of the study. You may find participation in the study helpful to have an in-depth look at the work with a particular client.

**Confidentiality:**

Your identity will be kept strictly confidential. A pseudonym will be used instead of your real name in the transcripts and in any communication of results. Any other names, places, dates or identifying information will also be changed to ensure your anonymity. Transcripts will be identified only by a code number and will be kept locked in a filing cabinet in the researcher’s office. Any computer file containing data from your interview will be password protected.

**Remuneration/Compensation:**

There will be no monetary compensation to participants

**Contact for information about the study:**

If you have any questions or concerns with respect to this study, you may contact Dr William Borgen or Mr Anthony Gatt at the numbers listed above.

**Contact for concerns about your rights as a participant:**

If you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.
Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without consequences of any kind.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Signature of Participant _______________ Date _______________

Printed Name of Participant signing above _______________

Thanks for accepting to participate in this study. Your contribution is deeply valued.
APPENDIX D

INTERVIEW PREPARATION FORM – COUNSELLOR VERSION

Interview Preparation (Kindly hand in this form during interview)

Part A

I invite you to take some time to think about the counseling experience you had with the identified client. Think of the experiences and specific events that you think have contributed positively to the client’s recovery. Also think of experiences and events that you think might have been unhelpful or hindering to the client. If it is helpful, you may jot down some notes and bring them with you for the interview.

Part B

Total Number of counselling sessions with client in out-patient setting: _____________
Period covered (year/month to year/month) _________________ to _________________

If you had multiple clusters of sessions over time:

(a) how many clusters did you have? _________________
Cluster 1 period covered __________ to ________ No. of sessions ________
Cluster 2 period covered __________ to ________ No. of sessions ________
Cluster 3 period covered __________ to ________ No. of sessions ________
Cluster 3 period covered __________ to ________ No. of sessions ________

Last session with client (month/year) _________________
Have you reached closure/termination with client: yes / no
Other services/treatment client received relating to addiction recovery
(apart from counseling sessions with you):
(year/month) __________________________________________
(year/month) __________________________________________
(year/month) __________________________________________
Counselling approaches used: __________________________________________
APPENDIX E

INTERVIEW GUIDE – CLIENT AND COUNSELLOR VERSIONS
Client-Participant Interview Guide

Demographic Data

Client Code:
Age:
Gender:
Race:
Educational Background:
Current Employment:
Employment background:
Marital Status – Children:
Socio-economic status:
Socio-economic status:
Mental and physical health:
Criminal Involvement:
Past Abuse:
Family History:

Addiction Background Data

Substance/s used:
Age at first use:
Length of addiction:
Time Abstinent:
Treatment history including past relapses:
Reasons for seeking treatment:
Reasons for quitting:

Introductory Questions

How did you decide to participate and why?
Did you have a chance to think about the counselling sessions with the client?
Critical Incident Interview for Client Participant

Invite participant to layout a time-line of his counselling experience representing the time between the start and the ending the outpatient counselling experience.

6. Think back through your counselling experience. What happened that helped you make changes regarding your addiction? You may want to think of most helpful experiences followed by next most helpful. What is the first thing that comes to mind?

7. Where does this incident fit on the time-line representing the time between your first and last sessions? (The participant can pin-point the approximate position of the event on the time-line drawn on a sheet of paper at the beginning of the critical incident interview).

8. What happened that could have hindered you in counselling? You may want to think of least helpful experiences followed by next least helpful. What is the first thing that comes to mind?

9. Where does this incident fit on the time-line?

10. If you had other counselling/treatment experiences apart from the counselling you had with your outpatient counsellor, what events where helpful in these other counselling experiences? What events were not helpful?

Clarification questions used to help participant articulate the event:

What exactly was the incident?
What lead up to it?
What were the after effects?
What exactly happened that was helpful/not helpful?
How did you know that event was helpful/not helpful?

Closing Questions:

Is there anything else you would like to add?

If you had to imagine a pie divided in 10 pieces - and this pie represents the experiences that helped you move out of addiction - how many pieces of the pie would be taken up by the outpatient counselling experience you were engaged in? What do the other pieces of the pie represent?

How do you feel after this interview? (Check-in Question)
Counsellor-Participant Interview Guide - Orientation

Demographic Data – Counsellor Information

Counsellor Code:
Years of Work Experience in Addictions Field:
Counselling Training:
Age:
Gender:
Race:
Drug Addiction History:

Introductory Questions

How did you decide to participate and why?
How did you identify the client participant?
Did you have a chance to think about the counselling sessions with the client?

Critical Incident Interview for Counsellor

Invite participant to layout a time-line of his counselling experience representing the time between the start and the ending the outpatient counselling experience.

1. Think back through your counselling experience with this client. What happened that helped your client make changes regarding his/her addiction? You may want to think of most helpful experiences followed by next most helpful. What is the first thing that comes to mind?
2. Where does this incident fit on the time-line representing the time between your first and last sessions? (The participant can pin-point the approximate position of the event on the time-line drawn on a sheet of paper at the beginning of the critical incident interview).
3. What happened that could have hindered your client in counselling? You may want to think of least helpful experiences followed by next least helpful. What is the first thing that comes to mind? What events/experiences might have not been helpful OR might have hindered?
4. Where does this incident fit on the time-line?
5. If the client had other counselling/treatment experiences apart from the counselling
he/she had with you; what events were helpful in these other counselling experiences?
What events were not helpful?

**Clarification questions used to help participant articulate the event:**
What exactly was the incident?
What lead up to it?
What were the after effects?
What exactly happened that was helpful/not helpful?
How did you know that event was helpful/not helpful?

**Closing questions:**
Is there anything else you would like to add?
If you had to imagine a pie divided in 10 pieces - and this pie represents the experiences that helped the client move out of addiction - how many pieces of the pie would be taken up by the outpatient counselling experience the client was engaged in with you? What do the other pieces of the pie represent?
How do you feel after this interview? (Check-in questions)