General Counselling Skills

RECOMMENDED USE

When it comes to counselling, there is nothing unique about the field of alcohol and other drugs. The same skills that are effective for general counselling are also effective for counselling people with drug-related problems. Research has shown that treatment for alcohol and other drug problems is more likely to be successful if therapists use empathic counselling skills (Miller, Benefield & Tonigan, 1993). On the other hand, counselling alone is not usually sufficient to change the drug-taking behaviour of most clients. Rather, good counselling skills will enable you to develop a strong working relationship with your client that will support the implementation of specific strategies designed to combat the drinking or drug problem.

GOALS

The counselling process therefore aims:

- To build a trusting relationship where your client can communicate her concerns and describe her behaviours without fear of judgement.
- To encourage your client to see treatment as a mutual enterprise where she makes active decisions and where you value her ideas and support her endeavours. Your client is encouraged to develop a sense of responsibility and self-confidence.
- To reduce your client’s fear and distrust of treatment programmes and thereby encourage her to continue attending treatment and follow-up appointments. Not all clients who are assessed will feel ready for treatment. If a client’s initial experience of the treatment staff and environment is positive, this may encourage her to return for treatment at some future point in time.
METHOD

The counselling style described here combines the client-centred approach outlined by Egan (2002) with the motivational interviewing style developed by Miller and Rollnick (2002). It is an approach that encourages your client to explore her own concerns through open-ended questions and empathic feedback. It is client-centred because your client defines which issues are important. However, it is not a wholly ‘non-directional’ approach, because the motivational interviewing style (Chapter 3) selectively emphasises those issues that favour a change in your client’s drug-using behaviour.

This approach is quite different from the style of counselling that involves confrontation. We do not recommend that you confront your client or argue with her in order to convince her of the need for change. In fact, confrontation can be quite counterproductive because it increases your client’s resistance to change and might even cause her to increase her substance use (Miller et al., 1993). Instead, we suggest that you foster your client’s self-confrontation through open-ended questions and selective feedback.

The ideal therapist is someone who:

- Shows empathy and respect for clients.
- Develops a supportive relationship with the client.
- Has an organised approach to each case and takes careful progress notes.
- Is creative and imaginative.
- Shows self-awareness by not imposing personal concerns on clients.
- Has good common sense and social intelligence.
- Is action-oriented.

In drug and alcohol work, there is an increasing focus on the engagement of clients in the treatment process. This focus is partly a response to the high number of clients dropping out of drug and alcohol treatment. The more engaged your client is in the treatment process as indicated by her attending and participating in sessions in a meaningful way, the more likely she is to succeed in her goals. Successful engagement depends both on client characteristics and on your ability to develop a strong therapeutic relationship which is perceived as helpful and empathic (Shand, Gates, Fawcett & Mattick, 2003). It is also helpful to discuss your client’s expectations about how long she will be in treatment. For example, you might agree to review her progress after a certain number of sessions. Research also suggests that engaging and retaining clients in treatment depends on overcoming any practical barriers (such as the need for transportation or child care) and the inclusion of relapse prevention training in your intervention.

When you and your client decide to terminate counselling, allow time to review your work together, to reflect on her feelings about finishing and to discuss your plan for extended care (Chapter 17, Extended Care). Of course, your client might drop out
of treatment before *you* think she is ready! If that happens, a follow-up phone call may help to renew contact.

The microskills that will assist you in effective engagement and counselling are described below.

**EMPATHY**

Empathy is both a counselling value and a communication skill. As a value, it means that you are committed to understanding your client from *her point of view*. It is as if you are standing in the other person’s shoes, looking at the world through her eyes and asking ‘What is it like to be this person?’

Empathy requires an *attitude of respect* towards your client. As an empathic therapist your role is to help your client to find her own solutions rather than to impose a solution on her. Show your client that you believe in her ability to make effective choices and that you value the time and effort you spend with her. Convey your empathy not only in what you say, but also in your intonation and body language. Be aware of any differences between you and your client in cultural background, age or gender and always check the accuracy of any assumptions you might make about your client’s experiences.

Empathy is different from sympathy. If you feel sympathy, you tend to take sides with your client, and this can distort your ability to hear the whole story. For example, when feeling sorry for your client, you might overlook the way in which self-pity is preventing her from taking constructive action. Being empathic does not mean that you always agree with your client’s opinion. Rather, it involves accepting her view and being interested in exploring its implications.

**THINGS TO AVOID**

The key to an empathic approach is to avoid judgemental or evaluative responses. You are trying to understand how it is for the client, not how *it should be*. Some non-empathic approaches can obstruct further understanding of your client’s perspective. Miller and Rollnick (2002) refer to these approaches as ‘roadblocks’. They include:

- Ordering or commanding.
- Warning or threatening.
- Giving advice or providing solutions.
- Arguing or persuading.
- Moralising.
- Disagreeing, judging or criticising.
- Ridiculing or labelling.
- Interpreting or analysing.
- Reassuring or sympathising.
- Withdrawing, distracting or humouring.


REFLECTIVE LISTENING

As a communication skill, empathy involves sharing your understanding of your client’s point of view. One way to do this is by listening reflectively. Listen to what your client says and notice other signs of emotional expression, such as her emphasis on certain words, her facial expressions and body language, and the intensity of her expressed feelings. Try to identify the core messages being expressed and then share them with your client. For example, Egan (2002) suggests a formula that you could use to guide you:

You feel . . . (add client’s expressed feelings)
Because . . . (add the experiences and behaviours that give rise to the feelings)

For example:

**CLIENT:** ‘I don’t even see why I have to be here! I wouldn’t have come except my parents threatened to kick me out of home if I didn’t.’

**THERAPIST:** ‘You feel really angry because your parents pressured you to come against your own judgement. You don’t want to get kicked out but you don’t want to be here either.’

Of course, this formula is only a starting point. If you start every sentence this way, your conversation will seem less than genuine. However, the formula is a useful reminder as you are developing your skills of empathy and reflective listening.

What we assume people mean is not necessarily what they really mean. Reflective listening enables you to:

- Show your client that you are really listening to her.
- Check whether your understanding of what your client has said is consistent with her intended meaning.
- Feed back your client’s stated concerns, thereby strengthening her awareness of her own reasons for change.
- Empower your client to correct inaccurate feedback, while studying herself through your reflection.

Miller and Rollnick (2002) have also suggested that feedback in the form of a statement, rather than a question, is likely to be more effective in encouraging your client to explore. The following example taken from their book shows how exploring one of your client’s concerns with reflective listening might encourage your client to identify other concerns:

**CLIENT:** ‘I worry sometimes that I may be drinking too much for my own good.’

**THERAPIST:** ‘You’ve been drinking quite a bit.’
Client: ‘I don’t really feel like it’s that much. I can drink a lot and not feel it.’
Therapist: ‘More than most people.’
Client: ‘Yes. I can drink most people under the table.’
Therapist: ‘And that’s what worries you.’
Client: ‘Well, that and how I feel. The next morning I’m usually in bad shape. I feel …’

(Miller & Rollnick, 2002, p. 70)

ROLLING WITH RESISTANCE

Resistance is an observable behaviour (such as arguing, interrupting, denying and ignoring) that occurs during treatment and signals that the client is moving away from a particular change. Resistant behaviours are often responses to the content and style of an interaction between a client and her therapist. It is important to avoid evoking or strengthening resistance because the more your client resists the less likely she is to change. That is, resistance allows clients to express well-practised reasons for not changing. There may be a number of reasons clients ‘resist’. For example, a client might have low self-esteem and little belief in her ability to change. Alternatively, she might have been coerced into treatment and therefore not yet be ready to consider change.

Miller and Rollnick (2002) have coined the term ‘rolling with resistance’ to describe non-confrontational methods for dealing with clients’ resistance. Most of these involve reflective listening techniques. For example, suppose your client says:

‘I don’t see why my drinking is such a problem. All my friends drink as much as I do.’

By using some of the methods outlined by Miller and Rollnick (2002), you could respond to this statement in the following ways.

Simple Reflection

Acknowledge your client’s resistance in your reflective response. For example:

‘You can’t see how your drinking can be a problem when your friends don’t seem to have any problems.’

Amplified Reflection

Couch your feedback in an amplified or exaggerated form to elicit the other side of your client’s ambivalence. This should be done in a way that avoids a sarcastic tone. For example:
‘If your friends have no problem with their drinking then there’s nothing for you to worry about.’

**Double-sided Reflection**

Acknowledge what your client has said and add the other side of your client’s ambivalence. Try to draw on things that your client has said previously.

‘I can see how this must be confusing for you. On the one hand you’ve come in because you’re concerned about drinking and how it affects you, and on the other hand, it seems like you’re not drinking any more than your friends do.’

Miller and Rollnick (2002) have provided further comprehensive examples and additional techniques in their chapter on *Responding to Resistance*.

**OPEN-ENDED QUESTIONS**

Ask your client questions that encourage further exploration. Closed questions that require a ‘yes’ or ‘no’ response or a one-word answer are useful for getting at specific information. They should be used sparingly, however, because they can turn the therapy session into a fact-finding mission. They discourage further exploration by your client. Try to transform them into open-ended questions. For example:

‘Has your drinking changed over time?’

vs.

‘How has your drinking changed over time?’

**ELABORATING**

Use open-ended questions to elaborate on any statements by your client that express concern about her substance use, her intention to make a particular change or her feelings of self-confidence. For example, when she expresses a desire to make a change in her substance use, flesh out the details by asking ‘What type of change?’ ‘When would be a good time?’ or ‘Can you give me an example?’

**REFRAMING**

Reframing is a way of acknowledging what your client has said and, at the same time, drawing her attention to a different meaning or interpretation that is likely to support change. For example, past experiences with treatment failure can be reframed as evidence that your client may not have found the approach most suitable
for her. Reframing your client’s explanation of tolerance can also be important (see p. 57).

**AFFIRMING THE POSITIVES**

Show support for your client’s efforts during therapy with direct affirmations. For example, you should acknowledge the courage involved in coming to therapy and commend your client for taking that step. Highlight your client’s strengths in coping or refraining from drug use. Draw her attention to those positive things that she might have trivialised. If your client seems to be overwhelmed by her problems, use solution-focused questions to identify exceptions to the problem (Chapter 18, *Case Management*).

**SUMMARISING**

Summary statements help to draw together the material that you have discussed with your client and can be used for many purposes. Show your client that you are actively listening by summarising the issues that she has raised. Use summaries to:

- Highlight important discoveries.
- Prompt a more thorough exploration.
- Give the broader picture when your client seems blocked.
- Provide an opportunity for your client to hear her own stated reasons for change.
- Highlight your client’s ambivalence by linking the negatives and positives together in the one statement (e.g., ‘On the one hand, you have said that you like drinking because . . . while, on the other hand, you are concerned about . . . So it sounds like you are torn two ways’).
- Close a discussion.

**CONFIDENCE TO CHANGE**

Raising your client’s confidence in her ability to change is an intermediate step towards changing her drug use. It is important to foster an optimistic view that change is achievable. Try to ensure that the weekly goals of therapy are within your client’s capabilities so that she will experience a sense of mastery. Your own belief that your client can succeed will also strongly influence her expectations. Be aware that there is a power relationship between you as the therapist and your client. The more you control the process, the less confidence you are placing in your client’s ability to make appropriate choices and to take responsibility for changing. Empower your client by helping her to make her own choices and congratulating her when she makes progress.
WORKING IN A GROUP

All of the techniques described in this book can be applied in a group situation. In fact, the group setting provides some unique features that enhance some of these techniques. For example, a group of people can generate a greater variety of ideas in a brainstorming exercise (pp. 97–98) than you and your client can alone. In learning communication skills, your client can benefit from practising with, and receiving feedback from, people with different perspectives. Her plans for relapse prevention might also become more refined as she observes what works and what doesn’t work for other people. Your client may also benefit from the opportunity for peer support. This is particularly the case if your clients continue their support for each other after treatment.

Some techniques require several sessions of ongoing group practice before the skills are acquired (e.g., relaxation therapy and assertiveness training). Other techniques could be used within an open group where members vary from week to week (e.g., relapse prevention and refusal skills could be applied in an open group). The following section mainly draws on the work of Vanicelli (1982) who has provided specific guidelines for running groups with alcohol-dependent people. We have also drawn from Monti, Kadden, Rohsenow, Cooney and Abrams (2002) on guidelines about group rules.

GROUP COMPOSITION

Groups need to have a common goal. Therefore, a group that includes people working towards abstinence as well as those with a goal of moderation runs the risk of resentment, confusion and a loss of common purpose. It is better to run separate groups for clients with these different goals.

Keep your group down to a size big enough for group interaction but small enough for everyone to be able to participate. Rose (1977), for example, recommended that the ideal size for a group lies between six and nine people. Such a number will also enable you to form sub-groups, which give all group members the chance to try out newly acquired skills.

Finally, in planning your group, give some consideration to the ratio of men to women. Research suggests that women in therapy benefit more from all female groups than from mixed sex groups (Jarvis, 1992). This is particularly true if issues such as sexual abuse or domestic violence are likely to arise in the course of the group discussion.

GROUP RULES

Be quite clear and explicit in defining the group’s primary goal and your clients’ responsibility in working towards that goal. Tell your clients exactly what you expect of their participation in the group. Your ground rules might state:
● The minimum number of sessions that you wish clients to attend.
● That clients should attend regularly, be on time and give advance notice if they are unable to meet these requirements. Try to prevent early drop-outs from the group by contacting those clients who miss any of the first few sessions and encouraging them to attend the next one.
● That clients should not come to sessions under the influence of alcohol or other drugs. Explain that such behaviour would interfere with their ability to concentrate on the group tasks and might also distract other members of the group. If a client breaks this rule, she will be asked to leave the session and encouraged to come next time, when she is sober.
● That the identities of fellow group members and all the personal issues discussed during group sessions should remain confidential and not be discussed with family members or friends outside the group.

**GROUP COMMUNICATION**

In the initial session, invite the group to negotiate an agreement about how they intend to communicate with each other. For example, some behaviours encourage an atmosphere of trust and openness (e.g., listening to each other without interruption) while other behaviours might disempower individuals and distract the group from their goals (e.g., dominating, ridiculing, scapegoating or encouraging others to use or drink). Having a few simple rules from the outset will enable you to remind clients when their communication is likely to make others feel uncomfortable. Further discussion about how to address resistance or iatrogenic group processes are given in Chapters 3, *Motivational Interviewing* and 19, *Working with Young People*.

The group is a powerful setting for behavioural change. As noted above, members need to feel that the group is working towards a common goal and that they are supported by others in the group. Encourage this kind of ‘togetherness’ by reinforcing any comments by clients that show interest, concern or acceptance of other group members or positive statements about the group as a whole. For example, you might say:

‘So you agree with X about . . . ’

Your group may go through a period where people challenge and disagree with you and each other. This is a natural process and, if handled correctly, the group will be able to move forward to a more stable and trusting level. It is important to make a distinction between disagreement that leads to constructive discussion within the group and disagreement that involves hostility. If group members become hostile to each other, they may undermine each other’s progress and disrupt the group. Deflect hostile interaction between group members by getting them to tell you about their concerns rather than abusing each other. Emphasise empathy rather than confrontation as a model for the group.
ROLE-PLAY

Role-play is a method of practising the use of a particular skill by rehearsing a situation that is likely to occur in real life. You can role-play situations with your client in individual therapy. However, the ideal setting for role-play is in a group that provides the opportunity for clients to learn from watching each other perform the same skills. When using role-plays, always begin by modelling the skills yourself, giving your clients an example to follow. At the end of each role-play ask the 'player' to say what she thought she did well and what she would have liked to have done differently. Then ask the group for some feedback, emphasising that comments must be constructive and specific, focusing on body language, tone or what was said. After the group have offered their feedback you can then offer your comments, restricting yourself to a couple of positive and critical points. Role-play can be used for groups learning problem solving, drink or drug refusal skills, assertiveness, communication skills and relapse prevention. It may also be useful in couples therapy (see Chapter 13, Involving Concerned Others).

TERMINATION

Prepare your group in advance for breaks in the group routine (such as public holidays) and for the time when the group is going to finish. For example, you might want to encourage sub-groups or pairs of clients to exchange phone numbers so that they can support each other’s maintenance plans in the absence of group sessions. Further suggestions that you might want to discuss with the group are in Chapter 17, Extended Care.

ETHICAL PRACTICE

Ethics are standards of professional behaviour set up to ensure that your client’s rights are respected throughout the treatment process. It is the responsibility of all therapists to maintain ethical behaviour in relation to their clients, trainees and colleagues. Ethical behaviour is guided by two principles: being helpful (beneficence) and not doing harm (nonmaleficence).

Your professional group will have a code of ethics to guide you. You can also look at state laws, licensing regulations and the agreed policy and procedures of your treatment programme. Regular supervision with a more experienced colleague is an excellent way of getting support and guidance to help you make competent, ethical decisions. Peer supervision meetings and case conferences also offer opportunities to discuss and clarify ethical matters.
BOUNDARIES

The professional boundary defines the extent and limitations of the relationship with your client. It preserves your client’s confidentiality and creates a ‘safe space’ for your client to reveal and explore personal issues. Boundaries are signified by the temporal and spatial routines of the counselling process: regular appointment times, consistent length of sessions and a dedicated counselling room. Compared with therapists, case managers and residential workers may have less firm routines of time and space (Chapter 18, Case Management). In these roles, you can firm the boundaries by ensuring that contact with your client is clearly linked to your professional role.

You will sometimes need to respond to situations where the boundary becomes less defined. These situations may seem ordinary and potentially harmless. For instance, would you accept a gift from your client? Your answer might depend on the context. An inexpensive token of thanks at the last session has a very different meaning from a gift offered by your client at a difficult stage in the counselling process. In the latter case, it would be ethical to politely decline the gift. Explain and discuss the benefits of keeping your relationship professional so that you can both focus on her counselling needs.

Boundaries are breached in two ways. Some breaches are inadvertent or not intentionally exploitative. These are known as boundary crossings. Commonly cited examples are: a goodbye hug initiated by your client at the completion of treatment; non-sexual physical reassurance at times of extreme stress; running a session over time; or selective self-disclosure. Repetitive boundary crossings are potentially harmful because they blur the boundary, thereby increasing the chances of boundary violation.

Boundary violation is a significant and potentially harmful breach where the therapist over-rides the client’s rights or actually does harm to the client. Some examples are: affectionate or flirtatious communication; self-disclosure about the therapist’s personal problems; engaging the client in illegal activities; breaking confidentiality; or having sex with a client.

PERSONAL FEELINGS IN COUNSELLING

Warm regard, trust and understanding are the basis of the counselling relationship. It is not unusual for your client to feel a degree of attachment towards you. It might even be the first time your client has experienced such an accepting relationship. However, the counselling relationship, by definition, involves unequal power. Your client is in a more exposed and vulnerable situation while you are acting from a position of expertise and relative security. Sometimes you might even have institutional authority over your client.

It is not unusual for these qualities of the counselling relationship to provoke strong emotional feelings. For example, your client might idealise you at times and, at other times, she might appear hostile. Sometimes disturbed clients can split these feelings across different workers (known as ‘splitting’, p. 284). Rather
than taking these reactions personally, use reflective listening to help your client explore their meaning, based on her own life experiences.

You might also have strong personal reactions to your client at times. This can happen when your client’s issues resonate with your own personal concerns. It can also happen if you have certain expectations which you want the client to meet. Consider, for example, how you would feel if you found out that your client had frequently lied to you about the extent of her drug use. While it is reasonable to discuss this behaviour and its consequences with your client, including how it impacts on your ability to help her—to what extent would you express your feelings of anger or sense of betrayal? A good rule of thumb is to monitor your own feelings without imposing them on your client. If you are distracted by a strong feeling, mentally put it to one side. Wait until after the session, then talk with your supervisor or deal with it personally.

There is debate about whether therapists should disclose personal things to their clients. In the 12-step approach, self-disclosure regarding one’s own recovery is seen as a positive way of sharing and role modelling. However, there is a risk of taking time and attention away from your client’s issues and burdening her with knowledge of your own problems.

Self-disclosure can also signal that the relationship is becoming more personal and can open the way for your client to ask further personal questions or seek friendship with you. Exactly where should you draw the line? It is helpful to ask yourself two questions before self-disclosing: (a) how will it benefit the client? and (b) how will it affect your professional boundaries? You should also consider your own privacy. For example, what if you and your client attend the same Alcoholics Anonymous meeting? Would this make it hard for you to get the full benefits of attending the meeting during times of stress or relapse?

**DUAL RELATIONSHIPS**

A dual relationship occurs when you take on two (or more) different roles, either at the same time or in succession, in relation to your client, your trainee or your colleague. Dual relationships cause boundary confusion because the two relationships have different boundary rules.

As an example, consider the following scenario (taken from Chapman, 1997). What might go wrong?

**Scenario**

You need some painting done in your office. Your client is unemployed, short of money and under-confident. You are thinking about hiring your client to do the job since it could have therapeutic benefits.

What if your client does a bad painting job? How would this impact on your counselling relationship? What if your client discloses in counselling that she has been drinking heavily? What impact might this have on your trust in her as a painter?
The personal relationship introduces issues that might impact on feelings of trust for either party. There are many types of dual relationships that could be relevant for your work. Some are described below.

**The unexpected encounter** Such encounters are particularly likely in rural settings or close communities. Consider how you might react to some of the following scenarios:

- Your child becomes friendly with your client’s child.
- You bump into your client while you are both drinking alcohol at a party.
- A mutual friend introduces your client as his new date.

It is a good idea to address the incident in your next session together. Explore your client’s reactions to the incident. Discuss what needs to be done to ensure her confidentiality and to rebuild the boundary in your counselling alliance.

**Dual professional relationships** Sometimes you will be required to take on more than one professional role when dealing with your client. Some examples are:

- Acting as both therapist and case manager for your client.
- A client who sees you individually also attends a group therapy programme where you are the facilitator.
- A former client becomes a co-worker.

With dual professional relationships there is the risk of the two roles becoming merged so that it is not clear which role is operating at any particular time. This can lead to a breach in confidentiality (e.g., when information from one context is inadvertently raised in a different context). It can also lead to a merging of the roles so that important work gets neglected (Chapter 18, *Case Management*). If a dual professional role cannot be avoided, make sure you define the boundaries explicitly. You can, for example, use different locations and times to distinguish concurrent roles. You and your client might also discuss the potential risks ahead of time and then debrief any boundary crossings as they occur.

**Personal and professional roles** The most common and potentially most harmful dual relationship occurs when you become personally involved with your client. Some examples are entering into business together, forming a friendship or inviting your client to dinner. Williams and Swartz (1998) made a useful distinction between ‘being friendly’ and being your client’s friend. If your client seems socially isolated, the counselling relationship might be her main close contact. Explore what she wants from a friendship and how to access potential friends in her community.
Sexual relationships are the most harmful example of this type of dual relationship. There is no justification for having sexual relations with your client. Given the power dynamics of the therapeutic relationship, any sexual behaviour by therapists towards clients would be exploitative and abusive.

If you feel sexually attracted to your client, consult with your supervisor before seeing her again. The attraction may be a temporary feeling arising from your own personal issues. Sorting this out with the help of your supervisor might reduce the power of the attraction. However, if the feelings persist and you think the risk of acting on them is high, you should refer the client to another therapist. Consult with your supervisor about the best way to frame this referral for your client.

If your client acts in a sexually flirtatious or physically affectionate manner towards you, your response should be therapeutic rather than personal. This requires some degree of sensitivity and tact! You might start by acknowledging that your client’s overtures reflect her sense of trust in the relationship. It’s a good idea to restate your reasons for staying at a professional level and not betraying this trust. If she responds with embarrassment or anger, take an empathic, non-judgmental approach and allow time for her to express these feelings.

There is some debate about whether personal relationships with former clients are okay and, if so, how long after the end of therapy you should wait. Once you have a personal relationship with your client, her opportunities for receiving follow-up counselling from you are effectively cut off. Being aware that you might have a later relationship with your client could also influence how you do counselling now.

**ETHICAL DILEMMAS**

Ethical dilemmas occur when two ethical principles clash. The main ethical dilemma you are likely to face in drug and alcohol work is the obligation to notify authorities when you believe your client might harm herself or somebody else. This involves a conflict between the ethics of confidentiality and the legal duty of care to prevent physical harm. It can sometimes also involve a further dilemma in taking away your client’s autonomy through involuntary admission to a psychiatric unit to prevent suicidal or homicidal behaviour. These ethical issues are further discussed in the context of dual diagnosis in Chapter 20.

**RESOURCES LIST**

Alcoholics Anonymous (undated). *AA Guidelines for AA Members Employed in the Alcoholism Field*.

—A short paper on how to avoid dual relationships that might arise for AA members. Available from G.S.O., Box 459, Grand Central Station, New York, NY 10163. Alternatively, link to ‘AA Guidelines’ on: [www.aa.org](http://www.aa.org)
Chapter 4 of this book provides guidelines on how to build a collaborative therapeutic relationship and Chapter 13 discusses crisis intervention with reference to commonly encountered crisis situations.


—Deals with ethical issues specific to the drug and alcohol field, including therapists in recovery.


—Defines ethical dilemmas and describes common examples in the drug and alcohol field.


—Written from a psychodynamic perspective, this paper gives ethical guidelines on how to prevent the sexual exploitation of clients by counsellors and therapists.


—A workbook for training empathic skills.


—A comprehensive manual on the application of an empathic, client-centred style of counselling.


—A study that compared men and women in treatment and found that, although their success rates are similar, they have different needs that should be addressed in treatment programmes.


—Gives evidence that therapists can modify group cohesiveness by selective reinforcement.


—This study found that clients had better outcomes if their therapists were empathic rather than confrontational.


—Strongly recommended as a guide to the motivational interviewing style of counselling. Chapters 5 and 8 give guidelines on how to recognise and respond effectively to your client’s resistance.

—Provides brief guidelines on building groups as well as a session-by-session plan for running skills training groups.

Nurses Registration Board of NSW (1999). Guidelines for Registered Nurses and Enrolled Nurses Regarding the Boundaries of Medical Practice. Callaghan, New South Wales: The Centre for Nursing Research and Practice Development, Faculty of Nursing, University of Newcastle.

Available at: http://www.nursesreg.nsw.gov.au/bounds/guidelin.htm#Information

—Although the case examples in this resource are specific to nursing, the resource has interesting models to help make ethical decisions and these are very relevant for drug and alcohol counselling.


—A detailed discussion of practical approaches to minimise or manage dual relationships.


—Provides guidelines for running behaviour therapy groups, based on research findings.


—Presents evidence-based recommendations for client engagement (p. 35) and effective counselling (pp. 99–105).


—Outlines problems that are unique to running groups aimed at achieving abstinence from alcohol, and tips for resolving them.


—Discusses the dynamics of using motivational interviewing in a group setting.


—An excellent discussion of professional boundaries with a drug and alcohol case example.