Establishing a Therapeutic Alliance With Substance Abusers

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To understand a research problem, it helps to first look back at its origins. For each of the three topics in this chapter, the authors first look back, then look ahead to see how to use what is known about (1) the concept of the alliance, (2) its translation into measures for substance abuse research, and (3) its use in improving psychotherapy outcomes in drug abuse treatment.

THE CONCEPT OF THE THERAPEUTIC ALLIANCE

Where else should the alliance concept have started but with Freud (1912)? Freud took for granted the need to first establish rapport as part of developing an alliance with the patient, an essential ingredient of effective treatment. Much later, Bordin (1976, 1980) elaborated a theoretical framework that also set the stage for the later development of measures of the alliance.

The influences of both Freud's and Bordin's concepts on the development of measures of the alliance are apparent. Bordin described three components in the alliance: goals, tasks, and bonds. In a well-functioning treatment relationship, the patient and therapist come to an agreement about the goals the patient wishes to achieve in the treatment. They also come to accept certain therapeutic tasks as potentially helpful for achieving those goals. The bonds that form between patient and therapist in the course of working on the tasks include the positive personal attachments that stimulate trust and confidence.

MEASURES OF THE ALLIANCE AND THEIR RESULTS IN SUBSTANCE ABUSE RESEARCH

In 1974, Bordin arranged a program on concepts of the alliance for the 1975 Society for Psychotherapy Research annual meeting and asked Luborsky to participate. To get ready for that meeting, Luborsky looked back over Bordin's concepts, examined transcripts of psychotherapy sessions, took note of the inferences about the

alliance, and started to develop operational alliance measures, including two transcript-of-sessions methods: the Helping Alliance Counting Signs method (HAcs) (Luborsky 1976) and a session-based rating method, the Helping Alliance Rating Method (HAr) (Morgan et al. 1982). About 1977, Woody, McLellan, and Luborsky began a study of opiate-dependent patients (Woody et al. 1983) involving the use of another alliance measure, the Helping Alliance questionnaire (HAq) (Luborsky 1984; Luborsky et al. 1985; see also a review of research with that questionnaire in Luborsky et al., unpublished). It is therefore fitting that the conference on the therapeutic alliance was sponsored by the National Institute on Drug Abuse (NIDA), because Woody and colleagues'(1983) NIDA-supported study was the first use of a questionnaire called an alliance measure as a predictor of the outcome of psychotherapy.

This review is restricted to measures that are called alliance measures. There were earlier studies, based on a variety of more general measures of relationship patterns (mostly called relationship measures), especially Barrett-Lennard's Relationship Inventory (Gurman 1977). The authors' shift in label to "alliance," however, may have been a substantive one reflecting more than just a change in the name, but also a greater focus on a specific active ingredient of the relationship, the alliance.

The remainder of this section describes the main substance abuse studies that have used alliance measures, Woody and colleagues (1983) and Luborsky and colleagues (1985). Their aim was to determine whether psychotherapy added significantly to treatment as usual (drug counseling) for opiate-dependent patients. Psychotherapy was found to add to the patients' benefits from treatment. For the combined sample of four types of treatment—cognitive-behavioral (CB), dynamic, supportive-expressive (SE), and drug counseling (DC)—the alliance, as measured by the HAq, significantly predicted outcomes of the psychotherapies ($r = 0.65$, $p < 0.01$). The Woody and associates study (1983) played a big part in the drug abuse field by stimulating what has become the popular use of alliance measures in psychosocial treatment studies with many types of psychiatric patients.

Several subscales on the Addiction Severity Index (ASI) (McLellan et al. 1980) (higher severity is associated with lower adherence) correlated highly with the HAq, such as drug use (0.72, $p < 0.01$) and psychological functioning (0.58, $p < 0.01$). These ASI scores were taken at the 7-month outcome point, 1 month after the 6 months

allotted treatment time. The therapist form of the HAq gave similar results.

Gerstley and colleagues (1989) offered a new analysis of the alliance data collected by Woody and associates (1983), specifically examining psychotherapy outcomes on patients with the diagnosis of antisocial personality disorder. Gerstley and associates (1989) built up the work of Woody and colleagues (1985), who compared four diagnostic subgroups: opiate dependence alone (N = 16), opiate dependence plus depression (N = 16), opiate dependence plus depression plus antisocial personality disorder (N = 17), and opiate dependence plus antisocial personality disorder (N = 13). Patients with opiate dependence plus antisocial personality disorder improved the least, showing change only on ratings of drug use. Patients with opiate dependence alone or with opiate dependence plus depression improved significantly and in many areas. Therefore, the general finding was that antisocial personality disorder alone is a negative predictor of psychotherapy outcome, but that co-occurring depression appears to improve the patient's amenability to psychotherapy.

It is noteworthy that in Woody and associates' (1983) study, 76 percent of the sample met research diagnostic criteria (RDC) for at least one psychiatric disorder in addition to drug dependence. Nineteen percent of the patients met RDC standards for antisocial personality disorder, but 45 percent of the patients met the antisocial personality disorder criteria when "Diagnostic and Statistical Manual of Mental Disorders," 3rd ed. (DSM-III) criteria were used.

Gerstley and associates (1989), using the same data as Woody and associates but with the HAq, examined patients' capacity to form an alliance with the therapist when the diagnosis met DSM-III antisocial personality disorder criteria. Their new findings were that some patients diagnosed with antisocial personality disorder were able to form a positive relationship with their therapist, as measured by their scores on the HAq-I, and that these scores correlated with improvement in psychotherapy. The HAq therefore helped in identifying which antisocial personality disorder patients would benefit from psychotherapy.

In a study by Luborsky and associates (in press), two alliance measures were compared with each other in the pilot phase of a large-scale NIDA multisite collaborative psychotherapy outcome study for cocaine disorder patients; the measures were the Penn Helping Alliance questionnaire-II (HAq-II) (Luborsky et al., in press) and the

California Psychotherapy Alliance Scale (CALPAS) (Marmar et al. 1989). The patient sample was drawn from the four sites of the NIDA collaborative study at hospitals in Nashua (NH), Philadelphia, Pittsburgh, and Boston. The two alliance scales were filled out by approximately 250 patients early and late in the course of 6 months of psychosocial treatment for cocaine dependence.

Two findings emerged (Luborsky et al., in press) from the analysis of the data: Internal consistency was high for the items of the HAq-II as well as for those of the CALPAS scale, and was also evident in both the patient and therapist forms for each measure. The HAq-II and the CALPAS were moderately correlated with each other, with correlations between the patient version of the two forms at sessions 2, 5, and 24 of 0.59, 0.64, and 0.75, respectively, and with similar correlations of 0.78, 0.79, and 0.94 for the therapist version of the two measures. (The predictions of outcome will be reported in a future publication.)

APPLICATIONS OF PROCEDURES FOR IMPROVING THE ALLIANCE AND THE OUTCOMES IN PSYCHOTHERAPY

The field is at an early stage in terms of studies of how to use the knowledge of the alliance to improve the alliance for both addicted patients and other patients. Although the field already has some applied quantitative studies, it is worth relying also on what has been learned clinically. These clinical studies are sampled below.

Clinical Procedures

Freud (1912) offered two specific recommendations to improve the rapport between patient and therapist: do nothing to interfere with the natural development of rapport, and listen with sympathetic under-standing. Similarly, Rogers (1957) recommends showing empathy and positive regard.

An extended set of recommendations was assembled for improving the alliance (Luborsky 1984, 1993).

1. Convey support for the patient's wish to achieve the patient's goals. This can be done by reviewing the patient's goals from time to time to clarify them and to relate what is being done in the therapy to meet these goals.
2. Offer understanding and acceptance of the patient.

3. Develop a liking for the patient or for important aspects of the patient.

4. Help the patient who needs support to hold on to vital defenses and activities that maintain the patient's level of functioning.

5. Convey a realistically hopeful attitude that the treatment goals are likely to be achieved and that the therapist is trying to help the patient achieve them.

6. Recognize on appropriate occasions that the patient has made some progress toward the goals.

7. Find ways to encourage some patients to express themselves on some occasions.

Clinical-Quantitative Procedures

The positive correlations of early alliance measures with treatment outcome imply that strengthening the alliance should improve the outcome of treatment. In fact, the current authors found a correlation in the Penn psychotherapy sample of 43 patients between the early sessions scores on the HAcs method (Luborsky et al. 1983) and outcome measures: 0.31 ($p < 0.05$) with rated benefit and 0.36 ($p < 0.05$) with residual gain. A meta-analysis of 24 studies by Horvath and Symonds (1991) found an average effect size of 0.26 of alliance scores with therapy outcome, although the mean correlation was diminished by counting all nonsignificant correlations as zero. It has also been reported that the state of the alliance is related to the choice of a therapist (Alexander et al. 1993).

But many of those in the field are part of the here-and-now generation of researchers who ask for clinical-quantitative verification of the value of any clinical methods for improving the alliance. Fortunately, the field has a few studies that deal with improving the level of the alliance. Although none of these studies involves patients with drug abuse problems, effects are likely to be similar across different types of patients (Luborsky et al. 1991). A sample of the recommendations from the applied studies follows.

Picking Successful Therapists. There is evidence that therapists who have a good level of success with patients have patients who

develop a good alliance with them (Luborsky et al. 1985). This is a promising finding and bears replication and analysis of the methods used by these therapists in establishing an alliance.

Repairing Ruptures in the Alliance. Foreman and Marmar (1985), followed by Gaston and colleagues (1989), were the first to assemble examples of impairments in the alliance and suggest a method for repairing them. Safran and associates (1990, 1994) have also set up methods for showing that ruptures in the alliance can be identified and that there are ways of healing them. The main way to improve the alliance, as suggested by Foreman and Marmar (1985) and Safran and associates, is to focus on the problems within the patient-therapist relationship, rather than on problems in outside-of-treatment relationships. The benefits of this kind of focus on the improvement of the patient-therapist relationship have been shown by others as well (Coady 1991).

Increasing Therapists' Alliance-Facilitating Behaviors. A likely area to search for evidence about factors influencing the development of the alliance is within therapists' behaviors that facilitate the alliance. One scale that may be useful to help focus this exploration is called the Therapist Facilitating Behaviors Scale (Luborsky et al. 1988). Scores on this scale have been found to correlate with the alliance scores. For 20 patients in the Penn psychotherapy sample, there was considerable association between the two types of measures; for example, early helping alliance ratings correlated 0.85 ($p < 0.001$) with early therapist's facilitating behaviors rating. It is natural with such a high correlation to suspect that one of the factors influencing formation of the helping alliance is the therapist's ability to facilitate alliances.

Dealing With the Relationship Problems. Several studies that are not specific to the therapeutic alliance may give suggestions about factors related to developing and maintaining such an alliance. Kivligahn and Schmidz (1992) showed that therapists who were more inclined to deal with the therapeutic relationship were more likely to improve the alliance than therapists who were less focused on the relationship. As noted earlier, Foreman and Marmar (1985) suggested that therapists may be able to improve the alliance by dealing with the therapy relationship directly.

Other studies have implied that therapists who relate effectively to patients influence the rate of patients' dropout (McLellan et al. 1988) and the level of patients' motivation (Miller and Rollnick 1991).

Interpreting Accurately. The accuracy of the therapist's interpretations appears to be associated with development of the therapeutic alliance (Crits-Christoph et al. 1993). The measure of accuracy of interpretation is based on the congruence of the therapist's interpretations with the patient's core conflictual relationship theme (CCRT), particularly accuracy on the CCRT dimensions of wish plus response from others; this congruence measure predicted changes in the therapeutic alliance. In an earlier study (Crits-Christoph et al. 1988), this congruence was associated with the patients' benefits from psychotherapy.

ADVANCING THE BENEFICIAL POWER OF THE TREATMENT ORGANIZATION

The qualities of the organization within which drug and alcohol treatment are given can strongly influence the alliance of patients who enter it. Among the earliest contributions in this area was the work of Ball and Ross (1991). McLellan and associates (McLellan and Durell 1995; McLellan et al., in press) have assembled a sample of about 200 such treatment organizations and are systematically relating the qualities of the organization, such as its supportiveness, to outcomes of treatment and to patient characteristics. A large collection of data on such organizations is also being assembled by Hser and associates (1992). This kind of information is probably more critically important for substance abuse patients whose treatment often takes place in a clinic setting.

THE ROLE OF REWARDS

Two other treatment procedures are very likely to foster the alliance. One is giving money as a reward when the patient successfully achieves goals such as abstinence. Stanton and Todd (1981) showed that giving money to the family for attendance and successful abstinence by the patient was effective. Higgins and Budney (1993) demonstrated that giving vouchers to patients was related to attendance, and attendance was related to continued cocaine abstinence and attendance at sessions. The effect of the vouchers may be to encourage patients to come more often, thus improving benefits. A more complex explanation is that as a result of coming more often, the patient may develop an alliance and then benefit

more. The presence of the intervening variable of developing an alliance is a probable inference that merits investigation.

Giving food, such as sandwiches and coffee, is another treatment aid that appears to have similar benefits; the same explanatory reasoning applies. The giver of the food is presumed to become associated with food, a powerful unconditioned reinforcer, which may help the alliance. Food also seems to help with attendance, which generally leads to increased benefits from treatment, but controlled studies on this have not yet been done.

All of these clinical and clinical-quantitative procedures appear to stimulate the alliance and so will have positive effects on the patient's improvement. These procedures may have a not-so-secret underlying common source of their benefits in stimulating the alliance. It becomes easier to recognize the commonality among the measures after slowly re-reading the list of alliance-stimulating procedures: The more the patient sees the therapist and the treatment organization as providing what the patient needs, the more the procedure qualifies as an alliance stimulant; the more that is given by the organization, the more the patient experiences caring and support in achieving the mutually agreed-upon goals.

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