

## Chapter 2.

# Evidence-Based and Empirically Supported College Counseling Center Treatment of Alcohol Related Issues

Ian T. Birky

**SUMMARY.** College counseling center administrators and staff counselors face the increasing challenge to provide best practice counseling in all domains of their work. The present chapter explores the evidence base for alcohol counseling, seeking to determine whether recent empirical evidence suggests the use of particular counseling strategies when working with alcohol related issues. A summary of research findings in general as well as specific to college counseling centers is provided, along with factors to consider when deciding how to best use the current evidence. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Evidence-based, empirical support, counseling center, alcohol treatment

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During the past two decades, university and college counseling center staff occasionally attempted to prove, sometimes with the support of the Fund for the Improvement of Postsecondary Education (FIPSE) and Department of Education (DOE) federal grants, that the right combination of creative strategizing, hard work, persistence and money could produce intervention programs capable of significantly diminishing the amount of alcohol consumed on college campuses as well as decrease drinking related problems. Alcohol services and programs were designed in accordance with grant-inspired promises, offices were built, staff members were hired, and administrative oversight was designed to address this challenge. Despite FIPSE and DOE guidelines discouraging reliance on “therapy” as the cure agent for the “alcohol problem,” some programmatic strategies explicitly contained “counseling” as one mechanism for change. This insistence on a “therapy” component was not surprising given that counselors and psychotherapists sometimes were members of the FIPSE teams. It was also evident that some of these counselors were unwilling to rely solely on ubiquitous information and education programs to alter drinking behavior in significant and lasting ways among college students, and defended counseling as a viable process for change.

Partly as a result of expectations linked to those grants, as well as broader challenges inspired by increasing institutional requirements for accountability in numerous university administrative domains, a growing challenge gradually developed to show that counseling-based alcohol interventions worked. Concurrently, there have been increasing efforts to determine whether there is evidential or empirical support for psychotherapeutic interventions. Evaluation of counseling center based treatments for problems related to alcohol have not escaped this scrutiny. Thus, the moment is right to evaluate the extent to which a credible evidence base exists for counseling center based alcohol treatments, and more broadly to consider if an evidence-based approach is a valuable and appropriate perspective from which to consider the alcohol-related work in college counseling centers. In order to maintain focus on the treatment issues in this chapter, the language used to reference therapists or counselors working in university or college mental health based counseling centers providing counseling or psychotherapy will simply make use of the words counseling and counseling center staff.

This chapter provides an overview of studies designed to evaluate the evidential base for alcohol treatments provided by counseling center staff. Also, it covers issues involved in conceptualizing the problem of how to evaluate studies designed to answer questions related to empiri-

cally based evidence for alcohol treatment in counseling centers. Finally, the chapter concludes with a number of comments regarding the feasibility and limitations of adhering to evidence-based treatment approaches when making decisions about alcohol-focused psychotherapy delivered within counseling centers, and provides brief suggestions for one conceptual framework with promise for informing contemporary treatment.

### **OVERVIEW**

At the outset, questions are raised in this chapter as to whether counselors or clinical administrators are in a position to promote and offer alcohol treatment therapies and protocols based on results arising from research evidence or other empirically based criteria. In an effort to answer these questions, some writers have recommended that counselors and researchers use broad-based determinants of evidence-based practice rather than simply those informed by positivistic, empirically based findings (Chwalisz, 2003). It is likely that this suggestion arises because to date, published survey and meta-analytic studies reporting on the success of specifically instituted therapies, and on therapies to address actual drinking-associated behaviors have found very limited evidence for claims of success (Werch, Pappas, & Castellon-Vogel, 1996; Nelson & Wechsler, 2001; Walters & Bennett, 2000). With regard to the alcohol treatment focus, these conclusions stand despite a vast but somewhat diffuse literature with purported claims that particular programs at specific universities with particular target audiences have been shown to significantly change the identified behaviors or conditions. A number of individual studies might convey such success, but Chambless and Hollon (1998) remind us that a careful analysis of the evidence suggests that treatment success most likely occurred on a particular campus because of factors specific to that college or university, the informed and participating personnel working there, and the specifically targeted and selected clientele solicited by the researchers. They also point out that far too few authors provided any significant real-world evidence of meaningful change and most were remiss in providing clear directions allowing for replication of their methodologies. In conclusion, they note that when the combined results of singular efforts to show treatment success were analyzed with meta-analytic methods and Bayesian approaches to hypothesis testing, there was little if any empirical evidence of success (Chambless & Hollon, 1998).

### **REVIEW OF EXISTING RESEARCH AND CONCEPTUAL FRAMEWORK**

Despite initial indications that the bar may be set too high if we demand practice policies formulated primarily from empirically based guidelines, a brief review of related literature may help us draw better conclusions regarding administrative and clinical decisions about treatment and competency guidelines for counselors addressing alcohol issues with college students. Before limiting our inquiry to counseling center based empirically tested interventions, it may be important for counselors to acknowledge the benefit of first determining whether there is empirical or evidence-based support for claims of alcohol counseling success in any setting (Wampold, Lichtenberg, & Waehler, 2002).

In looking at the research available, there does appear to be some evidence that specifically designed alcohol treatments “work.” Using the current prescriptive descriptions and relatively strict criteria of Chwalisz (2003) who promoted evidence-based exploration using a range of empirical, clinical summation and even single case studies, counselors will note that supportive-expressive therapy and cognitive therapy “hold promise” for treating alcohol problems (Chambless et al., 1998). So, too, do behavioral therapy and interventions providing reinforcement for abstinence (Project Match Research Group, 1997). According to a meta-analysis by DeRubeis and Crits-Christoph (1997) and the Project Match Research Group (1997, 1998) and in line with the level of certainty criteria proffered by Wampold et al. (2002), there also seems to be “some possible” evidential support for efficacious treatments using social skills training (Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002), cue exposure (Dawe, Rees, Mattick, Sitharthan, & Heather, 2002; Sitharthan, Sitharthan, Hough, & Kavanagh, 1997), “urge coping skills training” (Palfai, Monti, Colby, & Rohsenow, 1997), cognitive behavioral coping skills therapy (Kadden, Cooney, Getter, Litt, 1989; O’Leary & Monti, 2002), motivational enhancement therapy (Kahler et al., 2004), and 12-Step facilitation therapies (Tonigan, Toscova, & Miller, 1996). However, in making these statements, the evaluators of these meta-based studies equivocate in their support of the findings. They do so because they were frequently limited in their efforts to draw substantive conclusions by the necessity of reliance on research with questionable designs, poor generalizability, and difficult to replicate methodologies.

Given efforts to look specifically for evidence of effective therapy-based alcohol interventions derived from studies conducted on college campuses and specific to college counseling centers, counselors are quickly confronted with the paucity of applicable research. To attempt to complete their survey by utilizing evidence of “interventions” that work, Walters and Bennett (2000) point out that this effort is actually complicated by the fact that much of the literature is based on primary prevention work. Their review of the empirical support for this primary prevention work may be very helpful for counseling staff developing and delivering outreach programs, but they note that very little applicable research has been conducted assessing secondary or tertiary intervention outcomes. To select an alcohol treatment based on the results of primary alcohol prevention work on college campuses is equivalent to selecting one’s therapy approach for depression based on studies of counseling center staff conducting depression and suicide programs in the residence halls. Nevertheless, published literature addressing this question includes a number of claims for success utilizing brief alcohol related treatments.

Using the criteria of Chambless and Hollon (1998), who suggest that counseling decisions are best informed by empirically based findings, it is clear that there are few studies with strong evidence for claims of success in decreased drinking or drinking related problems among college students following counseling interventions. Nevertheless, there have been efforts to explore these questions. One study using a single-session intervention comprised of education and assessment of current usage in reference to peers reported results of decreased drinking and fewer negative consequences from drinking during the next four years of college (Marlatt et al., 1998; Baer, Kivlahan, Blume, McKnight, Marlatt, 2001). It should be noted, however, that the students treated were not drawn from the pool of regular counseling-center clientele, but rather were first-year students identified as heavy drinkers, selected by the university to undergo the single session counseling intervention. Using a similar brief, single counseling session intervention that provided feedback regarding personal consumption in relation to peer drinking norms, as well as education about alcohol-related problems, researchers found some support for claims of decreased drinking, although without coincident or significant drinking related problem reduction (Borsari & Carey, 2000).

With the exception of this research, counselors looking for guidance in treating students seeking assistance for alcohol-related problems are left with little supporting empirical evidence to guide their work. Even

for counseling center staff doing outreach programs, except for the quasi-experimental findings of health advocates such as Haines and Spear (1996) or Berkowitz and Perkins (1986) who have championed personalized and social norm educational strategies, stand-alone information-based educational methods show little promise for the everyday work of counseling centers. Personalized feedback, attitudinal change techniques, and skills-based approaches, however, show some promise for reducing alcohol problems, at least in the short term (Walters & Bennett, 2000).

Referenced in the previously identified counseling center based research was mention of brief or single-session interventions. In keeping with the trend toward brief treatment in counseling centers, alcohol research in the past decade has focused on brief individual therapy or brief individual interventions using personalized and social norm comparison feedback, motivational interviewing, education and behavioral monitoring (Borsari & Carey, 2000; Larimer et al., 2001; Roberts, Kivlahan, Baer, Neal, & Marlatt, 2000; Walters, Bennett, & Miller, 2000). There is some evidence that brief treatment for alcohol-related issues is equal to or more effective than long-term treatment, especially with self-referred clients (Bien, Miller, & Tonigan, 1993; Dimeff, Baer, Kivlahan, & Marlatt, 1999). These researchers also found that increasing treatment dosage does not correlate with similar increases in treatment gains. Although not supported by large amounts of evidence, brief treatments look fairly promising for alcohol counseling.

In sum, while there is no clear and strong evidence supporting a clinical agenda for persuading counseling center staff to begin using specific approaches to alcohol counseling, on the face of it, the number and variety of treatments purporting to demonstrate some individual counseling effectiveness is remarkable. Unless counselors remain wary, quantity rather than quality of research findings might influence treatment norms and create standards for practice. Because of this, counselors might attempt to convince themselves that professional integrity and open-mindedness require utilization of the “most promising” of the treatments studied, although this limitation hardly seems defensible without concurrently engaging in serious discussion about what to do with the numerous contrary claims and limited evidence. Awareness of the limitations of evidence-based practice in the treatment of college students with alcohol problems would be a helpful addition to that discussion.

**LIMITATIONS OF THE EVIDENCE-BASED APPROACH  
TO COLLEGE COUNSELING SERVICES**

Counselors, before agreeing to practice a specific alcohol treatment, might justifiably ask the following questions to determine whether the approach selected was based on replicable alcohol treatment-based studies: (1) Do the research participants upon whom the reported conclusions were based match the real-life students attending sessions in the counseling center? Many studies were conducted on voluntary participants unlike the preponderance of center clients mandated or referred for treatment by judicially minded deans. Moreover, some of the research participants were paid or otherwise rewarded for participation and some had symptom profiles (i.e., selected because of self reported binge drinking in high school) typically very different from the students with whom center staff engage and are familiar with in the counseling center (i.e., referred by a third party for drinking offenses (Sadler & Scott, 1993)). (2) What outcome measures were used and are they meaningful to the treatment mandate or goals agreed upon in the typical college setting? Published results were often based on outcome measures such as decreased stress levels, increased employment reliability, establishment of alternate recreational activities, and score changes on assessment instruments attuned to attitude and knowledge rather than to specifically measured behavior critical to thriving in college (Chambless & Hollon, 1998). Other conclusions were based on findings that brief therapy worked at least as well as long-term inpatient treatment. Such comparisons between clients of inpatient treatment and college students seeing counselors for underage drinking offenses hardly seem beneficial or relevant.

Other questions could include: (3) What differential-change factors or outcome measures were studied in the published research? Researchers sometimes assessed reported alcohol intake, levels of anxiety, social ease, and interpersonal involvement without necessarily evaluating measurable indices of property damage, social disruption, financial costs, and loss of productivity. Conclusions about real-world change become suspect given the infrequency of substantive long-term effects, evidence of high drop-out rates, and researcher selection of change factors other than abstinence or closely related secondary effects such as property damage that are typically of most concern to university administrators. Finally, (4) Are the investigations replicable and are the promoted therapies teachable to clinical staff? In all cases, the use of

replicable manualized intervention formats and randomized clinical trials were in short supply or absent.

It would seem that the careful and perhaps cautious reader of the literature would likely conclude that research evidence in this clinical area is often dependent on short-term laboratory interventions of questionable ecological validity and weak (even though statistically significant) empirical support. Actually, then, since findings from the research are equivocal at best, clinical practice influenced by this research is primarily based on gradual theoretically developed professional consensus. While such a professional consensus might be based on well meaning efforts to seek guidance from empirical research, at this point in time it is as likely that the “common factors” of effective counselor delivery may account for much of the reported change. Given that “common factors” such as a good therapeutic relationship account for some treatment induced change under almost any circumstance, at the present time there may be little advantage to claiming intervention selection guidance from the questionably relevant alcohol treatment studies. In attempting to make a decision whether to practice any particular treatment strategy, counselors left with some ambivalence might do well to appeal to the counseling profession’s own standards for guidance.

### ***RECOMMENDED APPROACH FOR COLLEGE COUNSELORS***

College-based counseling is generally recognized as a specialty clinical practice, and efforts are made constantly to provide services within the context of best practice standards that are guided by applicable research and wisdom gleaned from the totality of a long history of professional consensus acquired via research, case conferences and clinical experience. For various reasons, some of which will be addressed in the following, research in the area of alcohol counseling is still in its infancy (New STG on Evidence-Based Practice, 2004), presently offering only general constructs that counselors can try to integrate into clinical practice strongly influenced by our knowledge of common-factor elements for successful counseling. Lest counseling center staff, facing challenges to “make a difference” when treating the seemingly intractable problems of alcohol use on college campuses, feel inclined to maintain strict adherence to empirically based guidelines for providing “alcohol oriented treatment,” it becomes important to recognize the following limitations in taking such an approach.

First, empirically defined treatment is or might best be based on a clearly defined diagnostic criterion for treatment and perhaps DSM-IV criteria could be used for comparison purposes. However, because DSM-IV diagnoses of alcohol pathology or associated problems may be unhelpful and thus are frequently not used in working with the majority of college students (Winters, 2001), there does not appear to be a universal standard for comparison across subject populations at the present time. Perhaps because of difficulty obtaining adequate numbers of participants, counseling center-based research typically has not included those clients with alcohol dependence or diagnosed abusive drinking, but rather the traditional heavy-using high school graduate perceived to be at risk because of patterns of prior use. These voluntary research participants, given brief treatment interventions in an educational format, provide questionable comparisons to most college students who involuntarily attend counseling sessions because of a single episode of alcohol misuse. Finally, while some students do attend because of personal concerns about possible addiction, loss of control, or because of needing to manage significant consequences of drinking, studies in college counseling centers have not focused on this population.

Second, in the university setting, most students are referred to alcohol-related services in the counseling center because of legally defined underage drinking offenses rather than because of diagnosed psychopathology. Those coerced into contact for reasons other than underage drinking are typically mandated because of some behavioral indiscretion of which alcohol was assumed to have been the causal culprit. In either case, center administrators set policy about treating judicially mandated clients and center staff members are then faced with confirming attendance, or if providing further services, deciding whether the diagnostic assessment and invitation-to-treatment focus is on the behavior (i.e., violence, injury, property damage) or the alcohol use itself (i.e., amount, frequency, illegality). Little if any research has provided findings leading to recommendations regarding conceptualizing work with the alcohol mandated client or pertaining to operational definitions of successful treatment. For judicially referred alcohol misuse cases, treatment success might administratively be best defined as completing the paperwork notifying the referring dean that the student fulfilled the required visit to the counseling center. Treatment success might also be indicated by effective use of the time spent introducing the student to the full range of psychotherapeutic services, inviting future use of the services if needed, or providing support for ongoing contact with a parole officer, a dean, or perhaps the parents.

Third, few if any helpful guidelines regarding how and under what circumstances referrals should be made following assessment and how decisions might be informed by diagnostic considerations exist at the present time. Scholars have not addressed either the reality or effectiveness of counseling center interventions in which a student, because of behavioral infractions and diagnosed alcohol dependence, is given a referral to an outpatient alcohol specialist, to an outpatient programmed treatment setting, or back to the home environment. In such cases, center staff might be relieved to know that effective and best practice treatment may well be referral of such students elsewhere or to intensive drug treatment programs if they can be clearly identified with DSM-IV descriptors for abuse or dependency.

Fourth, most clients attending sessions because of alcohol-related issues do not present voluntarily and most do not believe they have a problem. Few students have experienced significant long-term or frequently consistent evidence of negative consequences to believe they have a problem requiring assistance (Smith & Anderson, 2001). Even if they have such a history, most are, at best, in the contemplative stage of problem acknowledgement and have little intent to set goals for change (Prochaska, DiClementi, & Norcross, 1992). Because clients with alcohol issues seldom present voluntarily on that account, research methodologies should take into consideration the possible and probable differences between these clients and those students with depression or anxiety who frequently self-refer for treatment (Westen & Morrison, 2001). Researchers and counselors would do well to ask whether the probability of any subsequent attendance is related to experiences during the mandated session, and which interventions or therapist characteristics prompt client compliance to invitations for continuing sessions. Many college counselors choose simply to assess, recommend, and offer invitations to engage in therapy rather than assume ongoing responsibility for mandated clients. A common-factors perspective may be critical for understanding which counselor variables such as attitude and style seem to be critical for most beneficially taking advantage of the brief window of opportunity for intervention (Miller, Kilmer, Kim, Weingardt, & Marlatt, 2001; Rollnick & Miller, 1995).

Fifth, perhaps more so than with other students, clients with alcohol issues typically present with problems diagnostically co-morbid with and influenced by a variety of other factors (Clark, Wood, & Cornelius, 2003). Alcohol co-morbid with depression may look different than when co-morbid with anxiety, character disorder diagnoses, poly-drug use, attention deficit disorders, or learning disabilities. Additionally, it

is reasonable for counselors to question whether and how treatment effectiveness varies with multicultural demographic variables such as academic status, social class, or with race and ethnicity. Gender and religious orientation may also correlate with treatment response and utilization. Especially with college students struggling with chemical substances, it is presumptuous for counselors to assume that it is helpful to discuss treatment efficacy related to some uni-dimensional factor such as amount or frequency of alcohol used.

### **CONCLUSION**

Perhaps it is not surprising to discover that little consensus has formed in support of specific evidence-based treatment efficacy with respect to the treatment of alcohol abuse or dependence. As the very recent Division 17 Special Task Group (New STG on evidence-based practice, 2004) realized and announced, selection of empirically based treatments for some presenting problems is functionally at a developmental stage whereby counselors are left to struggle with identification and conceptualization of the topical area itself. Further work is needed before we can determine how to bring the collaborative pieces together and recommend various models and strategies for research and practice. Elements for study necessarily include those of diagnostic problem assessment and identification, empirical and (or versus) qualitative results, co-morbidity with other diagnostic variables, influence of multicultural variables, treatment type or therapy orientation, referral factors, and other outcome variables.

In an effort to decide how to practice alcohol-related work while further evidence accumulates, counselors would do well to focus primarily on templates that can provide helpful heuristic and practical frameworks to assist their work with students struggling with alcohol related issues. Models created by such frameworks would allow counselors to address the treatment focus and effect as well as the amount of treatment provided. Using patient response-focused and dosage-effect models whereby the number of session contacts and measured gains are accounted for, college counselors may more successfully address matters of legitimate real-world intervention success in light of the number of sessions available for the intervention, the phase of treatment, and client commitment variables (Garfield, 1998).

As Chambless and Hollon (1998) point out, when counselors adopt such models, they can begin to determine the kinds of change and effect

sizes reasonably expectable in a real-world population of college students given the use of brief intervention treatments. Using this type of approach, university-based counselors can learn to appreciate the effects they can procure during the college years, without assuming that their failure to show drinking related effects 5 or 10 years into the future means their interventions were ineffective or ill-advised. Thus, if counselors determine, based on dose-effect outcomes, that it would take more sessions to procure a desired response than counseling center resources allow, then determinations of success would need to be assessed from the vantage of a broader perspective.

Successful counseling might ultimately include recommendations for withdrawal from the university or referral to a treatment program that can provide the full dosage effect (Lambert, Hansen, & Finch, 2001). Research informed by such a framework might prompt replicable quantitative and qualitative methodologies relevant and applicable to the counseling center setting. Finally, practice within the frame of such models may allow counselors, relying on a very contemporary post-modern blend of quantitative and qualitative research results, the means to determine with their clients how best to discuss matters of subjective well-being, symptom reduction, and recovery of life functioning gains even if these matters are likely to be more seriously addressed in some future counseling work.

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