A RELATIONAL INVESTIGATION OF THE THERAPEUTIC ALLIANCE IN SUBSTANCE

ABUSE TREATMENT: A QUALITATIVE INQUIRY

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ABSTRACT

Phenomenological inquiry was utilized to explore clients' lived experiences with the therapeutic alliance in substance abuse treatment at a low intensity residential treatment center in East-Central Minnesota. Five females and ten males ranging in ages between 20-55 years of age participated in individual interviews. Moustakas's (1994) modification of the Stevick-Colaizzi-Keen method was the approach utilized for data analysis. The researcher identified several themes and subthemes during data analysis. The researcher identified four major themes (Working with their counselor helped clients learn about themselves; Mutuality deepened the client-counselor relationship; Clients valued their counselors connecting them with resources; and Clients appreciated that their counselors held them accountable by inquiring about behaviors or progress toward identified goals). Several subthemes were identified (Uncovering hidden insights; Counselor genuine self-disclosure as a means of establishing mutuality and relatability; and Counselors sharing emotion). A relational framework was utilized to address alliance formation issues unique to addiction treatment, specifically client engagement. Implications for practice and research will be discussed.

Keywords: Relational-Cultural Theory, addiction counseling, phenomenology, qualitative

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DEDICATION

Dedicated in loving memory of Tim Brown and Randy Huckeby. I think of you every day.

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CHAPTER 1. INTRODUCTION

In this chapter the author provides an overview of this qualitative investigation. It includes the purpose, rationale, and the theoretical framework for the study. Additionally, the researcher outlines the research questions and defines important terms. Chapter one provides a foundation for reviewing the additional chapters including literature review, methodology, results, discussion, and implications for both practice and additional research.

Statement of the problem

The research about the role of the therapeutic alliance in mental health counseling is clear. The client-counselor relationship is paramount to the effectiveness of counseling (Leibert, Smith, & Agaskar, 2011). Although research has found that the alliance is just as important in substance abuse treatment, the relationship between the client and counselor within this context has garnered much less attention (Crits-Christoph, Connolly Gibbons, Crits-Christoph, Narducci, & Schamberger, 2011). This lack of attention is concerning given the crucial role the alliance plays in the effectiveness of treatment, particularly in terms of client engagement (Joe, Simpson, & Broome, 1999). Although there are various ideas about what constitutes an effective therapeutic alliance, there are few studies that explore clients' perspectives of their counselors during substance abuse treatment.

Purpose of the Study

The purpose of this study is to explore the relational aspects of the therapeutic alliance in substance abuse treatment from the client perspective. A recent article by Miller and Moyers (2014) highlights the need for further exploration of relational factors involved in the therapeutic alliance within substance abuse treatment. Given the significance of the therapeutic alliance in engaging clients in substance abuse treatment, it is important to explore relational aspects and

dynamics of the alliance that either nurture or impede the relationship between the client and counselor. Due to the relational nature of this study, the theoretical underpinning will be grounded in Relational Cultural Theory, which postulates that individuals grow through and toward connection throughout their lives (Jordan, 2010).

An additional purpose of this study is to identify the presence or absence of the characteristics of growth fostering relationships as proposed by Jean Baker Miller (1976) and ultimately, explore the connection between the presence or absence of these relational characteristics and the client's perception of the therapeutic alliance. Miller identified five characteristics of a growth fostering relationship which she coined the "five good things." The five good things of a growth fostering relationship are zest, a sense of worth, productivity, clarity, and wanting more connection (Jordan, 2010). In this study, participants will explore relational phenomena in their experiences within the client-counselor relationship.

Significance of the Study

Historically, substance abuse treatment has been characterized by confrontation (Polcin, Mulia, & Jones, 2012) and the precedent that in order to move toward recovery from drugs and alcohol, one must admit that they are powerless over drugs and alcohol (Shearer & King, 2001). These concepts inherent in the dominant treatment strategy in substance abuse undermine the concept that Jordan (2010) identified as necessary for growth fostering relationships. She stated that mutuality and power-with dynamics are necessary in order to fully participate in growth fostering relationships and for all intents and purposes, one could argue that the therapeutic alliance is or should be a growth fostering relationship. There is a growing body of evidence that supports the movement away from confrontational and power-over dynamics within the therapeutic alliance in substance abuse treatment (Shearer & King, 2001). The use of

confrontation and power-over dynamics may parallel the dynamics of relationships within the culture of substance abuse, thus working against connecting individuals with supportive people that focus on them in recovery. Although confrontation can vary in meaning among counselors and treatment approaches (Polcin, 2009), the lack of negative confrontation is not a sufficient condition for client change (Macdonald, Cartwright, & Brown, 2007). It is important to explore the relational factors that may contribute to the therapeutic alliance and work to increase client engagement in treatment.

In an effort to create a therapeutic alliance, it would make sense to investigate the opposing concepts of confrontation and power-over dynamics: mutuality and power-with dynamics. If confrontation and other power-over dynamics may lead to resistance and other destructive interpersonal interactions, what then, would come of the use of mutuality and power-with dynamics within the therapeutic alliance in substance abuse treatment? This is especially relevant given the high drop-out rates in substance abuse treatment, that may indeed stem from overly confrontational approaches (Cournoyer, Brochu, Landry, & Bergeron, 2007).

As we will discuss in the following chapter, the introduction of RCT into mainstream counseling led one to question the effectiveness and one-sidedness of counselor neutrality and encouraged counselors to examine their role in the client-counselor relationship. Along the same line, it is important for counselors to be aware of how one's actions (i.e. counselor neutrality or confrontation) may be perpetuating clients' unhealthy relationship patterns and maladaptive behaviors. Stated differently, Jordan (2010) discussed that when clients are met with counselor neutrality and one-sidedness (in other words, the client-counselor relationship lacks mutuality), clients' feelings of disconnection and isolation may be intensified. This is especially relevant to addiction counselors as clients entering treatment often have a history of unhealthy relationships

and social isolation. This may be a "chicken or the egg" argument in terms of which came first, addiction or isolation. Nonetheless, isolation and disconnection intensifies addiction.

As a result, addiction counselors need to be mindful not to perpetuate clients' feelings of disconnection and isolation by interacting with clients from a place of neutrality and/or unhelpful confrontation. The significance of the study, in part, lies in RCT's assertion that therapist relational factors enhance the therapeutic alliance and client engagement. Given the difficulty of engaging clients in addiction treatment and the lack of research on specific therapist relational factors, there is significance in exploring therapist relational factors that enhance the alliance and foster client engagement.

Theoretical Perspective

In recent years there is a growing body of literature endorsing Relational Cultural Theory as an effective approach to working with clients in mental health counseling (Duffey & Somody, 2011; Jordan, 2010). However, there are few instances of RCT being utilized in substance abuse treatment. This study proposes that RCT provides a framework to create a therapeutic alliance and growth-fostering relationship between the client and counselor in addiction treatment. RCT allows practitioners to rework the historical presence of confrontation and other power-over dynamics in substance abuse treatment that continue to perpetuate other unhelpful dynamics associated within the drug and alcohol culture. Additionally, it is important to begin specifying the non-specific elements, relational factors that will aid in building a strong therapeutic alliance and engage clients in addiction treatment (Sexton, Littauer, Sexton, & Tommeras, 2005). Due to the malleable nature of therapist interpersonal skills, implications from the proposed study could be integrated into counselor training to enhance the therapeutic alliance and improve outcomes in substance abuse treatment.

Research Questions

The research questions utilized in this study are as follows:

1.   What do clients care about in the therapeutic alliance?

2.   What relational characteristics of the counselor matter to clients?

3.   What counselor actions matter to clients?

Definition of Terms

Therapeutic alliance: Throughout the history of counseling, the relationship between the client and counselor has been defined in multiple ways. One of the most utilized definitions in the literature is Bordin's (1979) definition of the therapeutic alliance as consisting of three primary components: tasks, goals, and bond. Due to the relational nature of the proposed study, the therapeutic alliance will be defined as the emotional bond between the client and counselor.

Substance Use disorder: A substance use disorder is symptomology that results from the continued use of a substance despite experiencing issues from using the substance. Additionally, the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) specifies 11 diagnostic criteria (symptoms) for substance use disorders: 2-3 symptoms is indicative of a mild substance use disorder, 3-4 symptoms indicates a moderate substance use disorder, and 6 or more symptoms indicates a severe substance use disorder (American Psychiatric Association, 2013).

Substance abuse treatment: Often, substance abuse treatment and addiction treatment are used to describe treatment for individuals with substance use disorders. As a result, both terms will be used interchangeably. Substance abuse treatment is designed and implemented to address substance use disorders. The predominant modality for substance abuse treatment is group counseling. There are multiple levels of care including outpatient, inpatient, low intensity residential, and medium intensity residential (American Society for Addiction Medicine, 2013).

The study was conducted with participants from a residential substance abuse treatment center in east-central MN. In order to protect the confidentiality of individuals that participated in the study, the name of the treatment center will not be used and will be referred to as the Recovery Center. The recovery center offers low intensity residential treatment, which is generally referred to as a halfway house.

Low-Intensity Residential: Clinically managed low-intensity residential treatment is 24-hour structure with available personnel. Clients in the low-intensity level of care need to receive 5 hours of programming with a licensed addiction counselor per week (American Society for Addiction Medicine, 2013). The low intensity program at the Recovery Center primarily serves individuals that completed inpatient treatment prior to admission at the center. Clients in the low intensity level of care are required to attend 5 hours of programming a week including 4 hours of group with a licensed addiction counselor and an hour-long individual session with their primary counselor (their assigned counselor throughout the duration of their stay, unless the client requests a different counselor). The purpose of low intensity is to provide support and structure to individuals who are transitioning back to the community following treatment (or multiple treatments, incarceration, etc.). Primary goals of low intensity are finding employment, securing housing, and establishing a peer support network in the community that is conducive to recovery.

Relational Cultural Theory (RCT): RCT was developed by Jean Baker Miller and colleagues and posits that humans grow through and toward connection throughout their lives (Jordan, 2010).

Growth-fostering relationship: A growth-fostering relationship is when two or more individuals engage in a relationship that is characterized by mutuality and growth is experienced by all people involved (Jordan, 2010).

The 5 good things: Growth-fostering relationships result in five good things: productivity, increased clarity of oneself (and in relation to others), zest, increased self-worth, and a desire to obtain healthy connection (Jordan, 2010).

CHAPTER 2. LITERATURE REVIEW

The researcher's focus in this study is on the phenomenon of the therapeutic alliance in substance abuse counseling. To this end, the research relevant to this study includes a) existing definitions and perceptions of the therapeutic of the alliance, b) common factors of connection and relationship between client and counselor, c) relational factors within the alliance in substance abuse treatment, d) the theoretical framework of Relational-Cultural Theory. Additionally, as stated in the previous chapter, there is a strong link between the therapeutic alliance and treatment outcomes in mental health counseling. Therefore, the author begins the literature review focusing on the alliance and treatment outcomes for mental health counseling in general and then addresses the research specific to the field of substance abuse counseling.

Therapeutic Alliance and Mental Health Counseling

In reviewing the literature regarding the role of the therapeutic alliance in counseling and psychotherapy, several researchers have been prominent in defining and shaping the therapeutic alliance as well as contributing landmark research (Bordin, 1979; Freud, 1913; Greenson 1976; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Luborsky, 1976; Norcross, 2002; Rosenzweig 1936; Wampold & Brown, 2005). Over time, these researchers shaped the meaning and significance of the therapeutic alliance. The therapeutic alliance originated as a concept in psychoanalytic therapy. Freud (1913) introduced the first concept of the therapeutic alliance in a brief paper when he discussed the significance of the client developing a positive attachment to the therapist, which he described as a trusting relationship between client and therapist. Additionally, the work of Greenson (1965) generated the term working alliance in which he notes the importance of the extent to which the client is willing to work with the therapist. Like Freud, he thought of the alliance in terms of transference.

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The initial conceptualization of the alliance being rooted in psychoanalysis shifted due to the work of Luborsky (1976) and Bordin (1979). Both researchers proposed that the therapeutic alliance involves intentional efforts from both the client and counselor. Furthermore, they posited that the alliance moves beyond the theoretical underpinning of the various approaches of psychotherapy and is common to all approaches (Krause, Altimir, & Horvath, 2011). Bordin (1979) was fundamental in conceptualizing the therapeutic alliance as it is known today. He postulated that the concept of alliance is crucial to all approaches in psychotherapy. Furthermore, he asserted that the therapeutic alliance has several components including goals, tasks, and bond. Tasks are the activities in which the client and therapist agree upon in order to reach identified goals. Relevant to tasks within the alliance, is the timing of the tasks. Bordin (1979) identified that the client and therapist need to identify and agree upon goals that will be worked on in counseling. It is also important for clients to perceive that their therapist is committed to helping them reach their goals. He identified that the bond between the client and therapist is reflective of the emotional connection between the two people. Due to the limited scope of the literature review and the relevance to the curent study, the focus of this review will be largely centered on the factors that contribute to the emotional bond between the client and counselor.

Factors of Connection and Relationship in the Therapeutic Alliance

The concept of common factors in counseling was generated by Saul Rosenzweig in 1936 (Duncan, Miller, Wampold, & Hubble, 2010). The shift in focus from specific treatment modalities to common factors led researchers to develop models of common factors. An early model of common factors was developed by Michael Lambert upon conducting an expansive review of outcome research. Lambert (1992) asserted that there are four categories of therapeutic factors. Additionally, he estimated the impact of each therapeutic factor on treatment outcomes.

Lambert (1992) identified the four therapeutic factors and their estimated impact: client factors/extratherapeutic factors (40%), common factors (30%), placebo, hope and expectancy factors (15%), and treatment modalities (15%). Lambert's (1992) therapeutic factors were later identified as common factors shared by various treatment modalities (Hubble, Duncan, & Miller, 1999).

Common factors including the therapeutic alliance and counselor variables can account for up to 70% of the variance in treatment outcomes versus the 8% of variance attributed to treatment specifics (Leibert, Smith, and Agaskar, 2011). Due to the significant impact of common factors on treatment outcomes, there has been a shift in the focus of research from the efficacy of treatment modalities and impact on treatment outcomes to common factors and their impact on treatment outcomes (Wettersten, Lichtenberg, and Mallinckrodt, 2005). Leibert et al. (2011) asserted that further exploration of common factors is necessary in making gains in outcome research. Several researchers worked to identify and explore common factors affecting treatment outcomes, specifically the therapeutic alliance (Rautalinko, 2013). Leibert et al. (2011) asserted that relationship factors are among those with the largest impact on therapeutic change, accounting for approximately 30% of change. Furthermore, of the relationship factors, the therapeutic alliance has been found to be a consistent predictor of treatment outcomes.

Common Factors and Treatment Outcomes

Although the literature on the correlation between treatment outcomes and common factors is sparse; there is research that suggests common factors across treatment modalities are largely responsible for what makes treatment successful (Leibert & Dunne-Bryant, 2015; Leibert et al., 2011). There are research studies that emphasize the relationship between counselor and client as the major factor for successful treatment, regardless of the specific treatment modality.

Leibert and Dunne-Bryant (2015) recently explored several of the common factors from Hubble et al.'s (1999) model that were amenable to being measured using brief client self-report assessments. The authors found that two common factor categories, placebo, hope, and expectancy, and relationship factors were predictive of client outcomes. Placebo, hope, and expectancy accounted for 4% of the outcome and relationship factors accounted for 3% of the outcome. Leibert and Dunn-Bryant (2015) discussed that the findings of their study were congruent with previous research that evidenced a connection between the therapeutic alliance and positive treatment outcomes. Upon discussing their findings, the authors emphasized the significance of the client-counselor relationship when establishing trust with clients, especially clients who have experienced abuse and may find it difficult to begin trusting others.

Leibert and Dunne-Bryant (2015) recommended that counselors be mindful to select a treatment approach that emphasizes the role of the client-counselor relationship especially when abuse histories or other issues are present that could affect establishing client-counselor trust. In such cases, the authors give the example of choosing DBT over CBT given the emphasis DBT places on the client-counselor relationship. Leibert and Dunn-Bryant's (2015) findings are particularly relevant to the current study. The authors recommended choosing a treatment that emphasizes the role of the client-counselor relationship when working with clients that may be more difficult to engage with and establish trust. This is often the case with clients in substance abuse treatment as high rates of co-occurring trauma, among other issues, add to the difficulty of alliance formation.

The researcher's goal is to explore the relevance of Relational-Cultural Therapy (RCT) when working with clients who abuse substances. The researcher postulates that relational qualities of the counselor increase client engagement in treatment and enhance motivation to

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change. A more in-depth exploration of RCT and its relevance to the study will take place later in this literature review.

The Therapeutic Alliance and Treatment Outcomes

This section explores the link between the alliance and treatment outcomes. As discussed previously, although the focus of the current study is on relational factors within the alliance, noting the link between the alliance and treatment outcomes provides rationale for further investigation into factors that impact the alliance. Therapist factors and client perception of the alliance are discussed in the following paragraphs.

Horvath (2005) reflected on the growing body of research that supports the connection between early therapeutic alliance and successful treatment outcomes. He further noted that client-ratings of the alliance are better predictors of outcome and summarized research findings that support measures of the alliance early in treatment as being more predictive of treatment outcomes than measures of the alliance later in treatment. Another major focus of the literature on the therapeutic alliance in mental health counseling is the connection between the therapeutic alliance and treatment outcomes.

A strong therapeutic alliance has been linked to positive treatment outcomes (Baldwin, Wampold, Imel, 2007; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath & Symonds, 1991; Norcross, 2002). Prior to the work of Baldwin et al. (2007), the correlation between alliance and treatment outcomes was often reported without separating client and therapist variability. The authors found that client and therapist variability are not equally predictive of treatment outcomes. A significant finding of the study was that therapist variability in the client-rated alliance was predictive of treatment outcomes, whereas client variability was not. In other words, therapists that developed strong therapeutic alliances achieved better

treatment outcomes with their clients. Additionally, the authors postulate that therapist variability may be due in part to the therapist's ability to effectively resolve ruptures. Despite the recognition that the therapist plays a significant role in the development of the therapeutic alliance, specific therapist factors that contribute to a working alliance remain largely unknown.

Despite support for early therapeutic alliance (alliance formation early in treatment) as a predictor for treatment outcomes, dropout, and client-rated alliance (D'iuso, Blake, Fitzpatrick, & Drapeau, 2009; Fruhauf, Figlioli, Bock, & Caspar, 2015; Grace, Kivlighan, & Kunce, 1995; Hilsenroth, Peters, & Ackerman, 2004; Krieg &Tracey, 2016), what is known about the relational factors characteristic of the alliance remains vague (Cooper, 2012; Dollarhide, Shavers, Baker, Dagg, & Taylor, 2012). Considering that early formation of the therapeutic alliance consistently predicts treatment outcomes, identifying specific counselor variables including relational factors that aid in building the therapeutic alliance could help practitioners infuse these relational aspects into their work to address issues with alliance building and increase positive treatment outcomes (Krieg & Tracey, 2016; McClintock, Anderson, & Petrarca, 2015). Kramer, De Roten, Michel, and Despland (2009) asserted that relational formation between the client and counselor is as important as the technical facets of counseling.

The Therapist Factor

Hubble et al. (2010) discussed that the most impactful common factor, the therapist, has often been neglected in the research. In fact, the authors stressed that the therapist is the strongest predictor of outcome, accounting for more variance than treatment modalities. Hubble et al. (2010) further stated, however, that some therapists are more effective at forming alliances with their clients than other therapists. The results from Hubble et al. (2010) identified that effective therapists have a 50% less client dropout rate and 50% more improvement among their clients

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than less effective clinicians. Furthermore, he discussed that multiple therapist variables have been identified as not having an impact on therapist variability including age, gender, experience, level of training, type of licensure and degree, theoretical orientation, quantity of supervision received, type of treatment modality utilized, and whether or not the therapist had personal therapy of their own. The researchers asserted that although there is a plethora of information on therapist factors that have minimal impact on the alliance and treatment outcomes, specific therapist factors that account for a majority of therapist variance remain largely unknown. This finding provides further support that some therapists are more effective than others regarding alliance formation. As a result, further exploration of clients' perspectives regarding therapist variables are paramount when it comes to providing clients with effective substance abuse treatment.

The Power of Connection within the Therapeutic Alliance

Paramount to the current study is the research conducted by Sexton, Littauer, Sexton, and Tommeras (2005) regarding client-counselor connection. Sexton et al. (2005) asserted that a significant variance in the therapeutic alliance could be attributed to interactions between the client and counselor. The authors attempted to identify specific interactions or qualities that led to building the therapeutic alliance. Based on the empirical evidence that exists on early alliance formation and treatment outcomes, the authors studied the first few sessions between clients and counselors. The participants of the study consisted of clients from a psychiatric outpatient clinic and fourteen therapists. Instruments used included the Brief Symptom Inventory, the short form of the Index of Interpersonal Problems, and the NEO Personality Inventory. Ratings were gathered from patients prior to the beginning of counseling and after session two with their therapist. Therapists assessed client symptomology and functionality using the Global

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Assessment of Functioning and likert scales. Both the client and therapist filled out the Working Alliance Inventory. A trained rater noted certain client and therapist interactional aspects during the session. Client emotions, tension, engagement, topic, and verbal content were rated during sessions.

The authors identified connection as a quality that could be measured in client-counselor sessions that signified the early formation of the therapeutic alliance. Connection was defined as the level of "intimacy and mutuality" between the client and counselor during sessions (Sexton et al., 2005, p.104). Additionally, it was identified that deeper connection was associated with greater client engagement and involvement as well as clients being more in touch with their emotions. Deeper connection was also associated with active listening, warmth, and emotional content on the part of the therapist. Client engagement and emotional involvement in session was associated with relatively consistent connection between the client and therapist. Client and therapist connection decreased during sessions when therapists were not as engaged and when therapists engaged in more cognitive content rather than emotional content.

Alliance ratings were attributed, in part, to client personality and the degree of connection between client and counselor. The finding that is most pertinent to the proposed study was that the degree of connection in session one accounted for the notable increases in the therapeutic alliance in session two. Taking this finding into account, an implication from their study was a call for further exploration of specific alliance markers. Part of the authors' rationale for focusing on interpersonal factors lies in the malleable nature of interpersonal skills as well as the potential for integration into counselor training to enhance the therapeutic alliance and treatment outcomes.

Given the relational nature of connection, it makes sense to further explore relational factors that could aid in building the alliance between client and counselor. Similarly, Dollarhide, Shavers, Baker, Dagg, and Taylor (2012) encouraged counselors to create a connection with their clients in order to reach optimal growth and healing that extends beyond rapport building. The authors posited that certain interventions are not viable treatment options in the absence of client-counselor connection and the presence of a deep connection improves the therapeutic alliance. Furthermore, client-counselor connection establishes relational safety in order for clients to work through emotional pain and move towards growth and healing. Dollarhide et al. (2012) postulated that practitioners should gauge client progress in counseling by the quality of the client-counselor connection. This viewpoint is contrary to traditional standards of measurement regarding client progress and encourages counselors to emphasize and utilize their relational skills (in conjunction with counseling techniques and interventions) to build and strengthen the therapeutic alliance.

Although the current study does not focus on treatment outcomes, it is important to note the strong link between the alliance and treatment outcomes. Hubble et al. (2010) asserted that therapist factors that account for a majority of therapist variance remain largely unknown. Although research remains sparse, several researchers have answered this call by investigating relational factors (connection) that contribute to alliance formation (Dollarhide et al., 2012; Sexton et al., 2005). Dollarhide et al. (2012) and Sexton et al. (2005) emphasize the need for further exploration of relational factors that contribute to alliance formation.

Relational Cultural Theory

The following section will introduce Relational Cultural Theory (RCT), define core concepts, and discuss RCT's relevance to the proposed study. Given the importance of counselor

relational skills in alliance formation and strength, Relational-Cultural Therapy (RCT) is used as a theoretical underpinning for the proposed study. (RCT) was developed and pioneered by Jean Baker-Miller and colleagues. RCT developed in the wake of Miller's (1976) seminal book "Toward a Psychology of Women." The book stemmed from her experience in working as a psychiatrist with female patients in the 1970s. Miller identified discrepancies between the existing theories and approaches and the needs of women. She identified that Western theories and approaches that emphasized separation from others as well as independence and individualism as the picture of mental health were not meeting the needs of the female patients she worked with.

After the debut of her book in 1976, Miller and colleagues began meeting regularly and developing what is now known as Relational Cultural Theory (Jordan, 2010). Whereas RCT originally focused on meeting the needs of female clients, the concepts of the theory are meant to be relevant to all clients regardless of gender and demographics. Scholars identified that all humans are neurobiologically hard-wired for connection (Trepal & Duffey, 2016). At the heart of RCT is the concept that throughout life, humans grow through and toward connection. Upon the initial development of RCT by Miller and colleagues, most of the scholarly work and articles were generated by Miller and additional theorists of RCT (Jordan, 2010).

Upon RCT permeating the counseling field and entering into more mainstream counseling theories and ideas, there has been a growing body of literature regarding the application of RCT within the counseling field (Duffey & Trepal, 2015; Haberstroh & Moyer, 2012; Lenz, 2016). Additionally, reflective of this movement, was the development of a journal, The Journal of Creativity in Mental Health, within the American Counseling Association that was founded on the core concepts of RCT (Duffey, & Kerl-McClain, 2006). Included in the

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growing body of literature, is the application and efficacy of utilizing RCT to address today's

clinical issues and train the next generation of counselors and educators.

There are several core tenets of RCT that serve as the backbone of the theory and guide

application. Jordan (2010) identified seven core concepts of RCT:

1. Throughout life, people grow through and toward connection.

2. Rather than separation, healthy functioning is signified and characterized by mutuality.

3. Rather than seeking individuation from others, growth is characterized by differentiating
   and navigating the complexity of relationships with others.

4. Mutual empathy and mutual empowerment are fundamental in growth-fostering
   relationships.

5. Authenticity is paramount to engaging in growth-fostering relationships.

6. In a growth-fostering relationship, everyone involved participates in the relationship and
   grows as a result.

7. A goal of development from an RCT perspective is increasing relational capacity and
   competence over time.

RCT posits that rather than achieving separation and independence from others, the main

objective is to increase one's ability for relational resilience. Maintaining healthy relationships

helps individuals to navigate natural disconnections that accompany being connected to others as

well as increases capacities for mutual empowerment and mutual empathy. In other words,

development in a growth-fostering relationship is a two-way street and all people involved

benefit from being a part of the relationship. Miller identified "five good things" that result from

being a part of a growth-fostering relationship. The five good things include zest (increased

energy and vitality), clarity (increased understanding of self and others), increased self-worth, productivity, and the desire to generate more connection (Jordan, 2010).

In addition to the seven core concepts of RCT and the five good things that result from growth-fostering relationships, there are a number of terms that are fundamental to RCT and its application to counseling. Just as connection and a mutually empathic and empowering interaction between two or more people are fundamental to RCT, so is disconnection. In RCT, disconnection is defined as the absence of mutual empathy and empowerment (which can lead to feelings of disappointment and misunderstanding). Disconnection is an inherent part of connection, and an inevitable part of being in relationship with others. Furthermore, when disconnection occurs, the exploration and resolution of the disconnection can be a source of growth and increased understanding. However, if disconnection is not addressed, it may lead to a sense of isolation. A central tenant of Relational-Cultural Therapy is the effective navigation of disconnection and relational ruptures as they arise in counseling. In RCT, the therapist must be present in recognizing and acknowledging her/his part in the disconnection. In counseling, disconnections can result from the counselor misunderstanding, misinterpreting, or failing to give attention to content in session (Jordan, 2010). The counselor can address the disconnection by recognizing and communicating that a disconnection took place, being present with the client in addressing the disconnection, working to identify relational sources of the disconnection, and communicating how to begin working through the disconnection that took place (Jordan, 2010).

Mutual empathy is a core tenant of Relational-Cultural Therapy and is fundamental to not only the client-counselor relationship but to all growth-fostering relationships. Mutual empathy is when two or more people acknowledge and communicate the impact of the other(s) and as a result, experience increased connection and growth. Through mutual empathy, people are able to

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be themselves in their relationships and have increased motivation to do so. Mutual empathy is rooted in respect. From an RCT perspective, neutrality of the counselor (as conveyed in a number of mainstream counseling approaches and theories), does little to strengthen the client-counselor relationship and does not promote growth (Jordan, 2010). In RCT counseling, the counselor communicates the impact the client has on the counselor, in turn leading to mutual growth including the ability to empathize with one's self.

Another important concept in RCT counseling is working with the relational images of clients. Relational images represent what has happened to us in early significant relationships in our lives. As a result, we develop beliefs and expectations about future relationships relative to our early relationship experiences. It would make sense then, that in order to establish growth-fostering relationships, counselors need to work with clients to bring negative relational images into awareness and explore the impact relational images have on existing and future relationships (Jordan, 2010). Relevant to the current study, this strategy is especially useful in working with clients with substance use issues. Clients may develop relational images associated with trauma experienced in early childhood including growing up in households with parents or other family members who abuse substances, witnessing abuse, and experiencing physical, sexual, or verbal abuse (Wu, Schairer, Dellor, & Grella, 2010). As a result, it is important for addiction counselors to help clients identify and renegotiate established relational images that hinder their capacity for growth-fostering relationships.

Research indicates that social support is crucial when recovering from substance abuse (Johansen, Brendryen, Darnell, & Wennesland, 2013). A common function of substance abuse treatment is to aid the client in forming and generating healthy peer relationships that will provide crucial support to the client in maintaining recovery upon completion of treatment. From

an RCT perspective, it is crucial to aid clients in identifying and reworking unhealthy relational images that may hinder the development of growth-fostering relationships and perpetuate a client's addiction cycle. Additionally, of particular relevance to substance abuse treatment, is adjusting previous relational images and creating new ones that are more conducive to the development of growth-fostering relationships that will support and enhance recovery. This is paramount to substance abuse treatment, as clients with substance abuse issues are likely to be involved with others (family members, peers, and significant others) that abuse substances (Copello, Templeton, & Powell, 2010).

In addition to working with clients' relational images, there are several ways that addiction counselors can help clients develop healthy relationships. The most impactful of these is the client-counselor relationship. Within the safety of the therapeutic relationship, clients are afforded the opportunity to begin challenging and reworking negative relationship images (Jordan, 2010) that may hinder them from moving forward in recovery. The RCT addiction counselor's role is to engage mutually in the client-counselor relationship and facilitate relational change. This role involves aiding the client in navigating the vulnerability that accompanies interpersonal change. The alliance is negatively impacted if the counselor tries to assert control over the client (Najavits & Weiss, 1994). Jordan (2010) posits that the counselor assuming an authoritative position in the client-counselor relationship may hinder the formation of the therapeutic alliance and reinforce negative relational images from past relationships.

Furthermore, it may be difficult for counselors to renegotiate their authoritative role in the counseling relationship to one that is more conducive to a growth-fostering relationship. In light of unhealthy relationships that may accompany substance abuse, it is paramount that the addiction counselor works to provide a relational context in treatment. This necessitates that the

addiction counselor demonstrates vulnerability and courage when working with clients (Jordan, 2010). Additionally, counselor authenticity is necessary in fostering a relational context in counseling. In doing so, the counselor is able to effectively communicate relational information to the client in order to facilitate the reworking of relational images. Jordan (2010) encourages counselors to engage in therapeutic responsiveness (rather than reactiveness) by actively engaging the client in relationship.

RCT counselors work to validate the unique experiences of clients (Jordan, 2010). In addiction counseling, this may likely involve working through the stigma and discrimination that often accompanies substance abuse. This involves identifying contextual factors that contribute to stigma and discrimination. It is important for counselors to not engage in blaming clients (who abuse substances) for their own problems and misfortunes. This becomes especially relevant in situations in which clients struggle to take responsibility for their behaviors and consequences that may accompany substance abuse. In addition to naming contextual factors that contribute to the stigma surrounding substance abuse, it is important for counselors to aid clients in building relational resilience. Fundamental to relational counseling, is the concept that growth in relationship with others is a two-way street (Jordan, 2010). Inherent to relational resilience is mutuality. Not only do individuals have the desire to be in connection with others, there is also a desire to participate in another's well-being. Jordan (2010) posits that mutuality and relational resilience is often overlooked in support groups such as Alcoholics Anonymous. Mutuality is necessary in developing relational resilience. Relational resilience necessitates being able to move toward connection (and stay in connection) even when negative relational images and unhealthy relational patterns emerge (Jordan, 2010).

Earlier in this chapter, connection and the call for further exploration of relational factors (affecting the alliance) was discussed. Sexton et al. (2005) defined connection between client and counselor, in part, as "mutuality," which is a core concept of RCT. Based on the relevance and current focus of Relational Cultural Theory applications for counseling, the author chose it as the theoretical underpinning for the current study. RCT may help answer the call from researchers to further explore relational factors that contribute to alliance formation.

Therapist Factors in the Therapeutic Alliance

Tryon, Blackwell, and Hammel (2007) conducted a meta-analysis of alliance ratings from both the client and counselor factors that impact the therapeutic alliance. The authors discussed that clients with more severe symptomology and difficulty maintaining healthy relationships outside of counseling struggled to build an alliance. Although various treatment approaches yield similar treatment outcomes and effectiveness, theoretical orientation may affect various facets of the alliance relative to how the alliance is viewed. For example, counselors with a relational theoretical orientation may put more emphasis on the presence or absence of relational factors (i.e. mutuality, power dynamics) within the therapeutic alliance and counselors with a behavioral emphasis may put less emphasis on the therapeutic alliance (Wettersten et al., 2005).

Relational Skills

Therapist characteristics associated with a strong alliance include being flexible, warm, engaged, empathic, accepting, responsive, respectful, and facilitative of client emotions (Nissen-Lie, Monsen, & Ronnestad, 2010). Furthermore, therapist variability, as opposed to client variability, has been found to be predictive of outcomes (Baldwin, Wampold, & Imel, 2007; Nissen-Lie et al., 2010). In other words, the therapist's ability to develop effective therapeutic alliances with their clients is significantly tied to treatment outcomes. For example, a client with

less favorable treatment outcomes who worked with a counselor who forms poor working alliances may have fared better had they worked with a therapist who tends to be more effective in forming stronger working alliances. Additionally, it has been noted that therapist variability has a significant impact on client-ratings of the alliance (Nissen-Lie et al., 2010). Despite the significant impact of therapist effect on treatment outcomes, specific therapist behaviors that impact the alliance are not clearly and consistently defined (Hersoug, Hoglend, Havik, von der Lippe, and Monsen, 2009; Horvath & Bedi, 2002). Therefore, the counseling field stands to benefit significantly by a detailed examination of specific therapist behaviors that impact the alliance (Duff & Bedi, 2010).

Therapist variables that have been found to impact client-ratings of the alliance are reflective of the therapist's relational skills. Client hostility, among other challenges associated with developing and maintaining a therapeutic alliance, requires effective relational skills on the part of the therapist. Openness and nonjudgment on the part of the therapist have been associated with more positive therapeutic alliances. Therapists reacting with irritability and defensiveness strain the alliance (Nissen-Lie et al., 2010). Additionally, Ackerman and Hilsenroth (2003) identified that rigidity and uncertainty as well as appearing distracted and tense have a negative effect on the therapeutic alliance. The authors also found that inappropriate self-disclosure, use of silence, and excessive structuring of therapy on the part of the therapist negatively impacts the alliance. Similarly, Hersoug et al. (2009) found therapist characteristics that negatively impact the alliance include appearing distanced, indifferent, and disconnected. The authors also found that clients want therapists who are interpersonally active, supportive, and responsive. Furthermore, therapists who were accustomed to emotional closeness tended to develop stronger therapeutic alliances.

There is minimal research on therapist relational skills that aid in navigating client

hostility and other challenging client behaviors that make it difficult to develop a working

alliance. Nissen et al. (2010) found that 17% of variability in the therapeutic alliance could be

attributed to the differences between the therapists providing treatment. In other words, the

authors found that some therapists were better at developing strong therapeutic alliances than

others. This finding has been supported by research indicating that therapists vary in their

abilities to develop strong therapeutic alliances (Zuroff, Kelly, Leybman, Blatt, & Wampold,

2010). Furthermore, Wampold and Brown (2005) identified that differences between therapists

accounted for 5% of the variance in treatment outcomes. Similarly, Zuroff et al. (2010) found

that differences between therapists' ability to establish a strong therapeutic alliance attributed to

variance in treatment outcomes. The authors recommend that future research focus on the

differences between treatment providers. Specifically, the authors discussed that it is important

for research to focus on specific therapist characteristics that contribute to a strong alliance.

Nissen-Lie et al. (2010) found that a substantial portion of therapist effect in early

alliance formation is characterized by three predictors including interpersonal styles (specifically

therapist warmth), relational skills (the use of therapist and client emotion in the client-counselor

relationship), and how therapists experienced difficulties. Furthermore, Nissen-Lie et al. (2010)

found that the therapist's professional self-doubt and negative personal reaction were responsible

for a large portion of the variance. In other words, the authors discussed that more effective

therapists are willing to identify their own limitations as well as admit and communicate their

role in relational ruptures within the therapeutic alliance. Furthermore, the authors discussed that

therapists should be mindful of their emotions that come about from their interactions with

certain clients. Additionally, the authors postulated that therapists should further explore their

reactions and emotions when they experience a negative reaction to one of their clients. Therapists' use of their emotions and reactions may be an effective strategy in working with clients.

Clients' Perception of the Therapeutic Alliance

Given the current study's focus on clients' perspectives of the alliance, relevant literature is reviewed on this topic. Previous research has established that the clients' rating of the therapeutic alliance is more predictive of outcomes than that of the therapist (Horvath & Symonds, 1991). Additionally, obtaining and integrating client feedback into treatment has been found to significantly impact treatment outcomes (Tryon et al., 2007). This finding has important implications regarding future research of the alliance. Leibert et al. (2011) found that client-rated therapeutic alliances were correlated with a reduction in symptoms as opposed to clients with lower ratings of the alliance. Additionally, higher client ratings of the alliances were correlated with higher rates of improvement.

Client's perceptions of therapist characteristics may provide a more accurate account of the impact of therapist characteristics that affect both the alliance and outcomes (Ritter, Bowden, Murray, Ross, Greeley, & Pead, 2002). Clients who rate the therapeutic alliance more favorably often achieve better treatment outcomes. As suggested by Duff and Bedi (2010), attempts to identify specific therapist factors that impact the alliance have been largely identified by researchers or therapists. This is problematic due to client-ratings of the alliance being a better predictor of treatment outcomes than researcher or therapist ratings. It is important to explore client experiences in counseling in order to provide additional information that can aid in improving therapeutic alliances in counseling. Without obtaining clients' perceptions of the alliance as well as therapist factors that contribute to the alliance, necessary information is

lacking to strengthen the therapeutic alliance and increase the likelihood of reaching successful treatment outcomes (Duff & Bedi, 2010).

Duff and Bedi (2010) explored fifteen therapist behaviors that clients identified as important for developing and strengthening the therapeutic alliance. Five behaviors were strongly to moderately correlated with the client-counselor relationship. These behaviors included asking questions, encouraging comments, naming and reflecting clients' feelings, positive statements about the client, and affirming clients' experiences. From their research, Duff and Bedi (2010) concluded that those therapist behaviors that clients think impact the alliance do play a role in strengthening the alliance.

Summary of the Therapeutic Alliance

Literature on several major components of the current study were reviewed in this section. Horvath (2005) summarized the literature linking the therapeutic alliance to treatment outcomes. More relevant to the current study, is the shift in research focus from treatment outcomes to processes of the alliance. This shift may be due, in part, to the sizable research body that exists supporting early alliance formation as a predictor of treatment outcomes (Baldwin et al., 2007; Horvath & Symonds, 1991; Wampold & Brown, 2005). Bearing in mind the shift in research focus to the alliance, therapist variability has been found to be a predictor of treatment outcomes (Baldwin et al., 2007). Also relevant to the current study is that researchers have concluded that the client perspective of the therapeutic alliance is a better predictor of treatment outcomes than observer and therapist perspectives (Horvath, 2005). Pertinent to the current study, the client perspective provides a more substantial account of therapist characteristics that impact the alliance and treatment outcomes (Ritter et al., 2002).

The Therapeutic Alliance within the Context of Addiction Treatment

In the following section, the researcher reviews the existing research specifically on the therapeutic alliance and addiction treatment including alliance formation issues that are unique to addiction counseling, the alliance being critical to client engagement, and therapist variables that impact the alliance. Meiers, Barrowclough, and Donmall (2005) conducted an extensive review of the literature regarding the therapeutic alliance and addiction treatment. The authors discussed that multiple studies have explored the impact of the therapeutic alliance early in substance abuse treatment on retention as well as the completion of treatment.

Factors Supporting a Strong Alliance

Meiers et al. (2005) and Urbonoski, Kelly, Hoeppner, and Slaymaker (2012) identified a paucity of research on factors contributing to the strength of the alliance as well as how the strength of the alliance impacted other client problems. The authors discussed that the alliance has been found to predict less client involvement in illegal activity after substance abuse treatment. Meiers et. al (2005) identified an implication of their review as the need for further research on the changing nature of the alliance over time in substance abuse as well as research on the therapeutic alliance later in treatment as a majority of the previous research has focused on the alliance early in treatment. Additionally, the authors discussed that more information and research is needed on the specific nature of the alliance as well as the factors that impact the alliance.

Researchers have recently noted the importance of exploring factors outside of treatment modalities that account for variance in the therapeutic alliance and have begun differentiating between variance in the alliance that is attributed to either client or counselor variables (Urbanoski et al., 2012). As opposed to engagement, retention, and outcome research, less is

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known about specific (common) factors that account for variance in the therapeutic alliance (Urbanoski et al., 2012). Although there has been substantial research regarding the therapeutic alliance as a predictor for treatment outcomes, there is a paucity of research focused on the predictors of the therapeutic alliance. The limited research in this area is significant considering the large impact the therapeutic alliance has on treatment outcomes (Crits-Christoph, Hamilton, Ring-Kurtz, Gallop, McClure, Kulaga, & Rotrosen, 2011).

Therapist Variables Affecting the Therapeutic Alliance in Substance Abuse Treatment

In their literature review, Meiers et al. (2005) identified that less is known about counselor variables that impact the therapeutic alliance. Additionally, the authors concluded from their review that counselor age and gender is not predictive of the alliance. The variability in the therapeutic alliance has yet to be identified. Forman, Bovasso, and Woody (2001) explored the impact of staff beliefs on substance abuse treatment. Among the findings was the belief on the part of the counselor that research on evidenced based treatment approaches should be integrated into substance abuse treatment. However, the authors found that the use of several evidenced based practices was a point of contention among the counselors participating in their study. Although the participants were allocated from agencies that utilized motivational enhancement and contingency management strategies that seek to minimize confrontation and resistance when working with clients, the authors' findings were contradictory to the philosophies underpinning the treatment approaches utilized in the study.

Forman et al. (2001) found that 36% of staff in the study believed that clients that do not adhere to expectations should be discharged from treatment. Additionally, 46% of the clinicians indicated that confrontation should be utilized more in substance abuse treatment. The authors discussed that these findings were inconsistent with the treatment approaches utilized by the

clinicians endorsing confrontation. Forman et al. (2001) discussed that their study found significant counselor support for the use of confrontation in substance abuse treatment which is contrary to the evidenced based practices being endorsed by current researchers and practitioners. Furthermore, the authors discussed that the highest levels of endorsement for the use of confrontation came from counselors with lower levels of formal education. This endorsement may stem from unfamiliarity surrounding more effective treatment strategies. As a result of these findings, an implication of the study was the role of advanced clinicians in endorsing and utilizing evidenced based treatment strategies that involve lesser amounts of confrontation.

Crits-Christoph et al. (2011) postulate that despite previous findings that client pre-treatment characteristics are predictive of the alliance, counselor variables may account for a majority of the relationship between the alliance and treatment outcomes. Additionally, differences in counselor non-specific factors such as empathy could affect the strength of the alliance. Given the strong connection of the alliance to treatment outcomes, it is necessary to further explore counselor factors affecting the alliance in hopes of improving outcomes through the alliance. Therapist variability, rather than client variability, has been linked to treatment outcomes. Furthermore, Crits-Christph et al. (2011) discussed that the alliance has been shown to be an effective mediator between substance abuse programs and outcomes. They further postulate that counselor variability in alliance may be attributed to varying ability among counselors to form alliances with their clients. In other words, some counselors are more effective in forming alliances with their clients than other counselors. The proposed study sets out to explore counselor characteristics that are associated with better alliance formulation.

Ritter et al. (2002) found that of the characteristics measured, empathy, congruence, expertness, attractiveness, and trustworthiness, the characteristic that contributed most significantly to the variance in treatment outcome was expertness. The second therapist characteristic accounting for a significant portion of variance in outcome was therapist empathy. Additionally, Ritter et al. (2002) discussed that the implications of their study pertained to the training of addiction counselors. They went on to discuss that therapist expertness could be viewed in terms of counselors being organized, confident, concise, and rational. The authors discussed that the importance of developing these characteristics, as well as basic counseling skills, should be well integrated into the training for addiction counselors.

An earlier literature review conducted by Najavits and Weis (1994), although somewhat dated, provides a springboard in which to assess the progress made in exploring and identifying therapist characteristics within substance abuse treatment. The authors reviewed the literature at that time on therapist characteristics in substance abuse treatment. They went on to note that the research conducted on the topic at that time was sparse and the impact of therapist effects was largely neglected. This is problematic due to the integral role of the therapist as well as therapist factors being one of the most significant factors in substance abuse treatments regarding reaching positive treatment outcomes. Therapist interpersonal skills have been more strongly linked to treatment success than to the theoretical orientation of the therapist. Najavits and Weis (1994) postulated that there is more variation among therapists in substance abuse than in psychotherapy.

The authors asserted that this increased variation may be due in part to the difficulty associated with clients who abuse substances. This difficulty may stem from a plethora of issues associated with substance abuse including lower interpersonal functioning, family issues,

difficulty with employment, legal and housing issues, and health problems. Additionally, clients who are experiencing withdrawal from substances while learning to live without substances can often experience more intense reactions to everyday issues. Co-occurring mental health issues, when present, add a layer of complexity. Furthermore, varying retention and relapse rates among clients may be indicative of the variation in therapist interpersonal skills and effectiveness. Najavits and Weis (1994) discussed that the literature, at the time of their review, indicated that therapists were often conceptualized in one of two ways. The first was the professional status of addiction counselors (i.e. educational background, recovery status, etc.), and the second was whether or not the addiction counselor adhered to treatment manuals when implementing substance abuse treatment.

An earlier but still relevant study exploring therapist variability in treatment outcomes in substance abuse treatment was conducted by Miller, Tayler, and West (1980). Miller et al. (1980) studied the differing abilities in therapists providing substance abuse treatment and noted the extreme variance in treatment outcomes could be attributed to the nine therapists that participated in the study. Of the nine therapists, client success rates of each therapist varied from 25% to 100%. In other words, certain therapists were more effective in working with clients than other therapists in the study. Similarly, in another early study, McLellan, Woody, Luborsky, and Goehl (1988), identified that not only can therapists contribute to successful outcomes of their clients, therapists can also diminish the effectiveness of treatment. Therapists with better interpersonal skills were more effective when working with clients in substance abuse treatment (Najavits & Weis, 1994).

Additionally, Najavits and Weis (1994) postulated that it is important to research process variables in treatment that impact the alliance and treatment outcomes. In other words,

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implications for further research included exploring what it is that the therapist does in treatment that impacts the alliance and treatment outcomes. The authors found that favorable outcomes were achieved by the therapist communicating a sense of understanding, recognizing the importance of client-identified goals, helping and protecting the client, exerting effort to help the client, providing active support to promote client autonomy, and aiding the client to make use of available resources. Other attributes of effective addiction counselors include being more active with clients, not being rigid, being tolerable of client anger, being passionate and encouraging, having good emotional regulation, and avoiding power struggles. Najavits et al. (1994) discussed that ineffective therapist behaviors include neglecting client feelings, being overwhelmed, emphasizing comfort over change, using unhealthy ways of relating to the client, blaming, and attempting to exert control over the client.

Of particular relevance to the current study, is the qualitative study conducted by Allen and Olson (2016). The authors set out to explore factors that make substance abuse treatment effective. Building on research that the client-counselor relationship is more impactful than specific treatment modalities, the authors wanted to explore contextual factors that matter in substance abuse treatment. Additionally, the authors attempted to begin filling the gap in research regarding specific (common) factors that contribute to alliance formation. The participants in the study were recruited from a treatment center that provided both outpatient and inpatient substance abuse treatment. The authors asked the participants to reflect on the relationship they had with their counselors. Additionally, participants were asked about specific qualities of the therapist as well as activities and interventions utilized that enhanced the client-counselor relationship.

Allen and Olson (2016) identified several themes that emerged from their data that are specific to substance abuse treatment. The authors found that 60% of the participants discussed that feelings of guilt, shame, and grief arose in treatment. Additionally, the participants identified that an emotional bond was developed when therapists explored and focused on feelings that arose during treatment rather than focusing solely on substance abuse. The authors noted that one of the themes that emerged was that of flexibility. Participants noted a strengthening in their emotional bond with their counselor when they were allowed flexibility in exploring feelings and issues that arose rather than strictly adhering to their treatment plan. The authors also noted that participants identified that the alliance was strengthened when counselors viewed clients holistically.

Allen and Olson (2016) identified the counselor aiding the client in navigating the emotional distress that arises during treatment can lead to a strengthening of the alliance. The authors further identified that participants who gained insight into how certain emotions perpetuated their addiction cycle, identified that their insight resulted from therapists allowing them room to explore issues and emotions as they arose in treatment. Participants in the study identified that supportive and non-confrontational treatment settings were crucial in alliance formation. Additionally, participants noted a strengthening of the alliance when counselors worked with clients to identify what they wanted to work on and accomplish in treatment. In doing so, counselors are communicating to clients that they value what matters to the client. The authors also found that therapists' responses moderated clients' resistance to being mandated to treatment.

Allen and Olson (2016) also identified motivation enhancement as a theme of their study. The authors found that participants identified their therapists' skills as crucial in helping increase

their motivation. Additionally, participants identified their therapists' ability to enhance their motivation as an important component of the therapeutic alliance. Also, participants noted an increase in alliance strength when their therapists encouraged identifying and working towards goals that improved their overall mental health rather than focusing solely on issues related to substance abuse. Participants also found it helpful when therapists generated alternative perspectives that aided clients in approaching issues in a different way. Participants identified that therapists' encouragement elicited feelings of hope, motivation, and empowerment that contributed significantly to alliance formation and strength.

Allen and Olson (2016) concluded that participants referenced techniques or therapist traits that increased participant understanding. The authors noted that the therapeutic alliance serves to improve treatment efficacy by motivating clients to work towards healthy change. Additionally, the authors discussed that the strength of the alliance is a means for the therapist to channel encouragement and motivation to the client. As a result, Allen and Olson (2016) further asserted that alliance and treatment success are interwoven. In other words, a strong therapeutic alliance sets the stage for effective treatment and positive outcomes. Similarly, Ilgen, McKellar, Moos, and Finney (2006) found that a strong alliance correlated to decreased substance use among clients with less motivation. The authors' finding is hopeful, as it suggests that the client-counselor relationship can negate some of the effects of low client motivation. Additionally, this finding is significant in that low client motivation has been linked to treatment dropout and therefore pertinent to finding effective ways to increase motivation as well as retain clients in treatment. The authors also postulate that the therapist's perception of the client and the relationship is crucial especially regarding clients with low motivation. Ilgen et al. (2006)

identified that therapists who are mindful of client motivation may be more likely to adapt to the needs of their clients and as a result, increase client motivation and strengthen the alliance.

In another qualitative study regarding the alliance and substance abuse treatment, Godlaski, Butler, Heron, Debord, and Cauvin (2009) explored how women experienced engagement in treatment. The authors noted a significant theme among participant responses to inquiries about their engagement in treatment. Participants did not comment on or discuss the role of treatment modalities or interventions when they were asked about their engagement in substance abuse treatment. Participants focused instead on the quality of the relationships they had in treatment. Participants described their engagement as engaging with other individuals rather than engaging in treatment.

This finding is significant in that it affects how researchers and clinicians seek to explore and enhance client engagement. Instead of searching for technical aspects of treatment that enhance engagement, it is necessary to explore the relational aspects of treatment that foster engagement. Additionally, Godlaski et al. (2009) found that engagement was more likely when women felt they were warmly invited into treatment, felt a sense of belonging and validation from others, and had a sense that their personal experiences were valued. The authors also found that women identified that they needed to be with others that cultivated feelings of safety.

As a result of their research, Godlaski et al. (2009) found that facilitating factors of engagement (a sense of safety, warmth, belonging, validation, and understanding) provided a relational context that helped women tap into their own capacities for clarity, self-empowerment, and hope. While their study was conducted with all female participants, it has been noted that all humans are hard-wired for connection and seek a sense of belonging with others (Jordan, 2010). Godlaski et al. (2009) also found that participants were not expecting to be warmly welcomed to

treatment. The authors discussed that the participants may have grown accustomed to feeling rejected and as a result, expected to experience additional feelings of shame upon entering treatment.

The participants were able to identify if treatment was not meeting their needs. However, the authors found that within a relational context of treatment, participants communicated that they could withstand or overcome the deficit and were committed to moving forward in treatment and in recovery. The participants' relational engagement in treatment facilitated resiliency and perseverance. The authors identified implications of their study as treatment programs being mindful of client perceptions of the relational culture within the program. Godlaski et al. (2009) also recommended the use of qualitative research to explore potential improvements in treatment and to better understand clients' treatment needs.

Relational Factors within the Therapeutic Alliance in Substance Abuse Treatment

There is a paucity of research on specific interpersonal processes that contribute to alliance formation and strength (Macdonald et al., 2007). A recent article by Miller and Moyers (2014) highlighted the need for further exploration of relational factors involved in the therapeutic alliance within substance abuse treatment. The authors argue for a shift in focus regarding research in substance abuse from studying specific treatment approaches to non-specific factors including the alliance and therapist variables. They go on to discuss that much research to date has focused on and found support for various treatment approaches yielding similar, effective outcomes.

What has been overlooked and less studied, is the non-specific factors or common factors, specifically the relational factors of the therapeutic alliance and therapist. Miller and Moyers (2014) discussed that the therapeutic alliance accounts for more variance in treatment

outcomes than variance attributed to specific treatment approaches. Furthermore, the interpersonal skills of the therapist are also linked to more successful treatment outcomes. Empathy on the part of the therapist and interpersonal skills centered on the client, predicted sizable variance in treatment outcomes. The authors postulate that relational factors have a significant enough impact on treatment outcomes to necessitate a shift in research from specific factors to the common relational factors in treatment.

Furthermore, Miller and Moyers (2014) discussed that relational factors that have a significant impact on the alliance and outcome should not be impossible to detect and illustrate this example with discussing the significant impact empathy has on both the therapeutic alliance and treatment outcomes. The authors make the argument that specific (treatment modalities) and relational factors become fused together and thus inseparable when a treatment modality is implemented within an interpersonal relationship. Additionally, Miller and Moyers (2014) identify and discuss implications for further research regarding the relational factors within substance abuse treatment. The authors postulate that further research is needed regarding client and therapist effects on the alliance, and on relational factors that affect treatment processes. Specific client variables recommended for further study include the strength of client change talk and client confidence.

Of particular interest to the current study, are the variables of therapist relational effects that the authors recommended for further exploration. Miller and Moyers (2014) identify interpersonal functioning as a promising therapist variable that needs further exploration. The authors discussed that further investigation of therapist relational factors may aid in identifying specific relational factors that contribute to alliance formation and positive treatment outcomes. The authors recommended research be conducted on the working alliance and client feedback. It

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is reasonable to focus research efforts on therapist relational factors due to their flexible nature as opposed to fixed variables including therapist demographics.

Thompson, Bender, Lantry, and Flynn (2007) discussed two different conceptualizations of the therapeutic alliance, the task alliance and the relationship alliance. The task alliance focuses on the client-counselor navigation of the purpose and goals of treatment as well as the tasks necessary in reaching the identified and agreed upon goals. The relationship alliance, which is especially relevant to the proposed study, refers to the emotional connection between the client and counselor. It is the relationship alliance that empowers the client to make healthy changes that promotes their recovery from substances. The authors further discuss that both types of the alliance, task and relationship, are necessary in successful treatment outcomes. There are several interpersonal factors that contribute to a poor therapeutic alliance. Among these factors are the client feeling that their counselor perceives them as incompetent, feeling criticized by their counselor, and client perception that their counselor is withholding information from them. The therapeutic alliance was negatively impacted if the client perceives that their counselor is not committed to them and their treatment as well as perceiving that their counselor was disengaged. Macdonald et al. (2007) identified that interpersonal processes involving less confrontation are related to more positive treatment outcomes. Additionally, the authors found that indirect hostility on the part of the counselor negatively impacts client engagement in both the therapeutic alliance and in substance abuse treatment.

Saarino (2011) identified that there was a link between therapist interpersonal skills and beliefs about directiveness. He found that therapists who did not believe in being overly directive with clients had higher levels of interpersonal functioning. Additionally, he discussed that an important concept in Motivational Interviewing (MI), avoiding excessive directiveness, is linked

to higher interpersonal functioning. Sarrino (2011) further concluded that the findings of his study lend support as to why MI is so effective. Interpersonal functioning on the part of the therapist is crucial to alliance formation and strength, which is fundamental in MI. Additionally, it is well established that a strong therapeutic alliance is a predictor of positive treatment outcomes. While Saarino (2011) found support for the role of interpersonal functioning in evidenced based-treatment (MI), specific facets of interpersonal effectiveness continue to be vague. An important implication of his study is the need for further exploration of therapist interpersonal functioning in order to inform counselor training.

As discussed earlier, there is less research focused on understanding the common factors in mental health counseling versus specific treatment modalities; the same rings true in substance abuse treatment (Gifford, Ritsher, McKellar, & Moos, 2006). However, due to the favorable outcomes associated with a positive alliance between client and counselor, focus has shifted in recent years to the therapeutic alliance. There is a growing body of research indicating that the therapeutic alliance serves as more than a catalyst for successful treatment outcomes. Waters, Holttum, and Perrin (2013) concluded that clients' relationship with their therapist served as a safe place to process through the trauma that can accompany substance abuse while experiencing a mutually satisfying relationship. Additionally, Ackerman and Hilsenroth (2003) identified that techniques utilized by therapists can strengthen the alliance. These techniques included reflection, exploration, building on past progress in therapy, and valuing the clients' experiences.

Ritter et al. (2002) postulated that researchers are discounting an integral element in substance abuse treatment, the interpersonal style of the therapist. Therapist characteristics account for more variance than client characteristics and treatment modalities in substance abuse treatment. This mirrors the finding in the counseling field that therapist factors significantly

influence outcomes. It has been consistently found that therapist characteristics have differing success rates despite the treatment modalities utilized, characteristics of clients, and varying levels of therapist training. Ritter et al. (2002) discussed that therapist characteristics that are especially impactful regarding treatment outcomes in substance abuse include a strong working alliance, empathy, authenticity, and respect. Crits-Christoph, Connolly Gibbons, Crits-Christoph, Narducci, Schamberger, and Gallop (2006) asserted that it is difficult to teach interpersonal skills to counselors in training in order to instill counselors with alliance building skills.

Alliance Formation Issues Unique to Addiction Counseling

Initiating and maintaining a therapeutic alliance with clients in substance abuse treatment can be especially difficult due to the problems that often accompany substance use. Minimal emotional regulation, the presence of personality disorders, and histories of substance abuse are among the factors that increase the difficulty of counselors establishing trust and developing a therapeutic alliance with clients in substance abuse treatment (Urbanoski et al., 2012). The alliance between client and counselor in substance abuse treatment has been identified as a significant factor in treatment being successful. Despite the support in the literature regarding the significance of the alliance in treatment, information is lacking on the specifics of the alliance that facilitate client change (Urbanoski et al., 2012).

Wolfe, Kay-Lambkin, Bowman, and Childs (2013) conducted a study that explored the coercive nature that often accompanies substance abuse treatment and the potential impact on client engagement. Due to the involvement of illicit substances and impaired decision making, substance use can be associated with criminal behavior and as a result, nearly half of the referrals made to substance abuse treatment are from the legal system and mandatory in nature (Wolfe et al., 2013). The authors postulate that the role of coercion is understudied in the area of substance

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abuse treatment and cannot be ignored. Court-ordered treatment can stem from the involvement of services in the client's life including probation, the criminal-justice system, child protection and involvement with social services. The authors found that clients who were not coerced into treatment were more open with their counselors.

Additionally, Wolfe et al. (2013) identified that positive attributes of the alliance including warmth and empathy may counteract the power-over characteristics associated with coercion. In other words, the therapeutic alliance may be helpful in minimizing the negative effect of coercion. Furthermore, a strong therapeutic alliance was associated with higher internal motivation on the part of the client. The authors also found that there was a connection between client openness and motivation for treatment. This connection may be indicative of an increased receptiveness to engage with their counselor. The authors identified stigma being a barrier to engaging clients in substance abuse treatment.

Luoma et al. (2014) discussed that the stigma associated with substance abuse and seeking treatment may contribute to the high drop-out rates in substance abuse treatment. People with substance use disorders often experience enacted stigma, which is the act of discrimination and rejection. Enacted stigma has been associated with unfavorable outcomes amongst people with substance use disorders. People with substance use disorders may be reluctant in seeking treatment due to the stigma and discrimination surrounding substance use disorders, even among substance abuse treatment providers. A major finding of the study conducted by Luoma et al. (2014) is that clients who have experienced stigma related to their substance abuse tended to stay longer in residential treatment. The authors went on to discuss that clients who are experiencing stigma may worry about being judged by others as well as have minimal social support; and as a result, stay longer in the safe haven provided by residential treatment. The authors discussed that

their study has implications regarding how to work with clients experiencing stigma and needing the safe haven of treatment. In other words, the nonjudgmental relational nature of treatment may provide much needed relief from judgment and discrimination.

The Role of the Therapeutic Alliance for Engagement and Retention in Substance Abuse Treatment

The therapeutic alliance has been shown to be a consistent predictor of retention in substance abuse treatment (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013); independent of the instruments used (Meiers et.al., 2005). Despite this finding, it is unclear what specific factors of the alliance promote retention. Participation and engagement in substance abuse treatment is related to favorable treatment outcomes which is especially significant considering the high drop-out rate associated with treatment. (Luoma, Kulesza, Hayes, and Kohlenberg, 2014). Cournoyer et al. (2007) cited client dropout as a significant problem. The authors identified two primary factors that were tied to client drop out in substance abuse treatment: the clients' perspective of their own commitment to treatment and their view of therapist understanding and involvement. Additionally, the authors found that clients that were involved in the legal system (on probation, out on bail, court mandated, accrued legal charges in the last four months, or had pending legal charges) or were staying in a halfway house, were found to be less devoted to treatment and demonstrated negative dispositions in treatment. The authors stated that this finding may be due in part to the increased difficulty of engaging individuals when they are mandated to treatment.

Joe, Simpson, and Broome (1999) indicated a need to further explore the level of client engagement that is needed to produce meaningful change and positive treatment outcomes. While research has demonstrated that there is a positive connection between treatment

attendance and treatment outcomes, meaningful participation is more than attending counseling sessions and treatment groups. Meaningful and active engagement in treatment is evidenced by the level of client participation. Joe et al. (1999) highlighted the importance of the therapist in clients' engagement in treatment. The authors found that a strong therapeutic alliance fosters client engagement in substance abuse treatment. Cournoyer et al. (2007) discussed that client resistance in treatment can be a barrier to client engagement. The authors identified that therapists' assessment of client resistance among individuals mandated to treatment has been found to be predictive of dropout. In other words, a negative prognosis by the therapist at the beginning of treatment could endure throughout the entirety of treatment and affect how the therapist works with the client. The authors also discussed that client perception of therapist understanding is crucial regarding engaging clients in treatment and developing an alliance with clients that are mandated to treatment.

Therapeutic Alliance and Outcome Research

Ritter et al. (2002) discussed that outcome research in substance abuse has primarily focused on treatment approaches, the characteristics of the client, the addiction counselors' educational level, and the level of care (i.e. outpatient or inpatient). Additionally, outcome research has served to explore various treatment approaches and their effectiveness in treating clients with substance abuse disorders as well as identifying innovative approaches for the treatment of substance use. Research has consistently demonstrated the efficacy of various treatment modalities, regardless of theoretical underpinning (Leibert & Dunne-Bryant, 2015). While this research focus has proven fruitful in advancing substance abuse treatment, several researchers have noted that the time has come for a shift from exploring specific treatment modalities to focusing more on common factors (Miller and Moyers, 2014).

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Desired treatment outcomes of substance abuse treatment, regardless of the theoretical underpinning of the approach, commonly include motivation to abstain from or reduce substance use, increased self-efficacy to abstain from or reduce substance use, increased ability to effectively apply coping skills when experiencing triggers to use substances, and the involvement of support groups including AA and NA (Urbanoski et al., 2012). The therapeutic alliance has been linked to positive treatment outcomes regardless of treatment approaches utilized, the client population, and the instrument used to measure the alliance (Ruglass et al., 2012). Due to the various client factors among populations served and the various treatment approaches utilized in substance abuse treatment, this is a significant finding that has implications regarding the emphasis placed on the therapeutic alliance in substance abuse treatment.

Substance Abuse Treatment and Relational-Cultural Theory

The following section will discuss how Relational-Cultural Theory fits with substance-abuse treatment. RCT's philosophical underpinning is a good match for the unique needs of individuals experiencing addiction. Specific RCT terms and concepts relevant to substance abuse treatment will be identified and discussed. The existing literature on the topic will be reviewed, focusing largely on the work of Covington and Surrey (2000). This is due in part to the minimal research on the topic and to the applicability of the authors' work. It is interesting to note that one of the authors, Janet Surrey (2000), is one of the founding scholars of RCT.

Particularly significant to substance abuse counseling regarding integration of RCT, is the concept that not only does the counselor contribute their wisdom and experience to the counseling relationship, but the client is recognized as contributing their unique knowledge and experience. This is an important concept as clients with substance use issues often come to

treatment with a plethora of experiences ranging from life-threatening alcohol and drug usage histories to significant losses and traumatic experiences. It is powerful for clients to have their counselors mutually engage in their treatment and acknowledge the experience and wisdom clients bring to treatment. The neutrality on the part of the counselor that was often emphasized in psychotherapy may do more harm than good (Jordan, 2010).

In substance abuse treatment, clients are asked to share information that opens them up to profound feelings of shame and vulnerability. To be met with neutrality when sharing may perpetuate feelings of shame and vulnerability, making it difficult for clients to continue engaging on an emotional level in treatment. From an RCT perspective, counselors in substance abuse treatment are working with their clients to move from a place of disconnection, as clients are often disconnected from others when they are abusing substances, to a place of mutual connection. Covington and Surrey (2000) defines mutual empowerment as a relational interaction in which both people experience growth in strength and power. Jordan (2010) refers to this as power-with. Power-with is another powerful concept when applied to substance abuse treatment. Often clients in substance abuse treatment may be more accustomed to power-over relationships in which one person has more power than the other. As a result, entering into mutual connection with their counselors may be a meaningful experience for clients.

RCT posits that people are hard-wired for connection, which has been evidenced by neurobiological research (Jordan, 2010). As a result, it makes sense to view addiction and recovery from a relational perspective. If people are hard-wired to be connected to others, what happens when they do not feel connected to others? Covington and Surrey (2000) postulate that people turn to substances to fill the void when relationships are lacking. Disconnection, from an RCT perspective, happens when relationships are not mutual and this results in the opposite of

the five good things, decreased vitality and productivity, confusion, low self-worth, and isolating

from relationships. If one is not heard by the other(s) when communicating feelings of

disconnection within the relationship, especially in power-over relationships, chronic

disconnection may result. Additionally, Jordan (2010) identified that condemned isolation may

result from chronic disconnection. She defined condemned isolation as the intense feeling of

isolation when one feels cut off from connection with others.

When people are in condemned isolation, addiction can become a sort of relationship. In

other words, addiction becomes relationship (Covington & Surrey, 2000). It can be viewed then,

that someone with a substance use disorder is in relationship with alcohol, with marijuana, with

methamphetamine, with pain pills, with shopping, with gambling, with cutting, etc. The

relationship with addiction becomes a surrogate relationship that serves to provide what a

relationship with another person is not, including relief, vitality, increased self-worth, and

connection (Covington & Surrey, 2000). Initially and for a short duration, the relationship with

substances provides these benefits until the addiction becomes out of control and results in more

harm than benefit. Stated eloquently by Covington and Beckett (as cited in Covington & Surrey,

2000), "We could speak of addiction as a contraction of connection and recovery as an expansion

of connection" (p. 3). In other words, addiction is disconnection and recovery is connection.

Additionally, one's relationship with substances can be thought of in terms of lacking mutuality

in which the person gives themselves to addiction and receives nothing in return except

condemned isolation (Covington & Surrey, 2000).

In addition to one being in relationship with substances, Covington and Surrey (2000)

identified that one may use substances in order to maintain a relationship with a using partner.

Furthermore, the authors identified five types of relational disconnection that increase the

likelihood of substance use or relapse including being in a relationship that lacks mutuality, being isolated and shamed, having limiting relational images, experiencing abuse and violence, and sexual distortion. Often, especially in women, the need for connection is often pathologized and deemed codependent, which serves to further perpetuate low self-worth and debilitating shame. Covington and Surrey (2000) postulate that instead of focusing on one's need for connection which often succeeds in pathologizing the person with an addiction, shifting focus to relationships that lack mutuality. Non-mutual relationships may lead to caretaking and the opposite of the five good things as defined by Jordan (2010). The lack of mutuality in important relationships may lead to condemned isolation, the feeling that one is flawed and unable to have meaningful relationships with others (Jordan, 2010). Covington and Surrey (2000) identified that isolation is often accompanied by intense shame. According to Brene Brown (2008), shame is the intensely painful feeling that one is flawed and therefore unworthy of love and belonging. Furthermore, isolation may result when one attempts to connect with another and the attempt for connection is not substantiated and as a result, condemned isolation often accompanies shame and substance abuse (Covington & Surrey, 2000).

Additionally, limiting relational images may contribute to substance use (Covington & Surrey, 2000). People may use substances as an attempt to look how one thinks they should look or feel how one thinks they should feel. Trauma, including physical, sexual, and verbal abuse, has been found to be highly correlated with substance abuse (Wu et al., 2010). Furthermore, individuals with a history of trauma are at higher risk to abuse substances to cope with the effects of trauma (Calmes, Laux, Scott, Reynolds, Roseman, & Piazza, 2013).

Covington and Surrey (2000), from a relational perspective, offer poignant insight into how trauma early in one's life can affect all future relationships. It is important for counselors to

recognize the impact that trauma has had on the lives of clients in substance abuse treatment. Unless clients with co-occurring trauma and substance use are treated from a relational perspective, there is a risk of perpetuating the addiction cycle and continuing power-over relationships. Additionally, Covington and Surrey (2000) postulate that relationships, substance use, and sexuality can often become interwoven. As a result, substance abuse can become part of a romantic relationship. For example, one may be introduced to substance use by a romantic partner, which contributes to the seemingly inseparable nature of intimacy and drug use.

Covington and Surrey (2000) identified implications for establishing a relational underpinning in substance abuse treatment. The authors postulate that just as disconnection can serve as a catalyst for substance abuse, mutual connection fosters recovery. Additionally, Covington and Surrey (2000) discuss ways to infuse mutuality into existing concepts within substance abuse that appear to be lacking. As discussed earlier, there is a tendency to pathologize the need for connection. An example of this within substance abuse treatment is the use of the term codependency or codependent.

Covington and Surrey (2000) postulate that rather than condemn someone for needing and seeking out connection, it is more beneficial for counselors to aid clients in developing mutual growth-fostering relationships. One of the primary ways to illustrate the necessity and effectiveness of mutual relationships is for counselors to engage clients in mutual growth-fostering relationships. Covington and Surrey (2000) discussed that the focus on codependency takes away the relational context of relationships. Furthermore, the authors posit that trauma and power-over dynamics can simulate the symptoms of codependency. The authors discuss that rather than codependency, the focus of treatment should center on establishing a relational context in order to more fully understand how individuals have been impacted by trauma and

power-over dynamics. Additionally, the goal of substance abuse treatment and recovery should be mutual connection.

Summary

The researcher reviewed literature on several topics pertinent to the current study, and provided the foundation on which the current study is built. Although there is a more sizeable research base in mental health counseling, the therapeutic alliance is consistently identified as a predictor of treatment outcomes in both mental health and addiction counseling (Baldwin et al., 2007; Crits-Christoph et al., 2001). Given the significant impact the alliance has on treatment outcomes, while bearing in mind alliance formation issues that are unique to addiction treatment, further investigation of the alliance is warranted. Therapist interpersonal skills are identified as an effective means to engage clients in addiction treatment (Allen & Olson, 2016; Najavits & Weis, 1994). As a result, the theoretical underpinning for the current study is rooted in Relational Cultural Theory. Additionally, therapist variability and client perception of the alliance have been identified as predictors of both the alliance and treatment outcomes (Horvath, 2005; Wampold et al., 2007), setting the direction of this investigation into the alliance.

CHAPTER 3. METHODOLOGY

Research Design

The researcher utilized a phenomenological-qualitative design. According to Hays and Singh (2012), "The purpose of phenomenology is to discover and describe the meaning or essence of participants' lived experiences, or knowledge as it appears to consciousness (p. 50)." More specifically, phenomenological methodology aided the researcher in understanding and exploring clients' lived experiences with the therapeutic alliance in substance abuse treatment. Additionally, Godlaski et al. (2009) recommended the use of qualitative research to explore potential improvements in treatment and to better understand clients' treatment needs.

Theoretical Underpinning

Due to the importance of counselor relational skills in alliance formation and strength, the theoretical underpinning of the study is rooted in Relational-Cultural Therapy (RCT). This theory was developed and pioneered by Jean Baker-Miller, Irene Stiver, Judith Jordan, and Janet Surrey, also known as the founding scholars (Jordan, 2010). The founding scholars identified discrepancies between the existing theories and approaches and the needs of women. She identified that Western theories and approaches that emphasized separation from others as well as independence and individualism as the picture of mental health were not meeting the needs of the female patients she worked with. RCT is built on the concept that throughout life, humans grow through and toward connection (Jordan, 2010). Given the significance of the therapeutic alliance in engaging clients in addiction treatment (Meiers et al., 2005), it is important to explore relational aspects and dynamics of the alliance that either nurture or impede the relationship between the client and counselor. RCT provides the theoretical foundation to conceptualize

counselor interpersonal skills and other relational factors of the alliance that are crucial in alliance formation and strength.

Setting

The setting of the research study is a residential substance abuse treatment center located in east-central Minnesota. In order to protect confidentiality, the agency is referred to as the Recovery Center. The Recovery Center is licensed through the state of Minnesota to work with sixty-six clients at a time and employs five full-time licensed addiction counselors that work with clients both individually and in group settings. The level of care provided at the center is referred to as low-intensity residential treatment and is commonly referred to as a halfway house level of care. Clients are often referred to the Recovery Center by other treatment providers and by Rule 25 chemical dependency social workers who assess and case manage clients with substance use disorders. Rule 25 refers to funding for addiction treatment provided by the state of Minnesota.

Clients admitting to the Recovery Center are often mandated to follow treatment recommendations in order to fulfill legal requirements of child protection, civil commitment, or probation/parole. Most often clients are admitted to the Recovery Center upon completion of inpatient substance abuse treatment or after the completion of a prison or jail sentence, and have a history of multiple treatments and/or incarcerations. It is not uncommon for clients to have more than one drug of choice and several substance use disorders. Clients often have an extensive alcohol and/or drug usage history that has impacted their lives to the point that housing and employment are negatively affected. As a result, clients admitting to the Recovery center are usually homeless and unemployed.

Due to the severity of clients' substance use prior to admission, it is not uncommon for the Recovery Center to serve individuals who have not lived independently in the community for

a period of time. The purpose of the Recovery Center is to support individuals in their recovery efforts as they transition back to the community. This often entails helping clients gain employment, obtain housing, reconnect with family members or work to address issues within the family, and build a sober peer support network in the community while meeting expectations of any services or legal involvement (i.e. child protection services, probation, etc.). Additionally, counselors and staff at the Recovery Center help clients address and overcome barriers to transitioning to the community. Common barriers often involve obtaining housing and employment that is amenable to the client's legal history (if applicable). Often, poor credit scores and rental histories also make it difficult for clients to obtain housing. The program director of the Recovery Center agreed to allow the researcher to recruit clients to be participants of the study. Individual interviews were conducted in a private office at the Recovery Center that protected the confidentiality of the participants.

Participants

Purposeful sampling was utilized to identify clients who qualified to be participants in the study. The participants consisted of ten males and five females who were clients at the Recovery Center at the time of the study. Regarding ethnicity, two participants were of Hispanic origin, eight were Caucasian, four were Native American, and one participant was African American. The age span of participants ranged from 20-55 years of age. Many of the participants in the study were mandated to be at treatment in order to satisfy court and/or probation requirements. The list of demographic questions used in the study can be found in Appendix E.

All participants were required to be eighteen years of age (which is also a requirement of the Recovery Center) or older in order to qualify for the study. In order to minimize the potential for dual relationships, clients were ineligible to participate in the study if the researcher was their

primary counselor. The phenomenon under investigation is the client counselor-relationship; therefore, participants needed to be at the Recovery Center for a minimum of three weeks (which equates to three individual sessions) in order to have time to develop a relationship with their primary counselor. All participants have a documented Substance Use Disorder (clients admitting the Recovery Center are doing so because of their substance use and as a result have a diagnosis upon admission that is documented in their previous treatment records). It is not uncommon for clients at the Recovery Center to have co-occuring mental health issues that are addressed simultaneously throughout their stay. Detailed descriptions of the 15 participants who participated in the study are provided in the results section.

Research Questions

Research questions were identified in order to explore the relational aspects of the therapeutic alliance in substance abuse treatment from the client perspective and identify possible implications for treatment and future research. The research questions utilized in this study are as follows:

1. What do clients care about in the therapeutic alliance?

2. What relational characteristics of the counselor matter to clients?

3. What counselor actions matter to clients?

Procedures

The program director at the Recovery Center granted the researcher permission to recruit clients at the treatment center to be participants of the study as well as utilize the center as the setting for the study. The researcher received approval from the Institutional Review Board at North Dakota State University after the proposal meeting was held with the researcher's dissertation committee and prior to conducting interviews. In order to recruit participants for the

study, the researcher made an announcement prior to morning meditation that took place weekday mornings at 8:00am at the Recovery Center in which a majority of the clients were present. Clients who were interested in participating were instructed to go to the researcher's office and tell her that they were interested. The researcher screened the interested clients to ensure that they met the criteria discussed earlier.

Participants were asked to read and sign an informed consent form prior to engaging in the interview with the researcher. The informed consent outlined the researchers' role in the study. It was clearly stated that clients who have the researcher as a primary counselor at the Center are ineligible to participate in the study in order to minimize the potential for dual relationships. Additionally, the informed consent stated that the researcher will not be advocating for clients or playing a role in their treatment at the Recovery Center. Confidentiality as well as steps taken by the researcher to protect participant confidentiality was also outlined in the informed consent. It stated that information clients share as participants in the study will not be discussed with their counselor at the Recovery Center or with any other individual that is involved in their treatment (i.e. social worker, probation officer, etc.). Moreover, it was stated that any information individuals shared about their counselor at the Recovery Center would not be used in an evaluative manner. Individual interviews were conducted in a private office at the Recovery Center and lasted anywhere between 30 to 60 minutes. The researcher informed participants that the interview would be audio-taped as part of data collection for the researcher's dissertation. Two audio-recording devices were utilized to safe-guard against technology malfunction and loss of data. The audio-recordings were kept in a file cabinet in a locked room at the researcher's home when not in use.

Researcher Lens

In Phenomenology, it is necessary that the researchers identify their internal reflection and set aside personal assumptions. Moustakas (1994) discussed the importance of researchers identifying their own conceptions about the phenomenon under investigation before collecting data. According to Hayes and Singh (2012), "a critical pre-data analysis step is the bracketing of researcher bias and assumptions about the study's focus" (p. 354). Bracketing is the process of the researcher identifying and organizing their pre-understanding of the phenomenon (Moustakas, 1994). In other words, it is important for researchers to identify, explore, and be mindful of their own assumptions of the phenomenon under investigation. This is especially important when the researcher is analyzing the data in order to keep from projecting their own assumptions onto the data. The process of the researcher identifying and bracketing their personal assumptions is important in order to ensure that participants,' rather than the researcher's experience is captured.

As an addiction counselor who has provided substance abuse treatment for the past 7 years, I have developed my own conceptions of the phenomenon under investigation. My understanding of what makes treatment effective is what led to the development of this study. Upon entering a doctoral program for Counselor Education and Supervision, Relational Cultural Theory (RCT) was the first class I took. This class was my first taste of this theory. While learning about RCT, everything suddenly made more sense. Prior to this class I recognized the client-counselor relationship as paramount in reaching positive outcomes in counseling. However, this was about more than the concept of the therapeutic alliance. As I understood it, RCT is a way of interacting; a means of relating and taking in ideas and information. This was contradictory to almost everything I had previously learned. During my previous years of

schooling and experience as a counselor; neutrality and withholding my emotion was the epitome of an effective, professional counselor. I know now that there is a better way. I believe that counselor neutrality and stoicism, especially in the context of addiction treatment, intensifies disconnection and perpetuates clients' unhealthy relationship patterns that contribute to the vacuum of addiction, making it all that more difficult to break the cycle.

When I started working as an addiction counselor in an outpatient treatment for drugs and alcohol, I noticed that client-counselor relationships were often-one sided and confrontational in nature. Although deep down I knew that this was not a helpful, effective means of interacting with clients and implementing treatment, I conformed, until I learned about RCT. Learning about this theory was a breath of fresh air; permission to be myself as a counselor rather than playing the role of a counselor. I no longer carried the heavy burden of being the expert; of needing to be the one who knew better. I believe this has made me a better counselor. I began saying what was on my mind rather than searching for scripted dialogue that characterized addiction treatment as I had previously witnessed it. I began noticing that my relationships with clients were deepening; my interactions becoming more authentic. I believe that a relational approach to treatment is necessary in order to breech the initial mistrust clients may have when entering addiction treatment as well as engage clients in treatment. Without a relational context, I have noticed that addiction treatment takes on a punishing tone, rather than one of healing and understanding. As a result of my experience, I think that a relational approach to treatment considers the whole person, seeks to understand rather than confront, and is characterized by mutuality rather than expertise.

Data Collection

Individual interviews were utilized as a means of data collection in order to focus on understanding the structure of the phenomenon under investigation (Merriam, 2009). The researcher conducted interviews with qualifying participants that lasted anywhere from 30-60 minutes, depending on the amount of self-disclosure from the participant. The interviews were held in a private office at the Recovery Center that was conducive to participant confidentiality. The interview was recorded using two audio recorders that were kept in a file cabinet inside a locked room at the researchers' residence. The researcher utilized open-ended questions in order to uncover the participants lived experiences (Merriam, 2009) with their counselors in addiction treatment. Interviews were semi-structured using a short-list of questions. The interview questions can be found in Appendix F. Follow-up questions were added based on the participants' responses.

Phenomenological Analysis

During data analysis, the recorded interviews were transcribed and participant names were replaced with pseudonyms to ensure confidentiality. The purpose of this study was to examine participant's experiences with their counselors in substance abuse treatment. According to Moustakas (1994) as quoted in Hays and Singh, "phenomenology's sole focus is to understand the depth and meaning of these experiences." The researcher used phenomenological analysis in part to adhere to the theoretical framework in which the study was developed, and to understand the meaning of the participants' lived experiences. Specific to phenomenology, several approaches to data analysis have been identified and advanced. Creswell (2013) identified Moustakas's (1994) modification of the Stevick-Colaizzi-Keen method as the most practical and useful phenomenological approach to data analysis.

Moustakas's (1994) modification of the Stevick-Colaizzi-Keen method was the approach utilized for data analysis. According to Singh and Hayes (2012), data analysis using this approach involves four steps. The first step involves bracketing researcher assumptions. The researcher completed the first step in data analysis by identifying and bracketing personal experiences with the phenomenon. Before looking at the completed transcripts, the researcher engaged in a process of bracketing her personal beliefs and experiences with the phenomenon. She reflected on her personal experiences in the field of addictions and on the therapeutic alliance with clients in order to focus more fully and honestly on the participants' experience with the phenomenon.

The second step in data analysis is horizontalization, which refers to the process of identifying "large domains or categories of text" (Hayes & Singh, 2012, p. 354) To begin the process of analysis, the researcher read through all 15 transcripts. Following the initial review of the data, the researcher read through the transcripts a second time while taking notes and writing thoughts to identify common words, ideas, and descriptions of the data. The researcher utilized data analysis software, NVIVO, to help manage and organize the data. The researcher uploaded all 15 transcripts into NVIVO. Using the software, the researcher read through the transcripts a third time while highlighting word phrases pertaining to the phenomenon under investigation using the cursor from the computer mouse pad.

The third step in data analysis involves constructing a textual description. This involves "refining the horizontalization of data into a textual description of the phenomenon's essence" (Hayes & Singh, 2012, p. 355). According to Singh and Hayes (2012), a textual description "strives to understand the meaning and depth of the essence of the experience" (p. 355). Once all significant statements related to the phenomenon were highlighted, the researcher grouped the

highlighted statements into larger informational units called themes (Creswell, 2013). To complete this step, the researcher used NVIVO to move the statements from transcripts into themes. The researcher created individual folders for each potential theme based on the researcher's handwritten notes describing the significant highlighted words and statements. Using the cursor from the computer mousepad, the researcher pointed the cursor on a specific highlighted statement and dragged it to the respective theme folder. Once all significant statements had been sorted into theme folders that best described the statement, the researcher read through each folder eliminating repetitive statements and statements that did not fit the description of the theme. After the themes were identified, the researcher completed the fourth step in data analysis, which involves identifying a structural description. According to Hayes and Singh (2012), "a structural description is identified by the researcher and/or team, identifying multiple potential meanings within the textural description, in addition to variations among these meanings" (p. 355). This involves using direct quotes from participant interviews (Creswell, 2013). This step has been integrated into the results chapter.

The researcher identified four major themes (Working with their counselor helped clients learn about themselves; Mutuality deepened the client-counselor relationship; Clients valued their counselors connecting them with resources; and Clients appreciated that their counselors held them accountable by inquiring about behaviors or progress toward identified goals). Once all significant statements were placed under themes, the researcher grouped together similar statements and ideas as subthemes (Uncovering hidden insights; Counselors sharing emotion; and Counselor genuine self-disclosure as a means of establishing mutuality and relatability). This helped to avoid overlapping of ideas. Additionally, Relational-Cultural Theory provided a

framework for conceptualizing the data into relationally named themes. Lenz (2016) identified that RCT is an effective analytical framework to utilize within the counseling field.

Trustworthiness

In qualitative research, quality refers to theoretical and technical aspects related to research design and execution. According to Hayes and Singh (2012), criteria of trustworthiness refers to "the qualities that make our designs stronger" (p. 200). Of the ten criteria identified by the authors, four of the criteria apply to the current study and are discussed below. Additionally, the researcher will discuss strategies that were used to maximize trustworthiness.

Criteria of Trustworthiness

Credibility

Credibility refers to how "believable" the study is and if the results make sense (Hayes & Singh, 2012). To maximize credibility, the researcher described elements of the study in detail including rationale, design, procedures, implementation and data analysis.

Confirmability

Confirmability is the extent to which the results of a study reflect the experiences of the participants (Hayes & Singh, 2012). To achieve confirmability, the researcher bracketed her assumptions prior to analyzing the data in order to focus more fully on the experiences of participants.

Authenticity

Authenticity is the extent to which the researcher authentically represents participant perspectives (Hayes & Singh, 2012). In order to ensure that participant perspectives were authentically portrayed in the study, the researcher identified and described steps taken to design the study, implement procedures, and analyze the data.

Ethical Validation

According to Hayes and Singh (2012), ethical validation is "engaging in research that informs practice" (p. 202). In developing the study, the researcher drew from her experience as an addiction counselor and reviewed existing literature in order to ensure that the current study was "filling a gap." In other words, the researcher designed the current study to identify implications for practice that could be implemented in substance abuse treatment to improve the therapeutic alliance and treatment outcomes.

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Strategies of Trustworthiness

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Hayes and Singh (2012) referred to strategies of trustworthiness as "strategies available for maximizing the criteria for trustworthiness" (p. 205). The researcher utilized several strategies of trustworthiness including the use of reflexive journals and field notes, prolonged engagement, peer debriefing, and thick description.

Reflexive Journal and Field Notes

Throughout the duration of the study, including design, implementation, analysis, and write-up, the researcher utilized a reflexive journal. In doing so, the researcher wrote about her thoughts and reactions during all aspects of the study in order to be mindful of how the study was impacting her and to be aware of assumptions. Additionally, the researcher used field notes and memos throughout the process of data analysis in order to increase the accuracy of data analysis.

Prolonged Engagement

Prolonged engagement refers to the amount of time spent getting to know participants in their setting in order to ensure a more accurate description of clients' experiences with the phenomenon (Hayes & Singh, 2012). Due to the researcher working at the setting in which the

study took place, she developed relationships with the participants and was familiar with the setting. This helped the researcher to more accurately describe participant experiences.

Peer Debriefing

Peer debriefing involves consulting with a colleague that is not on the research team (Hayes & Singh, 2012). The purpose of this strategy is to challenge and discuss the researcher's findings. The researcher asked a colleague, who is a licensed professional clinical counselor as well as a licensed addiction counselor, to read through the data and challenge the researcher's findings. In doing so, it was concluded that the findings were representative of participant experiences.

Thick Description

Thick description involves providing a detailed delineation of all aspects of the study. Additionally, it is important for the researcher to capture the meaning of participant experiences that extends beyond describing details of participants and their experiences (Hayes & Singh, 2012). The researcher's prolonged engagement in the setting of the study added to her ability to provide a thick description of clients' experiences and perspectives. The researcher also kept field notes throughout data collection and analysis in order to provide a detailed account of participants' experiences with the phenomenon.

CHAPTER 4. RESULTS

Participants

In order to ensure confidentiality, the researcher replaced participants' names with pseudonyms and removed any identifying information. A description of each participant is provided in order to more fully understand their lived experiences and to provide context for the findings of the study. A summary of commonalities and characteristics will be provided following the descriptions of the participants.

Jerome

Jerome is a Hispanic male in his early twenties and had been at the Recovery Center for two months at the time of the interview. Jerome admitted to the low intensity program at the Recovery Center following his successful completion of inpatient substance abuse treatment. He is homeless and unemployed. His drug of choice is methamphetamine and he has been using since he was in his early teens. His longest period of sobriety was one year while he was incarcerated. He has an extensive legal history involving burglary and possession of stolen property. He was "high" on methamphetamine when he acquired his legal charges. He is court-ordered to follow treatment recommendations and is on probation. He has an extensive family history of substance abuse including his parents, brother, uncles, aunts, and cousins. His father is deceased and his mother lives in another state. He identified as being close to his mother and despite the distance, they talk frequently. He discussed that his mother is the only supportive person he has left. He joined a gang in his early teens and relocated to another state in order to get out of that lifestyle following the murder of his brother. Feeling a sense of belonging and being a part of something bigger than himself were reasons he cited for joining a gang. His other brother is serving a life-sentence in prison for killing their brother's murderer. He wants to make

healthy changes and stay sober as he believes that continued use and gang involvement will eventually lead to life-imprisonment or death. He talked extensively about wanting to live a life that his (deceased) brother would be proud of. He worked hard to address underlying anger and depression that perpetuated his addiction cycle. He has been working hard to challenge the negative way in which he views himself. Jerome identified that supportive people have played an instrumental role in helping him see himself in a more positive way. Jerome enjoys humor and he likes to laugh. Joking with staff and peers helps him to feel more comfortable and at ease.

Ellen

Ellen is a middle-aged, Native-American female and had been at the Recovery Center for two months at the time of the interview. She arrived at the Recovery Center following her completion of her first inpatient substance abuse treatment. Ellen is homeless and seeking a job in retail. She identified that she has co-ocurring mental health diagnoses of Borderline Personality Disorder, Anxiety, Depression, Intermittment Explosive Disorder, and PTSD. Her drugs of choice are marijuana and heroin, and she stated that she had extensive usage histories with multiple substances. Her longest period of sobriety was a little over 3 months. Ellen had an extensive history of physical and sexual abuse both as an adult and as a child. She is separated from her husband and has been divorced twice prior to her current marriage. All of her marriages were verbally and physically abusive, and one of her ex-husbands forced her into sex-trafficking. Both of her parents actively used substances throughout Ellen's childhood. She discussed that through treatment, she gained insight into how her traumatic childhood contributed to her substance abuse and mental health issues. She identified that watching her parent's unhealthy marriage contributed to her thinking that verbal and physical abuse were part of marriage. In treatment she became empowered upon gaining this insight and was motivated to begin making

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healthy changes. Ellen is kind and compassionate. She is empathic and feels what her peers feel when she sees they are going through trying times. In fact, she often cries with her peers leading to meaningful interactions.

Sara

Sara is a middle aged, divorced, Caucasian female and had been at the Recovery Center for one and a half months at the time of the interview. Like several of the other participants, she is unemployed and homeless. Her drug of choice is alcohol and this is her third treatment. Her longest period of sobriety is three and a half years. Her stay at the Recovery Center began following her brief stay in jail for obtaining her second DUI. She is court ordered to follow treatment recommendations and is on probation. Her father abused alcohol and her mother struggled with social anxiety throughout her childhood. She has college-aged daughters and discussed that treatment helped her to identify the impact her substance abuse was having on her daughters. She identified that family counseling was paramount in the healing process for her and her daughters. Sara is kind and respectful. She is supportive of her peers and provides compassionate feedback when she sees they are struggling.

Javier

Javier is a middle-aged, married, Hispanic male. His drugs of choice are methamphetamine and alcohol. His longest period of sobriety was 5 months. This is his third treatment for drugs and alcohol. He has an extensive legal history involving felony domestic assault, felony robbery, several counts of possession of illicit substances, possession of drug paraphernalia, driving while intoxicated, theft, and several charges of driving after revocation. He is court-ordered to follow recommendations of treatment and is on probation. He has a family history of substance abuse. Several uncles and brothers have histories of substance use. He did

not see his brothers often as they continued to abuse substances. He discussed that his parents are supportive of him but he identified that his mother continued to enable his brothers drug use. As a result, he put distance between himself and his mother. He and his wife have four children and his wife is pregnant with their fifth child. He identified that his wife is supportive. He discussed that he works hard to have empathy for his wife as he knows that his drug use and behaviors while using were hurtful to her and their children. He is working to transition back to living with his wife and children upon discharge from the Recovery Center. He obtained a job in construction. Him and his wife attend family counseling and are working hard to effectively navigate their relationship issues and behavioral issues with their youngest son and oldest daughter. Javier is mindful of the impact his drug use and behaviors have on his family. To this end he is working toward a deeper understanding of himself and his addiction cycle. He identified that support meetings play a crucial role in his recovery, however, he prefers cognitive support meetings to twelve step meetings. He often uses humor to connect with others and has a jovial personality that draws others to him. He works hard to understand his peers without judging.

Sandra

Sandra is a middle-aged Caucasian female. The Recovery Center was her third treatment. At the time of the interview she was beginning her second month at the Recovery center. Her drug of choice is methamphetamine and pain pills. She began using pain pills and methamphetamine heavily after the death of her husband five years ago. Sandra is homeless and unemployed. She is weighing the pros and cons associated with relocating to a new area upon discharge. She has a legal history including fifth degree possession and tampering with a prescription. She is court-ordered to follow treatment recommendations and is on probation. She

identified that compassion from her counselors has been instrumental in healing. Her two adult daughters are supportive of her recovery. Through treatment she identified the impact her drug use had on her daughters and on her relationship with her daughters. She is working to rebuild her relationships with her daughters and their children. She identified that her co-occuring anxiety has perpetuated her addiction cycle. During her stay at the Recovery Center, a major focus of treatment has been working toward an understanding of how her anxiety impacts her daily functioning and increases her relapse potential if left unaddressed. She acknowledges and values the healing power of connection and meaningful interpersonal relationships. She enjoyed helping others and was a listening ear to peers in need of support and compassion.

Tony

Tony is a single, Native American male in his late twenties. At the time of the interview he was in his third substance abuse treatment. His drugs of choice are heroin and methamphetamine, and he began using substances in his early teens. His longest period of sobriety is two months. He has a legal history involving possession of illicit substances, driving while intoxicated, and possession of paraphernalia. He was court-ordered to treatment and was on probation. He identified that the most helpful aspect of treatment is attending support meetings and participating in fellowship with peers. He identified that the most unhelpful thing about treatment is any unstructured time. Tony is quiet and reserved. He values interpersonal relationships with his peers. He has daily cravings for his drugs of choice and is open about needing support from others in order to keep his recovery intact.

Leon

Leon is a single, Native-American male in his early twenties. At the time of his interview he was in his sixth substance abuse treatment and had been at the Recovery Center for two

months. His drug of choice is alcohol and he began drinking heavily as a teenager. His longest period of sobriety was ten months while incarcerated and in treatment, consecutively. He has a legal history including felonies for possession of drug paraphernalia and receiving stolen property. He was court-ordered to follow treatment recommendations and is on probation. He has an extensive family history stating that "all of my family members have issues with alcohol." He had little guidance from adults when he was a child and was left to fend for himself. The only person he could rely on growing up was himself. He discussed that spirituality plays an important role in his treatment. He identified that the most helpful aspect of treatment is having the support of staff and peers. He stated that there has not been anything unhelpful about the treatments he has attended. Leon is quiet and reserved with strong values. He has a good sense of humor and enjoys joking with staff and peers once he felt comfortable with them.

Alexis

Alexis is a single, African-American female in her early twenties. She is in her second treatment, homeless, and has been at the Recovery Center for almost three-months. Alexis obtained a job at a restaurant and received a promotion to supervisor. Her drugs of choice are methamphetamine, alcohol, and marijuana. She began using drugs and alcohol in her early teens. Her longest period of sobriety is eight months. Alexis is court-ordered to follow treatment recommendations and is on probation. Her mother, father, and brother all have histories of substance abuse. Her father was physically abusive to her and her mother while she was growing up. During her childhood she witnessed extreme violence from her father toward her mother, resulting in her mother breaking several bones as well as other medical issues stemming from the abuse. She has mixed feelings about her father, wanting to love him because he is her father but hating him for the violence he inflicted upon her family. Alexis identified that treatment has been

helpful in gaining insight as to how her history of trauma contributed to her substance abuse. Alexis is introspective, upbeat, and charismatic.

Larry

Larry is a divorced, Native-American male in his mid-fifties. At the time of his interview he was in his fifth substance abuse treatment and entering his third month at the recovery center. His longest period of sobriety was a year while he was married to his ex-wife who did not drink. His drug of choice is alcohol and he began drinking in his early teens. His mother and father had histories with alcohol abuse. He discussed that his co-occuring depression contributed to his addiction and vice versa. He identified that being forced to treatment and being homeless when he got out of treatment was unhelpful. Larry obtained a job doing construction. His legal history made it difficult for him to obtain housing so as a first step he is working on getting into group residential housing upon discharge from the Recovery Center. By doing so, he could have more time to find an apartment that was amenable to his legal history. Larry has a dry sense of humor and enjoys joking with staff and with peers. Attending twelve-step meetings provided him with support that he identified as crucial to staying sober.

Bryce

Bryce is a single, Caucasian male in his late twenties. He is in his third substance abuse treatment and entering his third month at the Recovery Center. He identifies his drugs of choice as alcohol and Adderall (a stimulant commonly used to treat ADHD). He began using alcohol and other substances in his early teens. He has a legal history involving several counts of driving while intoxicated, was court-ordered to follow treatment recommendations, and is on probation. He has a family history of substance use, his father, two brothers, grandparents, aunts, and uncles all have histories with substance abuse. He values his family and spent quality time with his

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parents while he was on pass from treatment. His father is in recovery from substance use and he looks up to his father. He identified that his mother continues to enable one of his brother's substance use. He limits his time with his brother who is still actively using substances due to the risk to his own recovery. He also discussed that he limits his time with his brother who is in recovery due to his brother's arrogance about his recovery. He is homeless and looking for an apartment from a landlord that is amenable to his legal history. He obtained a job at a factory during his stay at the Recovery Center and was saving up for an apartment.

He identified that support meetings play a crucial role in his recovery, however, he preferred cognitive support meetings to twelve step meetings. Bryce valued the healthy connections he established with sober peers while in treatment. He worked hard to find a program of recovery (identifying meetings that he found beneficial and obtaining a supportive sponsor) that worked for him. Bryce is intellectual, self-aware, and mindful of how he affects others around him.

Dylan

Dylan is a single, Caucasian male in his late twenties and is in his second month at the Recovery Center. He had several prior substance abuse treatments. His drugs of choice were methamphetamine and alcohol. He had co-occuring anxiety that had been perpetuating his addiction cycle for years. He identified that he has had an ongoing struggle with anxiety and was working hard to find coping skills that helped him effectively address his anxiety. He discussed that talking with compassionate counselors and supportive peers helped him address his anxiety. He identified that the most unhelpful aspect of treatment has been when peers used in the facilities where he was receiving treatment. He originally thought that substance use helped him cope with his anxiety until he entered treatment and began realizing that substance use was

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worsening his anxiety. He identified that he has shame about how his substance use impacted and contributed to the end of his relationship with his ex-girlfriend. He worked hard to identify and end peer relationships that negatively impacted his recovery and was working to establish a sober peer network that was supportive of his recovery. During his stay he obtained a job in construction and was saving up to obtain an apartment prior to his discharge from the Recovery Center. Dylan worked hard to overcome his anxiety, develop and utilize coping skills for anxiety and triggers/urges to use, and demonstrated insight into how his negative self-talk negatively impacted his recovery.

Karl

Karl is a divorced, Caucasian male in his mid-fifties and is in his second month at the Recovery Center. He had three previous substance abuse treatment. His longest period of sobriety has been 3 years and he stated that he achieved this by going to twelve step meetings, inviting God into his life, and having a desire to stop drinking. His original drug of choice was cocaine before he switched to alcohol use in an effort to end his cocaine use. He discussed that his alcohol use was much more detrimental to his life than his cocaine use. He identified that the most helpful aspect of treatment was learning coping skills to stay sober and stated that there was nothing unhelpful about the treatments he attended. His legal history includes five counts of driving while intoxicated, possession of an illicit substance, shoplifting, and theft of a motor vehicle. He was court-ordered to follow treatment recommendations. He had co-occuring anxiety and depression. He discussed that his drug use contributed to the end of his marriage and his adult daughter does not speak to him. His mother and father abused alcohol throughout most of his childhood. He identified that he has been homeless for many years and the lowest point of his life was when he was eating out of dumpsters to survive. He had tears in his eyes when he

discussed that he never wanted to get experience that again. During his stay at the Recovery Center he got a job doing laundry but had difficulty working consistently due to his chronic back pain. He valued the friendships he developed with several sober peers that he went to treatment with and credited their support as invaluable to his recovery. He identified that his biggest risk to his recovery was becoming romantically involved with women while he was in treatment. He credited his previous counselors with bringing this to his attention.

Kelly

Kelly is a divorced, Caucasian male in his late forties and in his third month at the Recovery Center at the time of his interview. He has had two previous substance abuse treatments. He became addicted to pain pills after severely injuring his arm in a boating accident. He identified his drugs of choice as opiates and alcohol. He has a legal history involving two counts of driving while intoxicated. He was court-ordered to treatment and was on probation. His father, aunts, uncles, and cousins have histories of substance abuse. He obtained a job in construction to save money in order to obtain an apartment. He identified that attending treatment helped him "dig into" his recovery which helped him learn about himself and aided him in developing coping skills. He identified that his spirituality has been instrumental in his recovery. Kelly valued the support he received from family and peers and identified that he had several mentors/sponsors from both the church he attended and from attending meetings. Kelly was intellectual, self-aware, and valued the connections he established in recovery.

Adam

Adam is a single, Caucasian male in his late twenties. He is in his third month at the Recovery Center. He had one previous substance abuse treatment. He identified that his drug of choice was methamphetamine and he began using in his late teens. He has several counts of

felony possession of an illicit substance and is currently facing over 20 years in prison. He is court-ordered to treatment and is on probation. His mother and father both have histories of substance abuse but are currently in recovery. He identified that his parents are both supportive of him and his recovery. He identified that the most helpful thing about treatment is the knowledge he gained about himself, his addiction, and his recovery. He identified that too much structure in treatment was not helpful. He is homeless and obtained a job working at a restaurant. Adam identified that his co-occuring anxiety perpetuated his addiction cycle and worked to employ coping skills to help him manage and lessen his anxiety. He discussed that he felt as if he was in limbo due to not knowing if he would go to prison or would be accepted into drug court. He found comfort and support in his spirituality as well as his family and sober peers during this period of uncertainty. Adam has a dry sense of humor that helped him cope with his anxiety and pending legal charges. He often jokes with staff and peers as a means of healthy distraction.

Margo

Margo is a middle-aged, divorced, Caucasian female. She is in her third month at the Recovery. She has had six previous substance abuse treatments. She identified her drug of choice as opiates and marijuana. She began using substances as a teenager. She has a legal history that includes two counts of possession of a controlled substance and a felony possession of a fire arm. She is court-ordered to treatment and on probation. She has co-occuring medical conditions including chronic pain as well as co-occuring anxiety and depression. Her longest period of sobriety is eight months. She identified that she achieved sobriety by attending aftercare. She identified that the most helpful aspect of her previous treatments was working with counselors that cared about her. Margo was kind and compassionate to her peers, especially when they were going through a rough time.

There are several commonalities among participants. Commonalities include having a history of trauma, extensive family history of substance abuse, co-occuring mental health issues, interpersonal violence and abuse. Most of the participants have had several substance abuse treatments and minimal periods of sobriety. All of the participants envision a better life for themselves. A consistent focus of participants throughout treatment has been rebuilding and improving family relationships. Most of the participants' value fellowship and identify connection with their peers as a major source of support. Many of the participants are court-ordered to treatment and have probation/parole. All of the participants were homeless and unemployed upon admission to the Recovery Center.

Findings

The researcher identified several themes and subthemes during data analysis. The first theme was identified as: Working with their counselor helped clients learn about themselves. A sub-theme was identified: Uncovering hidden insights. A second theme was identified as: Mutuality deepened the client-counselor relationship. Two sub-themes were identified: Counselors sharing emotion, and Counselor genuine self-disclosure helped establish mutuality and relatability. The third theme was identified as: Clients valued their counselors connecting them with resources. The fourth and final theme was identified as: Clients appreciated that their counselors held them accountable by inquiring about behaviors or progress toward identified goals.

The author utilized the research questions as a backdrop to navigate and make sense of the research findings while adhering to Creswell's phenomenological analysis tasks. The research questions utilized in this study are as follows:

1. What do clients care about in the therapeutic alliance?

2.   What relational characteristics of the counselor matter to clients?

3.   What counselor actions matter to clients?

Additionally, when interpreting the results, the researcher considered the theoretical framework based on Relational Cultural Theory.

Theme 1: Working with their counselor helped clients learn about themselves.

Several participants discussed that working with their counselors helped them learn about themselves and shared how this increased knowledge impacted their recovery. In response to being asked "What goes on in session that you feel good after the session?" Tony discussed that the most helpful thing about working with his counselor in treatment has been "Learning about myself." He went on to discuss the growth he experienced from working with his counselor stemmed from the knowledge he gained about himself and his recovery. Similarly, Sandra discussed how her counselor helped her learn about herself and her addiction. The following quotes from Sandra's interview were in response to being asked "Could you tell me a little about your experience in past treatments?" Sandra then went on to tell her story and discuss that she began using heavily after the death of her husband. Sandra obtained legal charges as a result of her substance use and admitted to inpatient treatment. Her answer to this question describes the role her inpatient counselor played in her treatment and self-discovery.

I thought that he was asking me a lot of questions that weren't relevant to being there (in treatment)…but it turns out that they were in the end…they were questions about my daughters and at first I was angry with him, because I was like how dare you bring my daughters into this…they want nothing to do with me being here…but they did because it was my family that I had been pushing away…I didn't realize I had pushed my daughters so far back after the death of my husband…I just kind of isolated myself…so I really

kind of grew to trust him…and he really helped me with major breakthroughs with my

addiction and things that were really holding me back, I just broke down one day in his

office and I just cried, cried, and cried, I realized now I needed to get it out…I felt like I

could breathe again.

Sandra initially felt defensive about discussing her daughters. After her husband died, Sandra

coped with her grief and numbed her feelings by using pain pills and methamphetamine. As a

result, Sandra started isolating from others which resulted in becoming disconnected with her

daughters. This was a painful realization for Sandra as she did not intend to hurt her daughters

when she began using. She assumed that her daughters wanted nothing to do with her after her

drug use. However, through her interaction with her counselor, Sandra identified that her

daughters still care about her and still want to be a part of her life. Working with her counselor

led to increased self-clarity, especially regarding "things that were really holding me back," as

Sandra stated during the interview. In other words, through these interactions with her counselor,

Sandra began grieving the loss of her husband which helped her begin to heal, as Sandra put it "I

felt like I could breathe again." During the interview, Sandra described the conversation she had

with her counselor once she realized she had not yet started grieving the death of her husband.

Since the death of my husband, I was being selfish with not grieving and not being there

for them (her daughters) like I should…when I was using I stayed away from them

because I didn't want them to see me using…it was buttons you (her counselor) were

pushing at the time that I was angry with you about, but I now realized that I needed to

get it out…I explained it like my body trying to push out a sliver that you get in your

hand and it slowly pushes its way out…I told him (her counselor) that is what my body

has been trying to do was trying to get these feelings and emotions out that I had been

holding in for so long and once I did…I was so much happier and I started getting inner peace back and I was able to get rid of the shame and embarrassment and guilt and start that spiritual growth again…and I got my faith in god again, you know…so that was a major breakthrough at treatment when I was there with that counselor.

Sandra trusted that her counselor was leading her in a direction that led to healing, even though she had to walk through pain and discomfort to get there. While at the Recovery Center, Sandra often stated her mantra out loud both to herself and to others, "My pain today is my strength tomorrow." Sandra embodied that concept. She went on a painful (but enlightening) journey with her counselor in order to reconnect with herself, her emotions, and her daughters. Sandra gained insight about her emotions, using the analogy of her body pushing out a sliver. In working with her counselor, Sandra not only gained insight into her emotions and how she experienced them, she also became more willing and able to express herself to others. In doing so, Sandra found her voice and began trudging through the guilt and shame she had held onto for so long. It is also important to note that although Sandra was initially hesitant to talk with her counselor about her daughters, the end result of gaining self-knowledge and clarity deepened Sandra's relationship with her counselor because she could trust that his work with her was relevant and beneficial to her recovery.

Along the lines of gaining self-knowledge, Karl discussed that working with counselors helped him gain clarity about the role relationships have played throughout his life and in his addiction. "He saw my danger signs from loneliness and relationships…I never even thought of relationships like this before, both of my counselors (his counselor from his previous treatment and current counselor) picked up on it." In working with his counselor, Karl realized that he entered unhealthy relationships in order to relieve his loneliness and to get a "rush" that was

similar to using drugs. His counselor helped him identify unhealthy relationship patterns in order gain insight into how unhealthy relationships could be perpetuating his addiction cycle. Even though his counselor spoke directly about his concerns, Karl accepted and appreciated his counselor's honesty because he knew that his counselor had his best interest in mind when doing so. In the following quote, Karl described the discussion he had with his counselor about the relationship he was in upon entering inpatient (prior to admitting to the Recovery Center).

> He came right out and told me you know, you got to quit you have to get rid of this gal, you got to end that relationship, because she is a drug addict, but and an alcoholic, she doesn't drink anymore and hasn't for over a year, but she still takes drugs, pharmaceutical drugs and she was taking a lot of my drugs that I am supposed to be taking like prescribed by a doctor…and I told (his previous inpatient counselor) this…I kind of ousted her when I came here, I let her know that I am coming here you know, you've got your life move on….

In Karl's first quote, he discussed that his counselor saw warning signs that were difficult to see himself. Once his counselor shared this perspective with Karl, he gained insight into how unhealthy relationships, in which both him and his significant other used substances, were perpetuating his addiction cycle. Karl identified that almost all of his romantic relationships throughout his life involved him using substances with a significant other. Following this initial realization, Karl was open to what his counselor had to say on the topic even though his counselor very directly told Karl what he thought about his relationship with his significant other. Karl described feeling relieved after he had this conversation with his counselor. In this next quote, Karl discussed that him and his counselor were on the same page with the direction his treatment should take.

Um, to be honest with you, I kind of relieved…he asked me, what are your plans for

when you get out of here and I told him, I don't want to go back to (the town in which he

lived with his significant other) and what is weird…ironically that one day, uh, I went to

look for (inpatient counselor) to tell him that I can't and I don't want to go back to (the

town in which he lived with his significant other)…it turns out I caught him coming

down the hallway and he says I was just looking for you. I said that is weird I was just

coming to see…he says alright let's go talk…we went to his office and I said what do

you want to talk about, you go first…he says tell me what is on your mind? I said well, I

decided I can't go back to (the town in which he lived with his significant other) and I

don't really have any place to go and I heard about a halfway house and I said what are

the chances you can get me in there…he said that is too weird, when I came looking for

you, that is exactly what I wanted to talk to you about…

Upon learning about himself through the interactions he had with his counselor, Karl and his

counselor worked together to apply this knowledge to his recovery. As a result, both Karl and his

counselor felt it was in his best interest to relocate away from his significant other in order to

increase the likelihood that he would remain in recovery after completing inpatient.

It tells me that he has brought me…to the level of acceptance that I was comfortable

enough to tell him that I did not want to go back to her or that town…the bond that we

(Karl and his inpatient counselor)…we spent a lot of time, we did a lot of talking outside

of recovery stuff too…like friends we talked and it was just really neat…you know we

just got really close...I can't really say exactly what it is, but he made it so…His ability to

make me feel comfortable it really put a finger on what exactly that ability is…I think it

just boils down to his caring…about what happens to you…otherwise he wouldn't have

come looking for me to say look, I was going over your stuff and I'm not comfortable sending you back to Bemidji and that is what he said…as a matter of fact I need to call him and let him know how things are going…

In working with his counselor, Karl not only learned about himself, he accepted this information and applied it to his recovery. He was not blindly agreeing with his counselor when they were identifying and discussing Karl's unhealthy relationship patterns. Karl found truth in what his counselor brought to his attention and as a result, Karl learned about his recovery. He learned that it may be in his best interest to relocate and admit to a halfway house rather than returning to his previous town and relationship. In gaining this clarity and through his interactions with his counselor, Karl felt more connected to his counselor as indicated by "the bond" they shared. The counselor and the way he worked with Karl was instrumental in Karl's increased insight and acceptance of the information that was introduced by his counselor. In the next quote, Karl went more in-depth about the knowledge he obtained and how it related to his recovery.

(His counselor) telling me the relationship right off the bat (in early recovery) isn't a good thing, to be living with a girl right away, to avoid the loneliness, the first opportunity that I get to move in with somebody or have somebody with me, I would do it…cuz I hate being alone…and I don't give the relationship time to really get to know that person and then after we are living together, then I find things that turn into red flags. That will have an impact on my recovery…

In working with his counselor, Karl took the knowledge he gained about himself and took a more in-depth look at how it affected his recovery. As a result, Karl gained valuable insight into his addiction cycle and his recovery.

Another participant, Kelly, also discussed that working with his counselor resulted in self-exploration. In the following quote, Kelly talks about how his counselor encouraged self-introspection.

Right now my counselor has me working on the inside/outside house, you know, as far as if drinking was ever an issue...he just wants me to dig in deep enough to see if there really was a problem. Hey, I've had two DUIs, there has to be a little bit of a problem. Why would you get a second one? He wants me to uncover myself, things about myself. There is no reason not to open up about it right now, I mean if there is a time and a place, this is the time and the place.

Kelly discussed that his counselor encouraged self-exploration in order to uncover dynamics of his addiction that could later impact his recovery. Instead of focusing solely on Kelly's drinking problem, his counselor guided him through self-exploration while encouraging him to be open to alternative perspectives in order to gain insight. Kelly identified his drug of choice as opiates and discussed that he became addicted to pain pills after he severely injured his hand in a boating accident. However, Kelly was still on the fence about his alcohol use being an issue. Considering this information, it is interesting to note that Kelly identified another drug of choice as alcohol when he was filling out the demographic information prior to the interview. Kelly's work with his counselor encouraged Kelly to take a look at himself and uncover any information that might impact Kelly's recovery. The next quote illustrates that Kelly continues to explore the insight that was uncovered while working with his counselor.

Um, you know one thing about my counselor, is if I ask him anything he will always ask me back, what would you do…putting it, that is why this house thing, at first I really didn't understand what he wanted in the whole thing, I don't know if he does that with

everybody or not, but he seen something inside me…I'm not afraid or ashamed I don't

know why I'm toying with it so…maybe like… the other day when I was sitting in there,

I'm thinking to myself, does he just want me to say to him that I am an

alcoholic? Because I always say addict…you know in meditation or something like

that… addict… maybe I'm not saying that is what he is trying to get out of me, he is

trying to understand and explore deeper to see if that has been an issue…

In working with his counselor, Kelly continues the process of self-exploration and is actively

working to uncover his own truth. His counselor serves as the guide while Kelly continues to dig

deep.

Subtheme: Uncovering Hidden Insights

Participants discussed that their counselors helped uncover hidden insights by seeing in

them what participants were having difficulty seeing until it was brought into their awareness. In

response to being asked if there was a turning point in his relationship with any of the counselors

he has worked with, Leon described a time in which he began to trust his counselor because he

saw something in Leon that he did not see himself. However, Leon discussed that he was initially

confused by the interactions he had with his counselor.

I remember an old counselor (while at inpatient treatment), he would get pissed at me and

he would let me know when he was pissed at me…I didn't know what he was pissed

about…he wouldn't let me know …he said get your shit together…I would be like what

are you talking about? He would be like you know what I am talking about…but I am

like, what are you talking about dude? Like I seriously don't know what you are talking

about…he would be like you are going to learn soon enough… I did not know what he

was specifically talking about…maybe it was my act, the way I interacted with others, I

didn't know…I was like… he had me all bottled up and I would go lay in my bed going

   what…what was he talking about.

Leon did not know what to make of his counselor's comments. However, he discussed that as he

continued to work with his counselor, he began to see that his counselor's comments were

stemming from something that he saw in Leon.

   A little confusing…confusing…I tried to trust him more, because he saw something in

   me that I didn't see…it was helpful, but it was confusing too because it took me a little longer for

   me to see it and he didn't tell me right away. He saw things...that could hurt me…in the future,

   (his inpatient counselor told him) you are a good kid man…you're a great kid, I've seen a lot of

   kids come through here and you are a smart one…that is what he would say…not sure how many

   he said it to or if he said the same thing to other people or but…he was like I've seen a lot of

   people die and I don't want to see you die…

It was meaningful for Leon when his counselor pointed out potential obstacles in his recovery

that were difficult for Leon to identify without the help of his counselor. Seeing in Leon what he

was unable to see without the help of his counselor communicated to Leon that his counselor

cared enough to have these conversations with him. In the next quote, Leon went on to discuss

why this interaction with his counselor meant so much.

   I haven't really had very much guidance in my life…when it came to parenting or

   anything like that…positive or a role model…I don't know, pretty much tried to learn on

   my own and keep going…so…that was helpful…meeting up with each other and I mean

   just, just trying to understand one another…

It was powerful for Leon to see his counselor putting time and effort into understanding Leon

and helping him navigate recovery. This was especially meaningful for Leon since he did not

have people in his life, both in his childhood and early adulthood, that provided the guidance that he wanted and needed. It is interesting to note that Leon referenced that he and his counselor were "trying to understand one another." He was mindful that this interaction took effort from him and his counselor. He did not just expect his counselor to work to understand him, Leon also put in effort to understand where his counselor was coming from.

Additionally, this self-knowledge was uncovered by clients' learning how they were perceived by their counselor as well as the meaningful interaction that followed. In response to being asked what a counselor does or says that helped her know that her counselor cared about her, Ellen discussed her experience with learning about how her counselor perceived her. She stated:

> Um, I feel like (her inpatient counselor) really cared, she was very upbeat, positive all the time, she was always pointing out your positive attributes…very nurturing, kind of a mother type…you know, um…she was awesome…she (counselor) pointed out a lot of things to me that I never would have seen, she told me…you are such a strong person.

Learning about her counselor's perception of her impacted how Ellen saw herself. Additionally, clients discussed that they had grown so accustomed to viewing themselves in a negative way that it made it difficult to see themselves in a positive light. Jerome discussed the counselors he worked with were instrumental in helping him to see the good in himself that he had difficulty seeing on his own.

> They (counselors) would tell me…don't let your past… I remember (his inpatient counselor) told me…he told me a lot of positive things, you (Jerome) have a positive vibe, I see you making it in this world, just don't go back to your old ways…he told me a lot of things that just made me feel positive, but I would bring myself down….but for

somebody else to see it…Because of my past, I have a lot of guilt…things I have done in

the past and just a lot of things that have gone on that there are days that I remember

waking up…there was a night, before I went to bed, I told god to not wake me up

anymore.   I didn't feel like waking up, but I told him to not wake me up… I didn't feel

worthy of still having another day of life and um…I just feel like my past kind of haunts

me, it still does…and um, sometimes I just don't feel that I deserve to keep going you

know… It was something different (to hear counselors say positive things about him). I

can say something different…motivating…I guess I never had nobody…have a positive

vibe towards me…they (counselors) probably saved my life you know…

Jerome was surprised to hear that he had affected his counselors in a positive way and it allowed

for a moment of shared power between him and his counselors. In working with his counselor,

this client engaged in meaningful interactions and received authentic feedback that helped him

change his self-perspective. As a result, he experienced an increase in self-worth as well as

increased capacity for meaningful interactions with others.

In terms of actions taken by the counselor to enhance self-knowledge, several participants

discussed the ways their counselor introduced perspectives that ultimately led to increased self-

clarity and self-knowledge. It is interesting to note that some participants did not seek or expect

to accept learning new things about themselves. In response to being asked what Sara liked about

the counselors she has worked with, Sara described a time in which her counselor introduced her

to an alternative perspective that led to increased insight. Sara discussed that she gained insight

about her relationships and about herself.

When they listen, but it's good when they get you to like ask certain questions, not

leading questions, you know… sometimes you think oh gosh, I don't know what to say or

the words aren't coming to my mind…so and of course they are trained that way so most

of them are really good…all my counselors I've never really had a bad relationship with,

I understand that they are there to help…You know. Sometimes it would help me just

jog a memory back….you know somethings that I haven't really thought about, um. Get

some clarity…about…and it would go both ways how do you think that affected the other

person….how you do think it affected the other person or how did it affect

you? Sometimes I'm thinking so much about the other person, I didn't realize you know

that I was hurting too, I mean in just interpersonal relationships and things, I think just

showing me different perspectives…rather than just, you know of course in my mind, it is

opening my eyes to interpersonal relationships.

Sara found it meaningful when her counselor listened and encouraged her to explore how her

addiction impacted her relationships. In doing so, Sara also gained clarity into her emotions and

how she experienced her relationships.

Similarly, Ellen expressed that in addition to gaining clarity about her emotions, she also gained

insight about her life, her behavior, and her addiction. The counseling relationship helped her

understand the reasons for using substances. This next quote is from Ellen's interview when she

was asked about what was most meaningful or helpful about her previous treatments.

I did my, I think the most significant thing was doing my life line with my other

counselor and he was able to go all the way back to when I was an infant…um, and

straight up to the present time and then he went back and he you know, now I understand

so much of my life um, my parenting, um…my parents…um, probably um…how

unstable my life was and now unmanageable um, the reasons why I used…and how

unhappy I really was when I was thinking I was happy and I was super restless all the

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time and very um, argumentative and you know, I suffer from intermittent explosive

disorder, so you know, I used marijuana to be able to um, keep that anger at bay…I mean

there were things that I just couldn't see, but when he pointed them out I was

like..oh.. .he was the one (inpatient counselor) that helped me discover the reasons why I

used. Um, he helped me see that my parents were both orphans, they didn't know how to

parent and in my case when I became a parent, I kind of carried on the same as the way

my parents did, you know…my mom was in these domestic abuse relationships also with

my father and she was constantly moving and going away and then moved a lot when I

was a kid, and I kind of did the same thing, and I didn't realize my children needed the

stability that I never had…I was continuously looking for love in other people because I

never really received it when I was a child….I never had my parents tell me that they

loved me…um, I think I can count on one hand how many times my father said I love

you…that was basically before each surgery that he had. I'm trying to get my mom to

say it a lot more, but they were never very touchy feely, my dad would hug me a lot and

everything, but I don't remember him kissing me too much. Um…he drank, my mom

drank and they would go and drink all weekend and then fight and then end up

somewhere in a battered woman's shelter or something…you know in a totally different

school and I lived my life that way…and I kind of did the same thing to my kids and not

realizing that that wasn't normal, now I have a second chance, I have a 7 year old and I

can show her stability and make her feel secure and loved…because you know, I am

constantly telling her that I love her several times a day and she tells me that several

times a day and I'm always hugging and kissing her and cuddling her and stuff and they

were things I never received…. he (counselor) really helped me man…I don't know if I

would have done anything without him…I don't think my treatment would have

stuck…definitely not…

Her relationship with her counselor was a safe place to explore the most intimate, painful aspects of her life. Ellen began to understand the context of her addiction. Ellen became aware of the role intergenerational trauma played in her parents' lives, her life, and her children's lives. The client-counselor relationship was a vehicle for self-understanding, increased insight, and clarity. The next quote is in response to Ellen being asked what was helpful about how her counselor worked with her.

You know I would always talk to him and I never gave him BS, I never told him what he wanted to hear, I was always honest with him…with everything…because he cared…he wanted to know, he wanted you to know and I mean he wanted to teach you and doing the lifeline was definitely sobering for a lot of people, I saw a lot of people just do it, but just to get it over with and move on…you know, but I mean…with me uh, I think he considered it a success…if he can get 1 out of 10 people to take their sobriety sober…you know, I mean take their sobriety serious….and he basically saw in me what I wasn't able to…to accomplish that... He was like no nonsense, he didn't put up with your bullshit, pardon my language, but you know…you could just say what you thought he wanted to hear and he would say no…and he would continue to make you say what you thought, your opinion and even if he thought it wasn't pleasant, he would be satisfied with that. He was like pretty, he was pretty rough, but he was like you know very honest, very forth right and I really miss him a lot. When I moved out of inpatient, I just really missed him and I never got a chance to every time I got a chance to say hi or how's it going or whatever.

Ellen's relationship with her counselor was an integral part in her willingness to open up in treatment. She perceived that her counselor cared because he genuinely wanted to know about her, which encouraged her to be honest and open up to him. Ellen identified that her counselor seeing in her what she was unable to was crucial in her being successful in treatment. In other words, her counselor believing in her was instrumental to Ellen believing in herself.

Karl also discussed how working with his counselor helped him gain insight about how his addiction affected his emotions and his life. The next quote is in response to Karl being asked what his counselor did or said that was helpful.

Well he helped me to realize that my being so young when I first started out using, it didn't give me the opportunity to grow up (emotionally)…you know, he said that when you start polluting your mind that is my word, not his, but start using whatever age you start using at, is pretty much the mentality that you are going to be at when you stop, no matter how old you are…so in a roundabout way, I'm still an 11 year old…and sometimes I feel like it…the way I act, I have seen it in me when I'm drinking, but I'm sure it has been there, but I have this childish side…where I get so embarrassed later that I have done silly things that are really childish and I don't like talking about it…but you know…that and he is the one that made me see that light, not saying that I'm childish, but everybody has that in them, everybody has a sense of childishness…

This interaction with his counselor helped Karl gain awareness into how his substance abuse impacted his emotional functioning while allowing him to move through shame and guilt associated with how his addiction impacted him.

Theme 2: Mutuality deepened the client-counselor relationship.

One of the overarching themes that was identified from the data was that of mutuality. Jordan (2010) described mutuality as "The concept in RCT suggesting that we grow toward an increased capacity for respect, having an impact on the other, and being open to being changed by the other" (p.104). Within this overarching theme of mutuality, two subthemes were identified: Counselors showing emotion, and Counselor genuine self-disclosure as a means of establishing mutuality and relatability. The data reflected aspects of mutuality in the following ways.

Several participants discussed the meaningful interactions they had with their counselors in which mutuality was the cornerstone. Bryce discussed that he had a counselor from a previous treatment in which the relationship was lacking mutuality and another counselor in which mutuality was present in the relationship. The following quote from Bryce was in response to being asked to describe his relationship with his counselor.

Mutually satisfying…I'm getting what I'm needing out of it as well as I get a good feeling that I am making him think about stuff in different ways or different things…You leave with a good feeling. With my other counselor (previous inpatient counselor), he kind of would take in what I had to say but there was really not a lot of feedback…I don't know if he was actually taking it in the right context or what was actually getting through on the other side. It seemed like he was a little bit more withdrawn from the process, he wanted me to work through the stuff, but that is not what I feel I came to treatment for...it was kind of one-sided. There needs to be some kind of connection to be able to go through the situation because you have to have somebody, it is very beneficial to have somebody or feel there is somebody going through this stuff with you, instead of by

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yourself…those feelings of being alone that are perpetuated by drugs and alcohol…they don't just go away with the absence of the chemical, you still feel like you are alone going through the struggle and having somebody to walk next to you…which is usually more of a steep uphill climb.

Bryce discussed that the lack of "give and take" with his counselor was not beneficial to his treatment. He came into treatment to work collaboratively with others in order to move toward recovery. However, being met with a one-sided relationship inhibited his growth. Bryce went on to discuss how one-sided interaction with his counselor impacted the client-counselor relationship.

I think that made a definite disconnection between seeing him as more human…he was definitely guarded. I think that was one of his downfalls of him becoming a more successful counselor, and I guarantee that it has been brought up by more than one person.

Bryce identified that there was a lack of give and take in his previous counseling alliance. He did not engage the same way he does with his current counselor. He spoke about the differences and provided insight about how mutuality is present in a counseling relationship.

They are not just all in their head and thinking of things but are actually participating in the conversation…and if it goes a little bit off topic, not just cutting and bringing it back, being able to go back and forth...you know that personalized it and helped a lot…I feel that is just as valuable as talking about treatment related things. I didn't have to consciously work on dropping my guard and letting him see me…it was just a natural process.

When his counselor was willing to let Bryce express his thoughts and ideas, Bryce felt safe enough to be genuine and vulnerable. Through back and forth conversation, Bryce realized his counselor was interested in him as a person and it allowed Bryce to move forward in treatment instead of getting stuck and feeling dismissed.

Subtheme: Counselors showing emotion

An important aspect of mutuality for participants in the study was the willingness of counselors to express some emotions. Counselors showing emotion helped clients to see their counselors as active participants in the relationship. Several participants identified that they were moved when their counselors allowed them to see how they (counselors) were impacted by something that they shared with their counselor. When the researcher asked Adam if he could recall a time in which his counselor was affected by something Adam said or did, he replied:

> I made my counselor cry one time, I have seen different counselors tear up when I tell my story…I cried too, I believe it is part of recovery. You know, as a man it is hard for me, because I don't like showing that emotion, I don't like being weak or being perceived as weak…but there are a lot of emotional things from my active use that people could relate to both in recovery and from the counselor side of things…and it's important that we share them with each other. I feel that human connection, that positive human connection, is absolutely essential to treatment.

Adam seeing his counselor's emotion provided the opportunity for a shared moment in which he felt connected to his counselor. Adam recalled instances where the absence of counselor emotion and connection, or lack of mutuality, was not helpful and led to confusion. "I have had those counselors before…where they will just sit there and write the whole time…like are you doing a crossword puzzle, what are you doing, are you doodling…" Adam perceived that his counselor

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was not actively invested in his treatment, that their relationship lacked "give and take." Adam felt disconnected from his counselor and alone in his work to battle addition.

In response to being asked how she knew her counselor cared about her, Sara recalled a time in which she saw that her counselor was visibly impacted in their session. In this next quote, Sara described her thoughts about a family session with her daughters and her counselor.

> I think that seeing both my daughters' crying and me crying…I could tell her heart was in it…her eyes even got a little teary, and that doesn't…it isn't necessary to make me feel emotion, but after all the clients she has had, that she cares that much about her clients.

It was meaningful for Sara to see that her counselor was affected by her and her daughters. Her counselor's emotion was not a prerequisite for her own emotions; however, seeing her counselor's emotion made the interaction more meaningful and communicated that her counselor was invested in her treatment.

Some participants perceived that counselors who were willing to show some emotion helped them to share more personal aspects of their (participants) struggle. In response to being asked how she knew her counselor cared about her, Sandra described a time in which her counselor showed emotion.

> I was telling my counselor the story about how my husband died and I lost my house and my mother-in-law told me it was my fault…I literally lost everything but the clothes on my back. I saw him (counselor) start crying, getting watery eyes. It was emotional. It was kind of nice to know that I knew that he was really listening to what I had to say. He (counselor) doesn't always come off as very compassionate, he is more strict and by the book…but in the end…I got more out of it than in the beginning…when I saw him get teary eyed…I just had a different perspective…I looked at him differently about that. I

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saw that he actually cared…about my situation and maybe he does look at us all

differently…I know that they go through so many clients and I just felt like I was just

another client to him…until I was telling him that story and I saw how it was affecting

him…I thought that he actually does care.

For Sandra, seeing that her counselor was emotionally affected by her self-disclosure deepened

their relationship. This interaction also communicated to Sandra that her counselor was actively

listening to and understanding her. Similarly, Larry recalled a time that his counselor showed

that he was affected by something Larry said. He stated, "When my sister died, it seemed like he

was…kind of grieving with me…it made me respect him a little more…you know. It looked like

he really cared." Seeing emotion from his counselor deepened his relationship with his counselor

and communicated that his counselor cared about him. For Larry, seeing how he impacted his

counselor lead to increased respect. In these examples, counselors established mutuality in their

relationships with their clients by allowing themselves to be visibly impacted and open about the

emotions they were experiencing. It was powerful for participants to see that they had an impact

on their counselor.

Subtheme: Counselor genuine self-disclosure as a means of establishing mutuality and relatability

Counselor self-disclosure was another way participants' identified mutuality within their

relationship with their counselor. It helped clients to see that their counselors were actively

participating in the relationship and in their treatment. For example, Margo identified that her

counselor's self-disclosure was instrumental in building trust with him. Once Margo had this

trust in her counselor, she was able to confide in him about what she needed help with. Seeing

her counselor be vulnerable led the way for Margo to be vulnerable. Additionally, when the

interviewer asked what her counselor says or does that makes her want to work with her counselor, she stated:

> Sometimes they will share something a little bit personal, that helps you to realize they get it…I have had counselors that have been addicts…and I personally don't even know the difference…and that might be because my counselors have been good. It (counselor self-disclosure) kind of shows that they are understanding what you are saying…and then thinking about something in their own life…I think some people just by nature are just better…even the counselors that are bound to be really good communicators but some just…you can feel they are genuine about it…that they have empathy and they are listening to what you are saying…that is just their nature.

For Margo, in addition to building trust, counselor self-disclosure was a means of perceiving accurate empathy. It was meaningful for her to see that her counselor was understanding what she was saying while personally relating to Margo. Participants equated counselor self-disclosure and counselors showing some emotions with being human and relatable. Counselors showing emotion during sessions helped to establish the counselor as an "active participant" and engaged the participant in the relationship and in the session.

It is also important to point out that participants noted when counselors were unhelpful and disingenuous. Bryce described a session he felt strongly about.

> Yeah, he said I've (counselor) been kind of avoiding you just to see how you would react to the passive/aggressive stuff and he's (counselor) like did you figure that out? I was like yeah, I figured it out pretty quickly but, I thought it was kind of a dick move is what I said to him…To try something like that just to see how I would react or test me like that in a spot where I'm not ready to be tested myself. You know, I hadn't met with him for

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two weeks from when I first asked him and then 3-4 more days watching him walk

around and contact these other people, it was to see if I was going to react more

passively/aggressive and make comments to him or something like that or how I was

going to deal with it…but, the fact that I had to deal with that situation…it kind of put me

into a situation where I felt like we built some trust in the relationship and it kind of blew

that to pieces… It was very arrogant thing to do that in my opinion…like I said it kind of

blew the trust, um…cause I was his client but he left me…

For Bryce, his counselor's inauthentic and confrontational way of interacting with him

negatively impacted the client-counselor relationship. Additionally, the counselor's disingenuous

actions and interactions contributed to Bryce's impression that his counselor was distant and

withdrawn.

Throughout the data, multiple clients identified the importance of their counselor being

genuine with them. Often this involved their counselor being honest with them and telling the

participant what was on their (the counselor's) mind, even if it might be something that they did

not want to hear. In response to being asked what he liked about his counselor Jerome talked

about the importance of receiving genuine feedback from his counselor.

I think honesty…whether she thinks I'm doing something wrong I would like to

know…not sugar coating it. It helps, knowing what I am doing wrong. That is what helps

me catch if I'm mentally relapsing. Whether I like it or not…you know, some of the stuff

she might say, I might not like...but it is something I need to do...because it is true. I just

sit there and I know it's right, I know it's right and I sit there and stand the pain...the pain

of the truth. She (his counselor) tells me about my negative parts, you know…and I

appreciate that. But I don't want to hear it when I get mad and my face turns hot and I

just want to leave the room…but it's true.

Jerome found it helpful when his counselor was willing to tell him what was on their mind, even

when he did not want to hear it. This aided Jerome in identifying what he needed to work on in

his recovery.

The theme of mutuality, including genuine self-disclosure and expression of emotion

adds an important element to treatment efforts in addictions. In this study, participants identified

this genuine risk-taking as a sign that their counselor cared about them. Traditionally,

counselor's use of honesty may be seen as negative feedback or "confrontation," however,

participants defined this as the counselor being genuine with them. It is important to note that a

counselor's feedback that lacked genuineiness was more likely to be seen as confrontational in

nature.

Theme 3: Clients valued their counselors connecting them with resources.

Considering the focus on the therapeutic relationship in this study, at first glance this

theme (counselors connecting clients with resources) may not seem relational in nature.

However, while participants were not referring to direct conversational connection with their

counselors, they expressed how their counselors willingness to provide resources helped them to

know that their counselors cared and helped improve participants' lives in meaningful ways.

When discussing their work with their counselors, multiple participants identified that it was

helpful and meaningful when their counselors provided or connected them with resources. This

is especially important because during active addiction clients often become disconnected from

the community resulting in neglecting or not having access to services that improve or maintain

their overall wellbeing and quality of life.

When the author asked Alexis about the most meaningful aspect of her treatment she

discussed how much it meant when her counselor helped her find and utilize services in the

community. She stated:

> Most helpful is like resources, like you guys (counselors) pretty much say what you need
>
> to do and give you numbers for places to call that is the most helpful…getting help, doing
>
> things that I just wouldn't know where to start on my own…it is the most beneficial thing
>
> for me to get numbers and names and appointments set…I feel like I got something
>
> accomplished…like I get an appointment set or um…somewhere to start as far as
>
> numbers go or who to call or appointments is a big one…when I left there (inpatient
>
> treatment) I got phone numbers of the counselors and stuff and uh…I still got um…like
>
> calls that helped even when I was out of there…and um…I got a call from my old
>
> counselor and if I still needed work clothes that she would um…that she got me a
>
> voucher for (a clothing store).

Alexis found it beneficial when counselors helped her obtain resources and services. She felt that

the counselors' actions helped her to gain the traction she needed in order to begin doing these

things on her own. Similarly, Sandra discussed that she appreciated when her counselor took

initiative in connecting her with resources.

> The first thing I noticed about her (counselor) right way within the first week I got here,
>
> she came to me in group one day and she handed me this piece of paper and she said here
>
> fill this out and bring it back to me…she said everybody needs a phone and she
>
> (counselor) did that all on her own.

Participants discussed that it was helpful to have their counselors support in obtaining and

utilizing services and resources to address issues that impacted their recovery including mental

and physical health that was neglected during their addiction, as well as identifying housing and

clothing resources that helped them meet their goals. For instance, Dylan discussed that it was

helpful when his counselor connected him with dental services, "It was helpful that she helped

me find a dentist, my teeth affected how I saw myself." Dylan acknowledged that setting up

dental appointments did more than address his physical health. Making the steps toward better

health helped Dylan to begin increasing his self-image and self-worth. Similarly, Sandra

discussed that being connected to services she needed had a positive impact on her recovery.

> Right away she started as soon as she (counselor) helped me get medical insurance…she
>
> helped me find a doctor so I could call and make a doctor's appointment because I hadn't
>
> been to a doctor in 5 years and that was something that I needed, there is a lot of things I
>
> needed to talk to a doctor about, I wouldn't have even thought about it…but she came
>
> right to me and said this is what we need to do is work on these things.

Having her counselor help connect her with resources helped Sandra realize that addressing her

physical health was also important in her recovery. Larry shared the specific types of resources

that helped him to take some positive steps in his recovery.

> My counselor helped me with getting numbers to contact people, getting appointments
>
> set up to go to counseling. And helped me get my glasses…He has given me numbers for
>
> me to get my credit checked and to get a financial advisor.

Another relational aspect within this theme emphasized that the therapeutic alliance helped

clients to overcome barriers to meeting their goals. For Larry, this was most helpful. He shared:

> I have a few barriers to getting a job, I need to get my driver's license, social security
>
> card, and my birth certificate…she (his counselor) has gone a little outside the box to try
>
> and help me find the solution…and that is very helpful.

It was meaningful that Larry's counselor provided him with the resources to help him overcome barriers to reaching his goals. In summary, clients' perceptions of the therapeutic alliance included helpful resources and services. Counselors' willingness to be involved and to go beyond the counseling sessions was meaningful to participants.

Theme 4: Clients appreciated that their counselors held them accountable by inquiring about behaviors or progress toward identified goals.

In substance abuse treatment it is common for clients to go through multiple treatments. Based on this it is easy to assume that individuals are resistant to counselors holding them accountable for their actions. However, multiple participants in this study identified that when their counselors addressed accountability with them they appreciated it. Multiple participants discussed that it was helpful that their counselors held them accountable in various ways. Leon talked about how his counselor held him accountable.

> Well they acknowledge me first of all, they say hello, how am I doing…what's going on today…She (counselor) checks to see if I am progressing or if I am shaping up or getting to groups on time, she watches my mannerisms…to see what type of moves I am making, how I carry myself…it is hard to pay attention to that myself when I am on my own… I didn't think counselors did that, paid attention that much…I thought that maybe, I understand that I was young, I probably need a little more guidance than an older person would. She was keeping me in line…she was always on me about shit… I was pissed…did you get this done…well, you know…you know you need to get that done…and did you…you know you got…she would just talk to me about it and when it came to schooling…she would ask me how it was going and she would try to make calls for me and try to help me out….maybe she was doing a little too much for me…but I

really liked that, even though it got me mad, because I was never held accountable like that…by counselor…somebody I didn't know…I figured she was new on the job…I was irrational about because she is new, I am her first client…so she is trying to be on somebody's ass, because she…that is what I was first thinking, but I was really trying and I saw that she was taking her time and she was trying too…so that meant a lot to me.

Leon's need for guidance was met by his counselor holding him accountable. He appreciated the added perspective of his counselor and that it helped hold him accountable. Similarly, when the interviewer asked Bryce what his counselor said or did that communicated that she cared, he replied:

She (counselor) didn't let you off the hook for anything…you knew that going in there, she was going to make you work. She (counselor) held you accountable…didn't get you off the hook in the fact that there was work to do, that is why we were there, we weren't there to just uh, make friends and eat a bunch of food…we were there to work on stuff …and you know, that is going to happen.

Counselors working to make sure that clients got something meaningful out of treatment was seen as a form of accountability. Similarly, in response to being asked how he knew his counselor cared about him, Kelly recognized that his counselor held him accountable to ensure that he got the most out of treatment.

They (counselors) are always asking what do you need? Is there anything you need…he (inpatient counselor) was pretty much sold on I was going to go long term or aftercare…I do have probation…so he (inpatient counselor) was talking to my probation officer, through the whole thing…checking in with them, they want to know where you are at, status, all that…um, what do you think you want to do here as far as living

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conditions? That was one of the first things he asked me… what are my goals…for when I do leave here…it is an accomplishment…to finish this program…and just do what you guys ask of us to do on a daily basis…it is not easy…

Kelly found it meaningful that his counselor held him accountable in a variety of ways in order to increase the likelihood that Kelly would be successful when he left treatment. Another participant, Alexis, appreciated how her counselor helped her to stay on track to meeting her goals. In response to being asked about what her counselor did that helped her to know they cared, she replied, "I suppose when they just go off on something I said or something that I had forgotten about…like…have you done this have you done that." Although there were times when Alexis didn't want to face what she had not gotten done, it was meaningful that her counselor followed up with her to see if she accomplished her goals.

CHAPTER 5: DISCUSSION

Summary of Findings

The purpose of this study was to explore the relational aspects of the therapeutic alliance in substance abuse treatment from a client perspective. The research questions were developed to address the lack of information that exists surrounding counselor relational factors (and factors within the therapeutic alliance) that facilitate a strong alliance in substance abuse treatment. The research questions utilized in this study are as follows:

1.   What do clients care about in the therapeutic alliance?

2.   What relational characteristics of the counselor matter to clients?

3.   What counselor actions matter to clients?

The researcher identified several themes and subthemes using phenomenological analysis. The first theme identified was Working with their counselor helped clients learn about themselves. A sub-theme Uncovering hidden insights was identified. A second theme was identified as Mutuality deepened the client-counselor relationship. Two sub-themes were identified: Counselors showing emotion, and Counselor genuine self-disclosure as a means of establishing mutuality and relatability. The third theme was identified as Clients valued their counselors connecting them with resources. The fourth and final theme was identified as Clients appreciated that their counselors held them accountable by inquiring about behaviors or progress toward identified goals. The themes and sub-themes work together to answer the three research questions.

Participants consistently discussed that working with their counselor helped them to learn about themselves. Clients' increased self- knowledge and clarity ranged from learning about themselves as a person including identifying and processing their emotions, aspects of their

personality that impacted their addiction and recovery, learning about themselves in relation to others, and gaining insight into their addiction cycle. This theme, increased self-knowledge and clarity, is one of the five good things, an RCT concept, that results from being part of a growth-fostering relationship (Jordan, 2010). It is difficult to discern whether clients' learning about themselves can be contributed to the specific client, to the specific therapist, or to the alliance. However, since this theme was identified across nearly all of the interviews in the study, it seems likely that clients' learning about themselves is indicative of the quality of the therapeutic alliance and possibly a product of a strong therapeutic alliance. Additionally, it may be plausible to conceptualize the therapeutic alliance as a growth-fostering relationship. However, in order to come to this conclusion, further research is necessary to assess whether the other four characteristics (productivity, zest, self-worth, and a desire to obtain healthy connections) of a growth-fostering relationship are present.

There were several ways in which counselors helped clients learn about themselves. Counselors encouraged clients to engage in self-exploration and introspection both in general and regarding specific areas identified by the counselor and client. For example, one client discussed his ambivalence with quitting drinking. Although this client identified that he needed to quit using pain pills, he was ambivalent about quitting drinking. Rather than tell the client that he should quit using all substances, his counselor encouraged him to think about the impact alcohol use has had on his life. Although the counselor provided guidance regarding the area to focus on, the client came to his own conclusion about his alcohol use. While he had not reached a conclusion as to if he should quit using alcohol, he identified that he gained some clarity and insight about himself in relation to alcohol use. He credited this increase in self-knowledge to his work with his counselor. This relational exchange provided him with an opportunity to gain a

sense of personal power regarding his alcohol use. Unlike many modes of treatment in addictions, the counselor in this situation did not confront the client, but instead allowed the client to share in the work of confronting the effects of alcohol use. Thus, the client and counselor shared the experience of counseling.

Another way counselors aided clients in gaining self-knowledge was by sharing their perception of the client. Counselors identified aspects and qualities that clients did not or were not able to identify in themselves. It was powerful for counselors to share their perceptions which often helped clients challenge their negative views of themselves (as well as how they view themselves in relation to others) and begin re-building their self-worth that had been damaged by years of addiction and disconnection. This is supportive of Jordan's (2010) assertion that counselors play a crucial role in challenging negative relational images. Clients had become so accustomed to thinking of themselves negatively that it seemed impossible to change until counselors shared their perception of the client.

For example, one client discussed that she did not think that she was a strong person until her counselor shared this perspective. In working with her counselor, this client received authentic feedback that allowed her to begin identifying qualities in herself that were more conducive to maintaining recovery. Lenz (2016) described perceived mutuality as "an important component in relationships characterized by the ability to maintain a sense of self, yet be open to the change experiences that emerge from relating to others" (p. 416). Additionally, counselors sharing their perspectives on a variety of different topics introduced clients to a different way of thinking that led to increased clarity and insight. The topics in which clients experienced increased insight included emotions, behaviors, and relationships. This insight led to increased self-knowledge of clients' addiction and recovery. It is interesting to note that clients did not

expect to learn or accept new insights as a result of working with their counselor. This point of view reflects how often clients struggling with addiction get caught up in a negative stance. As is often the case, the majority of participants in this study had already been in several rounds of treatment. As a result, their expectations for experiencing something different or helpful were low. Because the therapeutic alliance was characterized by active sharing by counselors, clients identified that they were able to look at things in ways they had not done before.

It was meaningful for counselors to be active participants in the client-counselor relationship. This supports Hersoug et al.'s (2008) finding that clients want counselors that are interpersonally active, supportive, and responsive. Throughout the data, clients identified the importance of "give and take" in their relationships with their counselor. This "give and take" or mutuality, appeared in a variety of ways including counselors showing emotion, counselor self-disclosure, and mutual sharing. When counselors engage in mutual interaction, they demonstrate to clients that vulnerability fosters growth and connection and is necessary in producing healthy change (Lenz, 2016). Mutuality signified that counselors were as committed to treatment as clients. Several participants indicated that they had previously worked with counselors in which mutual interaction was lacking. In these cases, clients perceived counselors as indifferent, uncaring, withdrawn, aloof, inauthentic, disconnected, and not committed to providing effective treatment. As a result, client engagement suffered.

Participants who shared these negative past experiences emphasized Ackerman and Hilsenroth's (2003) finding that counselors appearing distracted negatively impacts the alliance. Along the same line, Hersoug et al. (2009) found that counselors appearing disconnected and indifferent also had a negative impact on the alliance. One participant in the current study identified that the client-counselor relationship is not as meaningful when the counselor is not an

active participant (i.e. showing emotion, giving authentic feedback, etc.). This supports Jordan's (2010) assertion that counselor neutrality does not promote growth and does little to strengthen the client-counselor relationship.

Another area that participants discussed was the sense of power within the therapeutic alliance. One participant described his former counselor's lack of participation as a "power struggle" in which unhelpful confrontation between client and counselor became likely. Unhelpful confrontation perpetuates an uneven power differential and is not conducive to achieving positive treatment outcomes. This statement aligns with Jordan's (2010) concern that counselors may have difficulty relinquishing an authoritative role. Mutuality demonstrates that treatment is a shared effort between client and counselor, thus promoting client engagement. The presence of mutuality in treatment discourages the "one size fits all" approach that can be dictated by the treatment provider. Mutuality sets the tone for shared power in the client-counselor relationship. This supports Macdonald et al.'s (2007) finding that interpersonal processes involving less confrontation are related to positive treatment outcomes. Although the current study did not focus on treatment outcomes, participants identified stronger relationships with counselors who did not use unhelpful confrontation. As discussed earlier, the therapeutic alliance has been consistently linked to positive treatment outcomes. Therefore, it would be reasonable to hypothesize that participants in the current study who reported strong alliances with their counselors have an increased likelihood of being successful following treatment.

The opposite was also true. In the current study, relationships that were characterized by unhelpful confrontation were perceived by clients as not beneficial. This supports Macdonald et al.'s (2007) finding that indirect hostility on the part of the counselor negatively impacts client engagement and the therapeutic alliance. Often clients in addiction treatment have a history of

power-over, authoritative relationships in which their voice is muffled. To be met with similar interactions from counselors increases the likelihood of perpetuating unhelpful relational patterns and uneven power dynamics.

One participant identified the importance of having a relationship with his counselor that is "mutually satisfying." Although it was important for this client to experience personal growth, it was also important to see that his counselor was growing as a result their interaction. This supports Jean Baker-Miller's (1986) concept that if both people in the relationship are not growing, then it is likely that neither will experience growth. It is powerful for clients to see that they have an impact on others (Jordan & Dooley, 2001). Addiction is often characterized by disconnection. During active addiction people can become disconnected from themselves and others. Mutuality reminded clients that they are valued members of the relationship and worthy of connection. This can be especially powerful after a period of isolation and disconnection from others and helps to instill hope that it is possible to have healthy, meaningful relationships.

Participants consistently identified that counselor authenticity and honesty were necessary in facilitating and producing healthy change. In order for counselors to be truly authentic and honest, the client-counselor relationship needed to be characterized by mutuality. A client-counselor relationship characterized by mutual interaction promotes respect and trust, which is a prerequisite for therapeutic growth. Therefore, the counselor is bringing their real self to the relationship and is referred to as relational authenticity. According to Lenz (2016), the counselor's authentic presence in the relationship is a means of knowledge that fosters increased clarity, self-worth, and healing as clients become aware that they have an effect on other people. Said differently, counselors' relational authenticity fosters client growth and mutuality.

Throughout the data, clients identified that learning about themselves was one of the most helpful aspects of working with their counselor. It is likely that clients were describing relational authenticity. Participants noted that they valued their counselors' honesty even if it was hard to hear. Additionally, several clients noted that they were surprised that they were open to this feedback from their counselor. If relational authenticity is present in the client-counselor relationship, clients will be more open to honest communication from their counselor. When growth-fostering qualities (mutuality, relational authenticity, etc.) are lacking, counselors' blunt honesty is likely to lead to confrontation. However, set within the context of a mutual client-counselor relationship, counselors' blunt honesty (genuine self-disclosure) can be a source of growth and increased insight.

In addition to achieving self-clarity and the importance of mutuality, clients appreciated when their counselors held them accountable. Several participants discussed that it was meaningful when counselors held them accountable. Although it was difficult to appreciate the accountability while it was happening, clients identified that this communicated that their counselors cared enough to take time to notice their behaviors and progress toward their goals. This accountability communicated to clients that their counselors cared enough to be active participants in the client-counselor relationship and in their treatment. Accountability meant that counselors noticed details about clients, their treatment, and their progress. It is important to note that clients' comments suggested that counselors can be straight-forward and hold clients accountable without being overly directive or confrontational. This finding is in opposition to a myth that counselors must be hardened, and take their clients to task in order to be effective. In this study, clients appreciated that their counselors confronted them, but maintained a caring framework.

It mattered to counselors that clients "got something out of treatment." This helped to establish a therapeutic alliance early in treatment as one client noted that he knew from the beginning of his treatment that his counselor was going to hold him accountable and "make him work." In other words, his counselor cared that his treatment was a worthwhile experience. This finding supports Fruhauf, et al.'s (2015) assertion that establishing a therapeutic alliance early in treatment is related to treatment effectiveness. Accountability helped to make his treatment experience meaningful and successful. It is important to note that accountability was particularly effective when set within a relational context, meaning that counselors utilized interpersonal skills to hold clients accountable (i.e. paying attention to detail as well as communicating and processing with clients) and communicate that they cared. Nissen-Lie et al. (2010) suggested that counselor interpersonal and relational skills impact early alliance development. This concept seems to be significant in the current study. Counselors holding clients accountable communicates that they care about clients and the quality of the treatment they receive, which helps to build the therapeutic alliance.

The last finding of the current study was clients' identified that it was meaningful and helpful when their counselors connected them with resources and held them accountable. These counselor behaviors communicated to the client that their counselor identified an area of need and took time to provide clients with what they needed in order to achieve their goals. Clients often identified that these behaviors indicated that their counselors went "above and beyond" what was expected of them. Participants identified that it was important when counselors helped them identify and obtain services that could improve the quality of their life and help them work toward their goals. The various services included disability services, mental health services, housing assistance, food and clothing resources, legal aid, support in gaining employment, and

financial services. When in active addiction, clients can become disconnected from society. As a result, part of recovery is helping clients obtain services and support that will help reconnect them to the community and to society. This is especially significant when working with individuals who are marginalized (Walker, 2004). Individuals experiencing addiction are often subject of stigma that leads to further disconnection. It becomes important for counselors to work to empower clients by helping them reconnect to the community and society.

Conclusion and Implications for Practice and Research

After exploring and discussing the findings of the study, this author concludes that relational factors within the alliance contribute to the overall quality of the alliance. This is important considering the crucial role the alliance plays in achieving positive treatment outcomes (Baldwin et al., 2007; Fluckiger et al., 2012; Horvath & Symonds, 1991; Norcross, 2002). As a result, there are important implications for practice. The first implication is for counselors to be aware of the significant role their interpersonal skills play in engaging clients in the alliance and treatment as well as cultivating a safe space for clients to be vulnerable.

It may be helpful to explore and be mindful of how one's theoretical orientation can affect interpersonal interactions with clients. For example, if one subscribes to a philosophy in which counselor neutrality and stoicism is valued, this may have a less than optimal impact on the quality of the alliance and the effectiveness of treatment. This is due in part to the finding of the study that clients value mutuality, which serves as a means of relatability and a vehicle for growth. It is important for counselors to challenge long-held beliefs that counselor neutrality and lack of emotion are effective conditions for therapeutic change. This may require that those who were trained in manualized group formats or in behaviorally oriented models have an opportunity for development. Due to the significant role counselor interpersonal and relational

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skills play in client engagement, it necessary for counselor educators to take this into consideration when designing and implementing curriculum when teaching addiction counseling.

The second implication for practice is for counselors to be aware of the presence they bring to the client-counselor relationship. Mutuality and relational authenticity set the tone for shared power, meaningful interaction, and an increased capacity for connection. However, the opposite is also true. Lack of mutuality may lead to an authoritative, one-sided client-counselor relationship that promotes a "one size fits all approach" to recovery. This can be especially damaging in addiction treatment as clients are more likely to have a history of power-over relationships and trauma. As a result, lack of mutuality serves to further marginalize and stigmatize. Mutuality, relational authenticity, and other relational counselor characteristics cultivate a safe place for clients to begin the vulnerable work of healing, reconnecting, and recognizing one's worth and impact on others. The third implication for practice is the importance of networking. It is important for counselors to establish a presence in the community they serve in order to access resources and services that can provide clients with the support they need to be successful in recovery. It is also important that counselors recognize the importance of connecting clients with resources and services that increase the likelihood that clients will reconnect with society and develop a sense of community.

A final implication for practice is the importance of treatment being set in a relational context. A majority of clients are mandated to addiction treatment by court for a variety of reasons. These reasons may include attending treatment as a requirement of probation, in order to regain parental rights, or as a stipulation of civil commitment. Therefore, upon entering treatment, clients may be externally motivated to meet one of the above requirements. If this is the case, the client might be initially resistant to any type of alliance with the counselor. These

circumstances would contribute to the difficulty associated with engaging clients in treatment. As a result, it is crucial that the counselor works with the client within a relational context. From an RCT perspective, this means that treatment is provided in a way that fosters growth. Taking into account comments from participants in this study, it was identified that counselors' honest communication, within the context of a growth-fostering client-counselor relationship, led a positive therapeutic alliance. Working from a relational perspective is not easy and the response from clients is not immediate and not always possible. However, if relational authenticity and other growth-fostering characteristics are absent from treatment, honest communication as well as other treatment techniques and modalities can lead to confrontation and discord between clients and treatment providers. In other words, a relational approach to treatment may equip treatment providers with a way to transform addiction treatment from a punishment into an opportunity for growth.

Recommendations for research involve further investigation of the relational factors within addiction treatment that foster client engagement in both the therapeutic alliance and in treatment. Given the limited research and literature focusing on addiction and Relational Cultural Theory, it is also recommended that researchers conduct studies that implement and assess the effectiveness of treatment from an RCT perspective. Due to limitations of this research, additional but similar studies in different settings (i.e. high intensity residential and outpatient treatment centers) may offer a wider number of diverse participants and yield further insight into the phenomenon under investigation. It would be beneficial for future researchers to further explore the relational concepts identified in the current study (mutuality, counselor self-disclosure, and counselors showing emotion) relative to the impact on treatment outcomes, especially recidivism rates.

Limitations

A limitation of the study was the potential dual relationship that exists between the researcher and participants due to the researcher utilizing participants from the agency in which she worked. However, the potential for dual relationships was minimized by choosing participants that did not have the researcher as a primary counselor. Additionally, it was discussed with participants that their participation in this study would not affect their treatment status or stay at the Recovery Center. Finally, due to the study utilizing participants from one agency and one level of care, the findings from this study may not be applicable to all substance abuse treatment programs and levels of care. In future studies on the topic, it is recommended that researchers utilize additional levels of care in order to gain additional perspectives. Additionally, it may be beneficial if the primary researcher is not an addiction counselor in order to generate multiple perspectives on the topic.

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NDSU NORTH DAKOTA
STATE UNIVERSITY

December 30, 2016

Dr. Brenda Hall
Department of Counselor Education & Supervision

IRB Approval of Protocol #HE17106, "A Relational Investigation of the Therapeutic Alliance in Substance
Abuse Treatment: A Qualitative Study"
Co-investigator(s) and research team: Jessica Brown

Approval period: 12/30/2016 to 12/29/2017   Continuing Review Report Due: 11/1/2017

Research site(s): Red River Recovery Center   Funding agency: n/a
Review Type: Full Board, meeting date – 12/9/2016
Risk Level: No more than minimal risk
IRB approval is based on original submission, with revised: protocol (received 12/25/2016) and updated consent
form (received 12/28/2016).

Additional approval is required:
o prior to implementation of any proposed changes to the protocol (Protocol Amendment Request Form).
o for continuation of the project beyond the approval period (Continuing Review/Completion Report Form). A
reminder is typically sent two months prior to the expiration date; timely submission of the report is your
responsibility. To avoid a lapse in approval, suspension of recruitment, and/or data collection, a report must be
received, and the protocol reviewed and approved prior to the expiration date.

A report is required for:
o any research-related injuries, adverse events, or other unanticipated problems involving risks to participants or
others within 72 hours of known occurrence (Report of Unanticipated Problem or Serious Adverse Event Form).
o any significant new findings that may affect risks to participants.
o closure of the project (Continuing Review/Completion Report Form).

Research records are subject to random or directed audits at any time to verify compliance with IRB regulations
and NDSU policies.

Thank you for cooperating with NDSU IRB procedures, and best wishes for a successful study.

Sincerely,

Kristy Shirley

Kristy Shirley, CIP
Research Compliance Administrator

For more information regarding IRB Office submissions and guidelines, please consult www.ndsu.edu/irb. This
Institution has an approved FederalWide Assurance with the Department of Health and Human Services:
FWA00002439.

INSTITUTIONAL REVIEW BOARD
NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | 701.231.8995 | Fax 701.231.8098 | ndsu.edu/irb

Shipping address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

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APPENDIX B. ORAL PARTICIPANT RECRUITMENT SCRIPT

My name is Jessie Brown. I am a Ph.D. student at North Dakota State University and I am working with my adviser, Dr. Brenda Hall (NDSU), on a study about the relationship between clients and counselors. We are interested in your perceptions regarding your relationship with your counselor. You will be 1 of 15 individuals invited to take part in this study. You will be asked to participate in an interview with Jessie that could last up to 60 minutes. It will be a structured interview in which she asks you questions about your experience with your counselor.

She will be gathering information on what you think is helpful and not helpful when it comes to building and maintaining a relationship with your counselor. She will also ask you how your relationship with your counselor impacts your treatment and recovery. If necessary, participants will be asked to participate in a follow up interview, lasting a maximum of 30 minutes, if clarification is needed following the initial 60 minute interview. All of your responses will be confidential and you will not be identified when results of the study are discussed. Your decision whether or not to participate will not affect your treatment or probation (if applicable) in any way. Participation is voluntary and you may withdraw at any time. Participation in this research study may not benefit you directly, but may benefit others in the future by providing information about the client-counselor relationship.

APPENDIX C. INFORMED CONSENT

NDSU North Dakota State University

Counselor Education and Supervision

SGC Building, 1919 N. University Drive

Fargo, ND 58108-6050

(701) 231-7202

Title of Research Study: Dissertation Proposal: A Relational Investigation of the Therapeutic Alliance in Substance Abuse Treatment: A Qualitative Study

This study is being conducted by: Jessie Brown is conducting the study. She is a Ph.D student in Counselor Education and Supervision at North Dakota State University. Dr. Brenda Hall (Department of Counselor Education and Supervision at North Dakota State University) is Jessica's adviser and is the primary investigator on record. Dr. Hall's phone number is 701-231-8077.

Why am I being asked to take part in this research study? Jessie is interested in clients' perception of the therapeutic alliance as well as what helps or hinders the client-counselor relationship. She is looking for ten to fifteen clients (who are currently residing at Red River Recovery Center) to be participants in this study. In order to be a part of the study, you need to have been a client at RRRC for a minimum of 2 weeks prior to participating in the study. You are not eligible to participate in the study if Jessie Brown is your primary counselor in order to minimize the potential for dual relationships.

What is the reason for doing the study? The purpose of the study is to gather information from clients in substance abuse treatment about their relationship with their counselor. This information will be used to improve client-counselor relationships in substance abuse treatment

in the future. The information gathered in the study is confidential and will not affect your

treatment or probation (if applicable). The researchers will not discuss this information with your

primary counselor at RRRC. The researcher will not be advocating for you or playing a role in

your treatment at RRRC.

What will I be asked to do? OR What Information will be collected about me?

You will be asked to participate in an interview with Jessie that could last up to 60 minutes. It

will be a structured interview in which she asks you questions about your experience with your

counselor. She will be gathering information on what you think is helpful and not helpful when it

comes to building and maintaining a relationship with your counselor. She will also ask you how

your relationship with your counselor impacts your treatment and recovery. If necessary,

participants will be asked to participate in a follow up interview, lasting a maximum of 30

minutes, if clarification is needed following the initial 60 minute interview.

Where is the study going to take place, and how long will it take?

You will be asked to participate in an interview with Jessie that could last up to 60 minutes. The

interview will take place at Red River Recovery in Jessie's office. If necessary, participants will

be asked to participate in a follow up interview, lasting a maximum of 30 minutes, if clarification

is needed following the initial 60 minute interview.

What are the risks and discomforts? Possible risks of participating in this study include the

loss of confidentiality and emotional, psychological distress and/or social implications. It is not

possible to identify all potential risks in research procedures, but the researchers have taken

reasonable safeguards to minimize any known risks to the participant.

Due to the researcher being a mandated reporter (counselor), confidentiality may be

broken for the following reasons:

1. If the participant indicates that they will harm themselves or another person

2. If the participant indicates that they are being physically harmed or financially exploited by another individual (as clients in residential treatment centers in MN are considered vulnerable adults).

3. If the interviewer becomes aware that another person, not the interviewee, is abusing a vulnerable adult or child.

Due to the researcher being part of the counseling team the Recovery Center:

If participants discuss currently using substances, which violates the conditions of their treatment, the researcher will discuss with the participant how to address this including the participant discussing their use with their counselor. It is important to note that there are limits of confidentialiy regarding participants disclosing substance use during their current treatment at Red River Recovery Center.

What are the benefits to me? A possible benefit from the study is to share your experience of working with your counselor(s) in treatment which may provide the opportunity for self-reflection. However, you may not get any benefit from being in this research study.

What are the benefits to other people?

Your participation in this study will allow us to obtain information that will be used to improve the quality of the therapeutic alliance in substance abuse treatment.

Do I have to take part in the study? Your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled. Your participation in this study is entirely voluntary and will in no way affect services in which you may be involved

(probation, child protection services, etc.). Your participation in the study will not be disclosed to the services in which you may be involved.

What are the alternatives to being in this research study?

Instead of being in this research study, you can choose not to participate.

Who will see the information that I give?

We will keep private all research records that identify you. Your information will be combined with information from other people taking part in the study. When we write about the study, we will write about the combined information that we have gathered. We may publish the results of the study; however, we will keep your name and other identifying information private. Any identifying information (i.e. name) will be replaced with a number in order to ensure confidentiality. This will take place when the audio-taped interview is typed into text. As a result, no identifying information will be included in the typed interview. The audio-taped interview will be kept under lock and key when not in use by the researchers. The audio-taped interview will be deleted when the interview has been typed into text format. All materials relating to the study will be kept under lock and key at the researcher's residence when not in use. If you withdraw before the research is over, your information will be removed at your request and we will not collect additional information about you.

What if I have questions?

Before you decide whether to accept this invitation to take part in the research study, please ask any questions that might come to mind now. Later, if you have any questions about the study, you can contact the researcher, Brenda Hall, at 701-231-8077 or email her at brenda.hall@ndsu.edu.

What are my rights as a research participant?

You have rights as a participant in research. If you have questions about your rights, or

complaints about this research, you may talk to the researcher or contact the NDSU Human

Research Protection Program by:

     Telephone: 701.231.8995 or toll-free 1.855.800.6717

     Email: ndsu.irb@ndsu.edu

     Mail: NDSU HRPP Office, NDSU Dept. 4000, PO Box 6050, Fargo, ND 58108-6050.

The role of the Human Research Protection Program is to see that your rights are protected in

this research; more information about your rights can be found at: www.ndsu.edu/irb .

Documentation of Informed Consent:

You are freely making a decision whether to be in this research study. Signing this form means

that you have read and understood this consent form you have had your questions answered, and

you have decided to be in the study. You will be given a copy of this consent form to keep.

APPENDIX D. DEMOGRAPHIC INFORMATION

1. What is your gender?

2. What is your relationship status?

3. What is your ethnicity or cultural background?

4. Where were you born?

5. Where were you raised?

6. Is there a history of addiction or mental health in your family? If so, who?

7. How many treatments have you had? How many of these treatments were successfully completed?

8. What was helpful about previous treatments you have had?

9. What was unhelpful about the previous treatments you have had?

10. What is your drug(s) of choice?

11. What is your longest period of sobriety? How did you achieve this?

12. Do you attend support meetings? If so, what kind of meetings?

13. Do you believe in a higher power?

14. Do you have a legal history? Please explain.

15. Do you have a probation officer?

16. Do you have any type of social service involvement?

17. Can you briefly describe your social supports? For example, do you have peers that support you

18. in your recovery efforts? Is your family supportive of your recovery?

APPENDIX E. INTERVIEW QUESTIONS

1. Could you tell me a little about what brought you to RRRC?

2. How many times have you been in treatment?

3. Can you tell me a little about your experience in past treatments?

4. What comes to mind when you think of the counselors you have had in past treatments?

5. What has been the most meaningful or helpful part/aspect of treatment(s)?

6. What was the gender of your past counselors? Of your current counselor?

7. What is your drug of choice?

8. When is the last time you had a craving?

9. What does your counselor do or say to help you with your cravings?

10. How would you describe your relationship with your counselor?

11. What is it like to work with your current counselor?

12. In your sessions with your counselor, what does your counselor do or say that helps you to feel that they care for you? In your sessions with your counselor, what does your counselor do or say that helps you to feel that they do not care about you?

13. What makes the difference in what the counselor says or does that makes you want to work with your counselor?

14. What do you like about your counselor? Anything you dislike?

15. Is there anything you would change about how your counselor works with you? If so, what?

16. What goes on in session that you feel good after the session? Or do not feel good after a session?

17. Has there been a turning point in your relationship with your counselor? For example, did

your relationship with your counselor start to improve or decline at a certain point? If so, what happened?

18. Could you share a time when your counselor showed that they were affected by something you said or did?