

Developing the Therapeutic Alliance as a Bridge to Treatment

Training Manual for the Therapeutic Alliance Intervention

***NIDA-CTN 0017: HIV and HCV Risk Reduction
Interventions in Drug Detoxification and Treatment
Settings***

Lead Investigator: Robert Booth, Ph.D.

Co-Lead Investigator: Laetitia Thompson, Ph.D.

Trainer and Manual Author: Barbara K. Campbell, Ph.D.

Introduction

This manual is a training guide for the Therapeutic Alliance intervention which will be used in the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN) protocol #0017, entitled *HIV and HCV Risk Reduction Interventions in Drug Detoxification and Treatment Settings*. The CTN is a cooperative research group which conducts clinical trials in community based drug treatment programs. Its mission is to join researchers and treatment providers in identifying research-based treatments which are effective in community treatment settings. The research study, *HIV and HCV Risk Reduction Interventions in Drug Detoxification and Treatment Settings*, will evaluate the effectiveness of two interventions in reducing HIV and HCV risk behavior related to intravenous drug use. One of the interventions, the Therapeutic Alliance (TA) intervention, is designed to increase clients' entry into outpatient treatment following detox. One outcome of participation in ongoing treatment is expected to be a reduction in HIV/HCV risk behavior.

Table of Contents

Therapeutic Alliance: Theoretical and Research Background	3
Introduction	3
Definitions	3
TA: A Transtheoretical Concept	4
Research on the TA	5
Interventions Designed to Enhance the TA	6
The TA Session: Overview	7
Goals	7
How the TA Session Addresses Motivation for Change	8
Content and Process “Ingredients”	8
Essential Therapist Behavior	10
Reflective Listening Skills Review	11
The TA Session:	14
Beginning the Session	14
Discussing Plans after Detox	14
Discussing Treatment Expectations	15
Discussing Treatment Goals	16
What Happens in Treatment	17
Ending the Session	19
Troubleshooting	21
References	25
Appendix I: TA Session Outline	27

Therapeutic Alliance: Theoretical and Research Background

Introduction

The session described in this manual is designed to develop a positive therapeutic alliance (TA), or working relationship, between outpatient counselor and client during their initial meeting. The session is scheduled to occur while the client participates in detoxification treatment. Its goal is to increase clients' participation in outpatient treatment after detox. The intervention is based on what both theory and research have indicated about the TA, that it involves a **positive bond** between counselor and client, who work collaboratively, and agree on the tasks and goals of treatment. It is an element of treatment which begins to develop immediately, and which has been shown to be one of the most significant factors affecting treatment retention and success. The TA operates in all kinds of substance abuse treatment. The current intervention, which focuses on ways to develop a positive TA at first contact with an outpatient treatment provider, can be used with any treatment orientation. A brief summary of what theory and research have informed us about the TA is provided below.

Therapeutic Alliance: Definitions

Workspace:

Please provide your definition of the therapeutic alliance:

Other Definitions:

The ability of the client and counselor to work together purposefully to achieve agreed upon goals (Greenson, 1971.)

The patient's experience of treatment or the relationship with the therapist as helpful in achieving the patient's goals (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983.)

The mutual human response of patient and therapist to each other, including undistorted perceptions and authentic liking, trust, and respect (Safran & Muran, 2000.)

Provide some of your own examples of good therapeutic alliance (TA) in action:

What do these examples indicate about the important elements of the TA?

Therapeutic Alliance: A Transtheoretical Concept

History of the Concept: Treatment takes place in the context of relationships. Over the years, many theorists have written about the importance of the relationship to treatment success. A few of these are briefly described below:

Psychoanalysis: The concept of the TA originated within psychoanalytic theory. In psychoanalysis, addressing the relationship between therapist and client is central to change. In general, psychoanalysis has focused on aspects of the treatment relationship, called the “transference,” in which the client perceives feels and responds to the therapist based on previous relationship experiences, especially those with primary caretakers. In addition, a number of psychoanalytic theorists have noted the importance of the “real” relationship between client and therapist in the therapeutic process (e.g., Greenson, 1971; Sterba, 1934.) They have suggested that the **reality based elements of a positive bond aid the process of therapy**. They call this the “working alliance” or the therapeutic alliance.

Rogers’ Client Centered Therapy: According to Carl Rogers (1951), the real relationship between counselor and client is **central to the change process** in psychotherapy. Roger’s theory has 3 central tenets regarding the role of the therapeutic relationship:
1) Relationship-oriented behavior of the therapist, namely, empathy, unconditional positive regard, and congruence, facilitate the client’s natural ability to change;
2) Therapist relationship behaviors are central to therapeutic change in **all** forms of therapy;

3) The therapist is responsible for creating the relationship conditions which enable client change.

Bordin: The Working Alliance as a Transtheoretical Concept: Edward Bordin (1979) proposed that the TA is the reality based, **“here and now” relationship between client and therapist which is common to all forms of psychotherapeutic treatment**, regardless of treatment orientation or approach. He stated that it develops through **participation of both client and therapist**, and that it is composed of three core elements. These include:

1. The **positive bond** which develops between client and counselor;
2. **Agreement about the tasks** of treatment,
3. **Agreement about the goals** of treatment.

The TA intervention in the current study is partially based upon this formulation and addresses each of these elements. Bordin postulated that the TA is both a **condition of treatment** which facilitates change driven by specific treatment components, as well as a **change agent in and of itself**. Other theorists have concurred, describing the relationship between therapist and client as the primary means through which client change occurs (Waterhouse & Strupp, 1984.)

Research on the Therapeutic Alliance

The role the therapeutic alliance in the process and outcome of psychotherapy, in general, and in drug treatment, specifically, has been very well researched. Studies have consistently shown that the TA is a robust predictor of treatment outcome (Safran & Muran, 2000.) The better the TA, the more positive change occurs for clients in **all** forms of treatment studied. In fact, a recent study using data from the NIMH Treatment of Depression Collaborative Research Program (Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, & Pilkonis, 1996) showed that measures of the TA predicted effectiveness of treatment, not only for cognitive behavioral treatment and interpersonal psychotherapy for depression, but even for medication treatment and placebo medication treatment.

In the analysis of what accounts for the effectiveness of different treatments, researchers have differentiated “common” factors from factors “specific” to particular treatment interventions. Based on evidence such as that described above, some argue that common factors, especially the therapeutic alliance, account for most of the effectiveness of treatment across treatment modalities (Ahn and Wampold, 2000.)

The strong finding of the significance of the TA holds true in studies of drug treatment as well. For example, Luborsky, Barber, Siqueland, McLellan and Woody (1997) found that measures of TA significantly predicted outcome for three different types of treatment offered to drug abusers, cognitive behavioral therapy, psychodynamic therapy, and standard drug counseling. That is, the better the TA, the better the client’s success, regardless of which form of drug treatment in which he or she participated.

Research has also found that **length of stay** in drug treatment is significantly predictive of long-term outcome (Simpson, 1981.) In general, the longer one stays in treatment the better his or her long term recovery. Studies show that the **quality of therapeutic relationship** significantly influences length of stay (Simpson, 1998.) The better the TA, the longer a client stays in treatment. However, the TA has its effect not merely by increasing length of treatment stay. Recently, Joe, Simpson, Dansereau, and Rowan-Szal, (2001) found that counseling rapport, a measure of the TA, contributed explicitly to the prediction of outcome in methadone maintenance treatment, independent of treatment retention. The TA, in and of itself, predicted who would do well after treatment, regardless of how long they stayed.

Interventions Designed to Enhance the TA

Despite development of scales to measure TA and research investigating its role in treatment outcome, there has been relatively little work on interventions designed to develop or enhance TA. In drug treatment, where initial drop out rates are high and rates of transition from detox to ongoing treatment are low (Kleinman, Millery, Scimeca, & Polissar, 2002), a few interventions related to the therapeutic alliance concept have been tested to increase initial retention in outpatient treatment and transfer from detox to further treatment. The TA intervention described in this manual is based on these.

Role Induction Interventions: “Role Induction” is a term used for interventions designed to introduce and educate clients about **what to expect** in treatment, especially their role, the counselor’s role, and common experiences which occur during treatment. Thus, this type of intervention directly addresses, the “tasks of treatment” element of the TA as described by Bordin, and indirectly addresses the creation of a “positive bond.”

In 1985, Stark and Kane tested a fifteen minute “role induction” intervention given during initial assessment to outpatient drug treatment at CODA, a CTN CTP. The role induction intervention briefly explained the process of outpatient drug treatment, the roles of both client and counselor, and common experiences to expect during treatment. These common experiences were framed as indications of treatment work, progress, and eventual success. They found that clients who participated in the role induction had significantly increased rates of attendance at the next counseling session in outpatient treatment relative to clients who participated in a standard intake.

Other studies have also found that role induction interventions increase people’s attendance in substance abuse treatment. Craigie and Ross (1980) conducted a role induction study with alcohol detoxification patients. They found that patients who participated in role induction were significantly more likely than control subjects who received an alcohol education group to leave detoxification treatment with a treatment referral and to make an initial post detox treatment contact. A recent study conducted in community outpatient substance abuse treatment (Katz, Brown, Schwartz, Weintraub, Barksdale & Robinson, 2004) added a role induction session to a group intake procedure. The role induction was a 45-minute individual session conducted **by the counselor with whom clients would continue in outpatient treatment**, as is done in the therapeutic

alliance session in the present study. They found that clients who participated in the role induction session returned for treatment after intake, stayed longer in treatment, and were more satisfied with treatment than clients who participated in standard intake only.

CODA a community treatment program in Portland, Oregon, adapted the role induction intervention for use in post-detoxification treatment retention. In a non published demonstration project, detox clients met with outpatient counselors and discussed the process of outpatient treatment, including developing a plan for attending. This intervention increased rates of attendance at first outpatient session from 25% to 72%.

To Recap, Therapeutic Alliance is a **Key Factor in Treatment Retention and Success:**

- Treatment always takes place in a **relational** context.
- Positive therapeutic alliance is a key “common” factor in success in counseling and psychotherapy in general (Ahn & Wampold, 2001.)
- Positive therapeutic alliance has been shown to increase retention in substance abuse treatment and improve treatment outcome, even independent of length of stay in treatment (Joe et al, 2001, Luborsky et al, 1997.)
- Having a role induction about outpatient counseling which describes what to expect in treatment significantly increases people’s treatment attendance. (Craigie & Ross, 1980; Katz, Brown, Schwartz, Weintraub, Barksdale & Robinson, 2004; Stark & Kane, 1985.)

The Therapeutic Alliance Session: Overview

The therapeutic alliance intervention developed for the current study builds on these findings. It utilizes components of the role induction intervention **as delivered by the counselor with whom the patient will be working** in outpatient treatment. The “role induction” intervention has been enhanced specifically to assist the development of core components of the TA based on Bordin’s (1979) conceptualization by addressing the tasks of treatment, the goals of treatment and the bond between counselor and client. The intervention addresses the TA at the first contact between client and counselor which research has shown to be important (Waterhouse & Strupp, 1984.) It is designed to address these issues:

- Detox only is a common form of treatment;
- Detox only is associated with poor long term outcome;
- The longer clients stay in treatment, the better their outcome in terms of reduced drug use, reduced HIV/HCV risk behavior and many other factors;

Session Goals:

1. Counselor and client develop a positive bond.
2. Client develops a positive expectation that treatment will be helpful.

3. Client develops a positive expectation that treatment will be collaborative, a partnership between client and counselor.
4. Counselor and client reach basic agreement about the tasks of treatment and the goals of treatment.
5. Client decides to continue treatment.

Ultimate Goal: Client will begin and complete outpatient treatment and as result will decrease drug use and risk behavior for HIV/HCV.

How the TA Intervention Addresses Motivation for Change

Some clients who enter detox may be in the preparation or action steps of change. However, just as reasons and motivation for entering detox are varied, clients' motivation for participating in further treatment certainly varies. The TA intervention does not address motivation for entering treatment by focusing directly on clients' decision making process, as might be done in motivational interviewing (Miller & Rollnick, 1991.) It works to increase motivation for treatment by facilitating the development of a positive relationship between client and counselor, as well as clients' positive expectations of treatment. The intervention is designed to be flexible so that it can be relevant for clients at various stages of readiness to enter treatment, along the continuum from "I don't think I need it" through "I'm not sure" to "I'm ready to sign up."

Content and Process "Ingredients"

All interpersonal interactions contain both **content** and *process* elements. In the TA intervention, both elements are important. They are defined as follows:

Content – The verbal communication which takes place in a treatment session, i.e., what is said.

Process – The emotional meaning which the verbal communication has for the relationship between or among the participants. Its elements include what is said, how it is said, and why it is said.

Workspace:

Please read the following brief case description and write comments below about some of the possible *process* elements that you identify:

The client, who has entered detox voluntarily and is about to complete it, is speaking with an outpatient counselor about whether to sign up for outpatient treatment. The client's significant other has been threatening to leave her and she thinks he is seeing someone else.

Client: "I'm not sure that I need anymore treatment now. I just needed to get clean. I know what I have to do and no one can do it but me."

Counselor: "But you'll need to develop some tools to stay clean. You owe that to yourself after getting this far."

Client: "My use wasn't that bad this time, anyway."

Counselor: "That sounds like denial to me."

Client: (lips tighten, voice tense) "Alright, I'll think about it."

Your Comments:

Below is an excerpt from a hypothetical TA intervention with the same client described above. Please read and write comments about some of the possible **process** elements that you identify:

The client, who has entered detox voluntarily and is about to complete it, is speaking with an outpatient counselor about whether to sign up for outpatient treatment. The client's significant other has been threatening to leave her and she thinks he is seeing someone else.

Client: "I'm not sure that I need anymore treatment now. I just needed to get clean. I know what I have to do and no one can do it but me."

Counselor: "Good for you. You know your recovery is up to you. If you do decide to come to treatment, we can work together to help you get the tools and support you deserve to succeed."

Client: "I'm not really on my own. I have a boyfriend, but he wouldn't want me tied up in sessions or having to give me a ride over here, especially if the groups are at night."

Counselor: "It sounds as though you're not sure how to make it work, between treatment and you boyfriend."

Client: "He didn't really want me to come to detox."

Counselor: "So, your decision to do it was a big one. You deserve a lot of credit for what you've done so far."

Your Comments:

Process Elements of the TA Intervention:

- Counselor's respect, positive regard and accurate empathy.
- Counselor and client taking a collaborative approach, i.e., viewing treatment work as a partnership.
- Counselor and client expecting treatment to be helpful.
- Counselor and client feeling understood and in agreement about treatment.

Essential Therapist Behavior

There are four core elements of the TA intervention. These are:

1. The **positive bond** which develops between client and counselor;
2. Developing a **"team"** approach
3. **Agreement about the goals** of treatment
4. **Agreement about the tasks** of treatment

There are some therapist beliefs, feelings and behavior which are essential to developing these core elements. They involve both content and process ingredients and are outlined below:

1. Developing a **Positive Bond**

Counselor beliefs, feeling and behavior which are associated with developing a positive bond include:

1. Respect; nonjudgmental observation, warmth;
2. Good listening skills, including reflective listening;
3. Hope and realistic expectation of success for hard work and effort;
4. Praise of client's courage, effort, and behavioral change, following demonstration of such.

2. Developing a **"Team"** Approach

Counselor beliefs, feeling and behavior which are associated with developing a team approach include:

1. Thinking and talking about treatment as a **partnership**;
 2. Engaging **together** in nonjudgmental observation of the client's feelings, thoughts, behaviors;
 3. Engaging in a **joint search** for understanding, behavior change and the client's recovery;
 4. Making note of each member of the "**team**" doing his/her part;
 5. Discussing some of the treatment work in terms of "**we.**"
3. Developing **Agreement on the Goals** of Treatment
Counselor beliefs, feeling and behavior which are associated with developing agreement about goals include:
1. Discussing, negotiating and reaching joint understanding of goals;
 2. Continuing joint discussion and goal setting as these evolve in ongoing treatment.
4. Developing **Agreement on the Tasks** of Treatment
Counselor beliefs, feeling and behavior which are associated with coming to agreement about the tasks of treatment include:
1. Exploring the client's expectations of treatment;
 2. Describing what happens in treatment, including client's and counselor's role and tasks;
 3. Describing common experiences people have during treatment and how to handle them.

Reflective Listening Skills Review

The fundamental communication skill required of the counselor to assist the development of these core elements in the treatment relationship is that of reflective listening. Reflective listening involves carefully listening to the client and communicating back what the client says, often in a slightly modified form, and sometimes including reflection of the client's stated or implied feelings. Reflection does not include advice, or the therapist's opinion. Types of reflective listening range from simple to complex and include:

- Nonverbal Attending
- Hypothesis testing in the form of questions - listener checks to see whether he/she understood speaker's meaning (E.g., "Are you saying that...?" "May I check to see if I understand what you're saying ...?")
- Hypothesis testing in the form of statements, as opposed to questions. (E.g., A It sounds like you...@ A So, you...@ A It seems to you that...@)
- Reflective statements:
 - a. Repeating
 - b. Rephrasing - using slightly different word
 - c. Paraphrasing - using words which infer and extend meaning of what was said

- d. Reflection of feeling - infers and emphasizes the emotional meaning of what was said.

Examples of reflective statements:

Client: "I've made it through the worst of the detox and I'm not going to waste it."

- *Rephrasing: "You've handled the worst of the detox and you're not going to let it go to waste."*
- *Paraphrasing: "You've put in a lot of effort to get through detox and you're not going to throw away what you've accomplished."*
- *Reflection of feeling: "It sounds as though you feel proud of how you've hung in there and made it through so far, and you're determined not to waste your effort."*

Workspace:

Practice reflective listening for the following treatment scenario. Write down your reflective response following the client's statements.

The client, who is about to complete detox, is speaking with an outpatient counselor about whether to sign up for outpatient treatment.

Client: "I feel better. I think I've made it over the hump."

Counselor:

Client: "I hope I can stay clean this time. I'm doing it for my kids. I want to be there for them."

Counselor:

Client: "I don't know how I'm going to handle everything. I really need to get a job, and then there's time seeing my kids. How can I do treatment, too?"

Counselor:

The process elements of reflective listening are important. They include:

- Showing respect for what the client is saying,
- Showing understanding what the client is saying,
- Providing an opportunity for selective emphasis and expansion of what the client is saying.

As you practice the TA intervention, you will notice that it combines various forms of communication, including

- Questions,
- Reflective listening and summarizing,
- Providing information,
- Providing positive feedback.

The Therapeutic Alliance Session

I. Beginning the Session (2 minutes)

Content

1. **Introduction** –

“Hi, I’m _____. I’m a counselor with our outpatient program and I’ll be available to work with you if you decide to come to treatment there.”

2. **Purpose** –

“I’d like to talk about your plans after detox and tell you about outpatient treatment, and how **we** might work together. This can help you decide about treatment. I’d like to answer any questions you may have and find out what’s important to you for recovery.”

3. **Inquiry** –

“How has your detox been going so far?”

4. **Reflection** –

“Sounds as though you.... ”

Process

- Convey friendliness, warmth, respect
- Show interest in how client is doing
- Convey the “we-ness” of treatment collaboration

II. Discussing Plans after Detox (5 minutes)

Content

1. **Inquiry** – Ask all questions below:

- a. “Tell me about your plans after detox.”
- b. “What ideas do you have about how to stay clean and sober?”
- c. “What have you thought about going to outpatient treatment?”
- d. “What are some of the pros and cons for you about continuing treatment?”

2. **Reflection** – Use reflection to summarize client’s statements.

“It sounds as though you ...”

3. **Repeat purpose** of session using information from client’s description of his/her plan –

“So you think that you’ll..... Treatment can fit with the plans you’ve begun to tell me about. For instance, treatment matches with...”

Process

- Reflective listening shows interest in and respect for client’s view.
- Accepting client’s discussion of plans while continuing to offer information about treatment conveys that the client’s plans and the treatment option might be compatible.

III. Treatment Expectations (8 minutes)

Content

1. **Introduction** –

“Before telling you about our program, I’d like to find out about your experiences in treatment before or what you’ve heard about it.”

2. **Prior treatment experience** –

- a) “Have you been in treatment other than this detox before?”
 - i) If *yes*, “What was helpful?” “What wasn’t?”
 - (1) **Reflect and summarize**: “It sounds as though you really liked ... , but you didn’t like ...”
 - (2) **Praise positive treatment behavior**: “You really seemed to ...”
 - (3) **Emphasize positive treatment experience which can be incorporated into future treatment**: “It seems that what works best for you is We can make sure we emphasize that.”
 - ii) If *no*, “From what you’ve heard about treatment, what do you expect it will be like?” “What do you think would work best for you in treatment?”
 - (1) **Reflect and summarize**: “You’ve heard that it... ..,”
 - (2) “...**Praise positive treatment expectations or realistic knowledge**, etc: “You really seem to ...”
 - (3) **Emphasize positive treatment expectations which can be incorporated into future treatment**: “It seems that what will work best for you is We can make sure we emphasize that.”

Process

- Reflective listening shows interest in and respect for client’s view.
- Discussing expectations conveys acceptance of client’s hopes and doubts, clarifies confusion, helps develop realistic expectations including hope and a positive expectation of client’s ability to succeed.

IV. Treatment Goals (10 minutes)

1. Inquiry

“If you come to treatment, what would you like to get out of it?” “What are your main goals?”

If client has stated clearly that he/she does not plan to come to treatment after detox, ask: “What are the main goals you have for your life after detox?... These could be goals worked on in treatment, if you ever decided to come.”

2. Develop agreement - . Include reflection and summarization of client goals, linking with counselor’s ideas about goals, and stressing joint goals you will work on together.

“What’s important to you is to stay clean and learn....That’s the most important goal, I agree.” “You also want toWe can work on that by...”

3. Developing expectation of success–

a) Inquiry –

“How likely do you think it is that you’ll reach your goals?”

If client has not yet decided to continue, ask client to consider each scenario “How do you think you can stay clean or achieve your goals, such as ...with/without treatment?”

b) Reflection - Include a summary of both positive and negative expectations, if the client stated both.

c) Increasing or maintaining confidence –

“What things might increase your confidence about reaching your goals?”

Or/ “What things might help you maintain a high level of confidence about reaching your goals?”

d) Convey positive expectations –

i) General expectations - “Research show that **people who go to treatment have good success** in staying clean. It shows that their lives get better in other ways, too. Give examples:

- “They are more likely to have a job or be in school, and
- to be in better shape legally (e.g., no new arrests, not in jail, etc.)
- They’re also more likely to ...” (Use an example, relevant for the client and his/her goals.)

ii) Specific expectations using client info - “You’ve done great in sticking out detox so far. You’ve started on your recovery path. You’ve demonstrated(note positive behaviors.) It all predicts that you’ll do well in treatment.”

Process

- Reflective listening shows interest in and respect for client's view.
- Agreeing on goals conveys "teamwork."
- Discussing expectations conveys listening to client's hopes and doubts, while conveying hope and a positive expectation of client's ability to succeed.

V. What Happens in Treatment (15-20 minutes)

Content

1. Introduction/ Linking what "will work for client" to treatment description –
 - a) "Let's talk about what happens in treatment at our outpatient program."
 - b) Repeat some of the things which the client said about goals and/or what will be helpful or "work" for him/her in treatment (discussed under treatment expectations.) Indicate that outpatient treatment will include those things: "You've mentioned that it's important for you to work on Treatment at our program does focus on those things to help people succeed."

2. Description of treatment –

- c) Brief overview of schedule
 - "People in our outpatient program usually start out by attending ... (e.g., "a group and an individual session each week.") Discuss **flexibility in scheduling** to meet client's needs (to the extent your program can offer it.).
- d) Group sessions: What happens in group(s)
 - i) Inquiry – What does client expect?
 - "What do you imagine happens in group? If has had prior treatment, "What has happened in groups you've been in before?"
 - ii) Description*:
 - "Overall, our groups focus on helping people stay motivated about recovery, learn skills, and give and receive support. Some things which happen include:
 - (1) Group members talk honestly about feelings, thoughts, and behavior, including urges to use and using;
 - (2) Group members learn tools and skills to stay clean;
 - (3) Group members give and receive support. It's a situation in which people really understand what others are going through. No one's alone in it.
 - (4) Group members increase communication and relationship skills.
 - iii) Answer any further questions: "Can I answer any questions for you about group?"

d) Individual sessions: What happens in individual sessions.

NOTE: Do not include if your program does not conduct any individual counseling. If your program conducts any sessions individually, for example, treatment planning or review sessions, include this section and modify points below to fit what your program offers.

i) Inquiry – What does client expect?

“What do you imagine happens in individual sessions? If has had prior treatment, “What has happened in individual sessions you’ve been in before?”

ii) Description*

- (1) We’ll discuss goals some more and make a plan together;
- (2) We’ll talk about your feelings, thoughts, and behavior, especially about using and not using;
- (3) You’ll practice tools and skills to not use drugs and to handle life without drugs;
- (4) I hope that I’ll provide respect, support, and good information to help you reach your goals.

iii) Answer any further questions: “Can I answer any questions for you about individual sessions?”

*NOTE: These points can be adapted to use the language used in your program to describe these concepts and behaviors.

3. Treatment challenges –

Dialogue with the client about some of the challenges which can come up in treatment.

a) Explanation –

“Before we finish, I’d like to talk about some of the common challenges that come up in treatment. We’ve found that these challenges are a **normal** part of treatment and recovery. We’ve also found that people who **know what to expect**, can handle them well when they come up.

b) Inquiry –

“What were the challenges have you come across before in treatment? How would you handle that if it came up again?”

Or, if first treatment episode: “What might be challenging for you in treatment this time? How do you think you might handle that?”

c) Reflection –

“So it was hard to ... but you can...”

d) **Description of common challenges.** As you describe each challenge leave time for research participant to respond and discuss how the

challenge may apply to him/her. You may prompt by saying after some of these ““Does this ring a bell for you?”

“There are some challenges that pretty much everyone deals with in treatment and recovery. For example... ” Discuss

- (1) Practical challenges getting to sessions (e.g., transportation, childcare
- (2) Challenges related to feelings –
 - (i) Feeling good – “don’t need it anymore.”
 - (ii) Feeling bad – “It’s no use.”
- (3) Challenges associated with other people - How other people react to you getting clean and being in treatment; “It can be challenging to change (e.g., stay clean) when others want you to stay the same (e.g., keep using.)”
- (4) Challenges relate to discussing urges and use. “Sometimes it’s hard to talk about cravings, slips, and relapse. You may want to avoid UAs. When you do it anyway, give yourself credit. It’s all part of being successful in the recovery process.”
- (5) The challenge of feeling worse temporarily. “Sometimes people feel worse, emotionally or physically. For example, feelings that people numbed by using drugs begin to come out. That’s a good thing, a sign of progress. It’s temporary, and a part of the recovery process.”

ii) Handling Challenges –

(1) Inquiry–

“What are your ideas about how you might handle these challenges?”
How have you handled things like this in past treatment?”

(2) **What to do:**

- (a) “**Talk to your self.** Remind yourself, you expected this, it’s a sign of progress, part of the normal ups and downs of recovery.
- (b) Tell yourself to **come to treatment** anyway.
- (c) **Talk about it in treatment**, with me and in group. It’s what treatment is for. We work together to find solutions.”

Process

- Discussing roles conveys that both are active partners in treatment.
- Discussing roles decreases anxiety and uncertainty about what will happen.
- Predicting challenges improves chances for handling them well when they arise.

VI. Ending the Session (5-10 minutes)

Content

1. **Praise –**

“You’ve had some positive ideas about how to use treatment.” (Give examples)

2. **Positive Bond and Positive Expectations** –
 - a) “I look forward to working together.” (Or “I hope we get the chance to work together.” or if leaving the area, “if you go to treatment, you have a head start by discussing it with me today”)
 - b) “From what we’ve discussed today, it sounds as though we have lots of agreement about what’s important for you. We have a head start in talking about plans, goals, and what will probably work for you in treatment.”

3. **Appointment** -
 - a) Offer to make an appointment **right now** with client for outpatient treatment.
 - i) Offer to set up an appointment at the outpatient program. Explain that client can see you for treatment (explain your role) or see another counselor if client prefers.
 - ii) Explain whether client will see you for that first appointment or go through some other intake procedure.
 - iii) If client agrees to an appointment, schedule it **now** for the client and provide him/her with an appointment notice.

 - b) For clients who have not yet decided, or who have decided not to do treatment now, or who are leaving the area:
 - i) Provide written information about program, how to contact you, and how to make an appointment, and/or.
 - ii) Provide information about other treatment options.

4. **Praise** for change steps taken so far.

“You’ve already started your recovery, and done really well getting through detox.”

Process

- Ending the session in a manner which conveys respect.
- Ending the session in a way which conveys a new partnership.
- Ending the session with the next step in treatment planned.

Troubleshooting

Part of the skill in therapeutic alliance building for this intervention, as well as in counseling in general, is the ability to respond to unexpected or negative communication from clients calmly, with respect, and with continued intent to foster the development of a positive relationship. This TA skill utilizes:

- Reflective listening
 - See pages 11-13 of this manual.

- Reframing – restating the client’s comment in favor of a positive interpretation. Find what is positive, valid or realistic about client’s comment. Repeat that and add a positive interpretation of the “raw” information the client has supplied.
 - Example from page 9:
Client: “I’m not sure that I need anymore treatment now. I just needed to get clean. I know what I have to do and no one can tell me anything I don’t already know.”
*Counselor: “Good for you. **You know your recovery is up to you.** If you do decide to come to treatment, we can work together to practice, strengthen and support what you already know.”*

- Rolling with resistance - a principle of motivational interviewing (Miller & Rollnick, 1991) in which “resistance” is not confronted, disputed or argued, but “rolled with” with a goal of shifting clients’ perceptions in the process of discussion. It essentially involves accepting and respecting what the client is saying. The therapist may then invite the client to consider a new perspective, additional information or a new interpretation of the information, perhaps using reframing. The therapist’s open attitude conveys “take what you want and leave the rest.” (Miller & Rollnick, 1991, p.60.)
 - Example:
Client: “I’ve been in lots of treatment and it really hasn’t done anything for me.”
Counselor: “The fact that you’ve kept working on recovery, even though it’s been hard, says something positive about you and your commitment. Discussing what hasn’t been helpful for you before gives us good information for planning this treatment.”

Workspace:

Below are some examples of unexpected or negative client communications which may occur during the TA session. Write your responses following the client’s statements.

Beginning the Session

Counselor: "How has your detox been going so far?"

Client: "It's been really terrible. They don't understand how bad I feel. Would you tell them that I need to see the nurse?"

Counselor:

Discussing Plans after Detox

Counselor: "Tell me about your plans after detox?"

Client: "My life is a total mess. I don't think I can make it."

Counselor:

Counselor: "What thoughts have you had about going to outpatient treatment?"

Client: "I'm not going to do treatment. All I need is meetings."

Counselor:

Counselor: "What thoughts have you had about going to outpatient treatment?"

Client: "I can't do treatment here. I'm going back to Lincoln City where I live."

Counselor:

Discussing Treatment Expectations

Client: "I've been in treatment before. All they focused on was whether you broke the rules or had dirty UAs."

Counselor:

Describing What Happens in Treatment

Client: "I don't need to hear this. I've been in treatment before."

Counselor:

Ending the Session

Client: "What's this research about?"

Counselor:

Examples of possible responses:

Beginning the Session

Counselor: "How has your detox been going so far?"

Client: "It's been really terrible. They don't understand how bad I feel. Would you tell them that I need to see the nurse?"

Counselor: "Given how hard it's been, it says something positive about you that you've hung in there. At the end of our session, you can tell me what the usual procedure is for seeing a nurse and I'll see if I can help."

Discussing Plans after Detox

Counselor: "Tell me about your plans after detox?"

Client: "My life is a total mess. I don't think I can make it."

Counselor: "It sounds as though you feel a bit overwhelmed. Tell me a little about it and we can talk about how treatment can help."

Counselor: "What thoughts have you had about going to outpatient treatment?"

Client: "I'm not going to do treatment. All I need is meetings."

Counselor: "Meetings are a great idea. Let me tell you more about treatment, how it works and what it has to offer, in case you hit some rough spots in staying clean and decide you could use more help."

Counselor: "What thoughts have you had about going to outpatient treatment?"

Client: "I can't do treatment here. I'm going back to Lincoln City where I live."

Counselor: "Thanks for letting me know. The things we talk about can help you decide about doing treatment nearer to where you live. If you decide to pursue it, I can help you with some information and referrals."

Discussing Treatment Expectations

Client: "I've been in treatment before. All they focused on was whether you broke the rules or had dirty UAs."

Counselor: "I'm glad you told me about it. It's hard to consider treatment when you've not had a good experience before. By talking about it, we get a chance to figure out what will be helpful and how to make it work for you.."

Describing What Happens in Treatment

Client: "I don't need to hear this. I've been in treatment before."

Counselor: "Tell me what you found helpful and what you didn't. Then I can tell you how it compares with what we do and we can figure out what might be useful for you."

Ending the Session

Client: "What's this research about?"

Counselor: "It's about finding ways to help people stay clean and avoid risky behavior after detox. You've made a big decision to turn your life around and hung in there successfully through detox. We want to find the best ways, like outpatient treatment, to help people stay clean after such a good start."

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APPENDIX I

PROTOCOL 0017

Therapeutic Alliance Session Outline

I. Beginning the Session (2 minutes)

- Introduction
- Purpose of session
 - Your plans
 - Tell about Tx
 - How we might work together
 - Help decide
 - Answer questions
 - Find out what's important
- Inquiry about detox
 - reflection

II. Plans after Detox (5 minutes)

- Inquiry
 - Plans after detox?
 - How you'll stay clean?
 - Thoughts about treatment?
 - Pros & cons of going to treatment
- Reflection
- Repetition of purpose of session using client's information
 - Tx can fit with your plans...It matches with...

III. Treatment Expectations (8 minutes)

- Introduction
- Prior treatment experience or what you've heard
 - What worked/ not; what expect will work/not
 - Reflection and summary
 - Praise for positive, realistic ideas (what did work or will work, what not)
 - Emphasize how can do what "works" in proposed Tx

IV. Treatment Goals (10 minutes)

- Inquiry
- Developing agreement: “Agree...we can work on...”
- Developing expectation of success
 - Level of confidence in reaching goals?
 - Summary/reflection
 - Increase confidence?
 - Positive expectations – general : “Research shows..
 - Job and/or school
 - Improved legal status
 - Example using a client goal
 - Positive expectations - client specific: “You’ve shown...”

V. What Happens in Treatment (10-15 minutes)

- Introduction
 - Working on client goals, what’s “worked” for client
 - Schedule overview

- Description: Group
 - What client expects?
 - Talk about feelings, thoughts, behavior
 - Learn skills
 - Give/receive support
 - Learn communications & relationship skills
 - Answer any questions?

- Description: Individual Sessions
 - What client expects?
 - Develop goals and plan
 - Talk about feelings, thoughts, behavior
 - Learn skills
 - Provide info, respect, support
 - Answer any questions?

- Treatment challenges (5-10 minutes)
 - Introduction – normal and helps to know what to expect
 - Inquiry – client ideas about challenges & handling them
 - Reflection/summary
 - Common challenges

- Practical ones, such as getting to Tx
 - Feelings – good (don't need it), bad (give up)
 - Other people uncomfortable with you changing, staying clean, going to Tx
 - Hard to come and talk about cravings, use, having ua's, etc.
 - Feel worse before feeling better. Feelings emerge- sign of progress
- Handling Challenges
 - Client ideas: How to handle?
 - To do:
 - Self-talk – expected, normal, sign of progress
 - Come to Tx – Remind self – Keep coming to Tx
 - Talk about in treatment, bring them up – we'll work together to find solutions

VI. Ending the Session *(5- 10 minutes)*

- Praise for client's input & ideas during session
- Positive bond – look forward to working together
- Positive expectations – areas of agreement; “head start” in tx
- Appointment for outpatient treatment or referral information
- Praise for changes so far and plans for recovery

