

Establishing and Maintaining a Therapeutic Alliance With Substance Abuse Patients: A Cognitive Therapy Approach

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INTRODUCTION

A positive, collaborative therapeutic relationship is an essential component of the cognitive therapy of substance abuse (Beck et al. 1993). To engage substance abuse patients in treatment, therapists will need not only to connect with the patients but also gain their trust. Otherwise, the patients will be less likely to benefit from treatment, and their rates of no-show and dropout are apt to increase. Therefore, therapists must work diligently to form a working alliance by demonstrating general good will and a respectful desire to help. Further, they must carefully attend to any signs that the patients are losing interest or having adverse emotional reactions, and intervene promptly.

COMMON OBSTACLES TO FORMING A THERAPEUTIC ALLIANCE

Substance-abusing patients are an especially difficult population with whom to establish a commitment to change. A glance at the troubled family life of a substance abuser is instructive. At the height of his or her use of drugs, a patient often obtains far more gratification from the drugs than from the love and companionship of significant others, friends, and relatives. Therefore, the positive social reinforcement from a supportive therapist may pale in comparison to the high that the patient gets from a line of cocaine or a hit of crack. Thus, the therapist's capacity to act as an agent of change is more limited and fragile than with many other patient populations for whom the therapist's approval and guidance have greater relative significance.

As a result, the therapist will need to build the relationship when the patient is in a period of diminished drug use or abstinence. During this time, the benefits of having meaningful interpersonal relationships should be underscored at the same time as the drawbacks of drug use are being highlighted. The intention of this strategy is to enhance the

patient's perceived reasons for remaining drug free, to motivate the patient to strive for relationship preservation, and to communicate the kind of therapeutic support that the patient will value.

Additionally, substance abusers often enter treatment with ambivalence about relinquishing their habits (Carroll et al. 1991*a*, 1991*b*; Havassy et al. 1991). Within the framework of Prochaska and colleagues' (1993) stages of change model, one sees that many substance abusers do not enter treatment at the stages of action or maintenance. Instead, they commence therapy with a notion that it might be beneficial to give up the use of drugs, or with a wavering desire to cut back on their use (i.e., the contemplative stage). In extreme cases, such as when patients are remanded by the courts to attend drug abuse rehabilitation sessions, the patients may not acknowledge that they have a problem with drugs or even that they use them at all (the precontemplative stage).

From the very start, therapists will need to ascertain their patients' respective levels of commitment to change in order to have the best chance of communicating an empathic understanding and to minimize the risk of pushing an unwanted agenda onto patients whose resistance then will likely increase. It is generally not a good idea to accuse patients of "not really wanting to change," or of "wanting to suffer," or of "being in denial" (Newman 1994*a*). It is one thing to confront patients in this manner when they are in the protective confines of an inpatient (perhaps group therapy) setting. It is quite another to do this in an individual outpatient setting where the patient can easily leave treatment and never return if he or she takes offense at the therapist's methods. It is far more preferable to acknowledge that the patient has mixed emotions, and then to assess and get to know the part of the patient that likes to use drugs and the other part that would rather be free of them. In this manner, the therapist demonstrates that he or she is not so naive as to believe that the patient's goal is unequivocal and immediate abstinence, but instead to recognize the complexities and difficulties involved in trying to stop using drugs. Further, the therapist avoids the potentially damaging pitfall of communicating in a judgmental, unempathic tone.

ESTABLISHING RAPPORT AT THE OUTSET OF TREATMENT

The initial interactions between the patient and therapist are extremely important, as substance abuse patients often will be silently sizing up their therapists to determine whether they can be trusted and know what they are doing (Perez 1992). The lack of a positive start to treatment may lead a patient to choose not to return for further sessions, or may foster negative expectancies in the patient that often exacerbate passive resistance or contentious behavior in session. On the other hand, a positive start to treatment may instill hope in the patient, thus encouraging him or her to stay in treatment and to consider the prospects of therapeutic change more seriously.

The following are some common methods by which therapists can connect with their substance-abusing patients as treatment begins:

1. Speak directly, simply, and honestly.
2. Ask about the patient's thoughts and feelings about being in therapy.
3. Focus on the patient's distress.
4. Acknowledge the patient's ambivalence.
5. Explore the purpose and goals of treatment.
6. Discuss the issue of confidentiality.
7. Avoid judgmental comments.
8. Appeal to the patient's areas of positive self-esteem.
9. Acknowledge that therapy is difficult.
10. Ask open-ended questions, then be a good listener.

Speak Directly, Simply, and Honestly

The development of rapport is hindered when patients cannot understand their therapists due to the therapist's unbridled use of psychological jargon. Similarly, patients often do not appreciate it when they perceive that their therapists are talking down to them, or

are speaking to them in the manner of a teacher addressing a grade school class.

The remedy is to endeavor to speak adult to adult, rather than authority to subordinate. For example, the cognitive therapist would be ill-advised to speak in the following manner: "I'll be assessing your thought processes so as to spot the kinds of cognitive distortions that lead you to engage in dysfunctional and antisocial activities."

Instead, the therapist might say: "If it's okay with you, I'd like to understand your point of view about things. I don't want to assume that I already understand what it's like to live your life. I'm interested in listening to your thoughts so I get the real story."

Although the therapist in the second example does not really start teaching the patient about cognitive therapy, he or she establishes some of the groundwork. More important at this early stage, the therapist comes across as being a real person who is understandable. As the patient progresses through succeeding sessions, the therapist will be able to elaborate gradually on the specifics of cognitive therapy, and to teach some of the basic nomenclature.

Additionally, it is important for therapists to share their own thoughts and opinions openly (and diplomatically) when patients ask for them, rather than remaining mysterious figures. Substance abusers, either by virtue of their own developmental/personality issues or their experiences with dishonest drug-abusing associates, often have major problems in trusting others. A therapist who makes an earnest effort to respond to questions can provide the patient with evidence that the therapist does not have a hidden agenda. As a qualifier to the above, it is important to note that the therapist should feel free to ask the patient many questions as well, lest the patient put the responsibility for the work of therapy entirely (and inappropriately) on the therapist.

Ask About the Patient's Thoughts and Feelings About Being in Therapy

The therapist should assume neither that the patient is highly motivated for treatment nor that he or she is resistant and hostile. The best way to obtain valid data and at the same time demonstrate that the therapist cares to understand how the patient feels is to ask the patient directly about his or her experience of coming to the therapist's office.

Such questions can involve asking about the patient's doubts and concerns, as well as expectations, goals, and hopes for therapy. If the patient expresses misgivings about being in treatment, these negative reactions can be addressed on the spot, thus reducing the risk of early dropout. At the same time, the therapist can utilize this interaction to begin to teach the patient the cognitive therapy model. For example, a patient who expects to be disrespected by the therapist may harbor feelings of anger. By contrast, if the patient expects to be helped, he or she may feel a sense of relief and have a high degree of motivation. This example begins to demonstrate one of the central tenets of cognitive therapy, namely, that the patient's thoughts will influence his or her feelings, intentions, and actions.

Focus on the Patient's Distress

In light of the high rates of dual diagnoses in substance abusers who present for treatment (Castaneda et al. 1989; Evans and Sullivan 1990; Nace et al. 1991; Rounsaville et al. 1991), it is likely that these patients will be suffering from affective disorders, anxiety disorders, or other psychological maladies when they enter treatment. If therapists show an interest in sympathizing with and addressing these emotional problems, in contrast to focusing exclusively on the substance abuse per se, they can demonstrate that they are interested in the entirety of the patient's well-being. In this manner, therapists show that they are interested in getting to know the patient as a person, and not simply as an addict.

Such an approach is especially indicated for substance-abusing patients who also meet diagnostic criteria for antisocial personality disorder (ASPD). These patients typically are unmotivated to change unless they are in emotional distress, in which case there is a desire to participate in therapy to gain relief (Alterman and Cacciola 1991; Woody et al. 1990). By helping these ASPD/depressed drug abusers to improve their mood, therapists may be able to form an interpersonal alliance with patients who otherwise might not bond with a helper.

Even when patients do not technically meet criteria for dual diagnoses, they may often experience emotional suffering related to having reached points of crisis in their lives (Kosten et al. 1986; Newman and Wright 1994; Sobell et al. 1988). Therefore, it is quite appropriate for therapists to put such topics as current areas of stress and family problems on the therapeutic agenda. In addition to providing the patients with understanding and empathy, this approach also calls patients' attention to the fact that substance abuse is an

important cause of their general malaise in life. This may further motivate patients to consider the cessation of substance abuse as a major goal of treatment.

Acknowledge the Patient's Ambivalence

Anecdotally, some drug-abusing patients report that they doubt (at least early on) that therapists who have not had drug problems themselves can truly understand their patients' plights. However, upon further questioning, it typically becomes apparent that this misconception arises when the patients perceive that their therapists take the view that, "Of course you want to quit using drugs. You have everything to gain and nothing to lose by becoming clean and sober." Patients then conclude that their therapists don't understand the power and allure of drugs such as cocaine.

Therefore, it is advisable for therapists to admit that cocaine is a difficult drug to relinquish, and that it would be reasonable and understandable for the patients to have a sense of grief about having to give up the drug (Jennings 1991). By acknowledging and asking about the patients' ambivalence, therapists communicate more accurate empathy, and open up a vital area of discussion that patients otherwise might believe it best to conceal.

In fact, one of the standard techniques in the repertoire of the cognitive therapist depends on the therapist's awareness of the patient's mixed emotions and attitudes—the advantages/disadvantages analysis (Beck et al. 1993). Here, therapist and patient explore the pros and cons of both using and not using drugs. Many patients express pleasant surprise that their therapists really are willing to discuss the pros of continuing to abuse drugs. Although the ultimate goal obviously is to strengthen the patients' resolve, know-how, and commitment to be drug free, an exploration of the seductive aspects of drug use can help the formation of a trusting, collaborative therapeutic relationship.

Explore the Purpose and Goals of Treatment

Cognitive therapy contains a significant psychoeducational component (Beck et al. 1979). A long-term goal of treatment is to empower the patient—to increase a sense of self-efficacy and to teach the patient to become his or her own therapist. One way to achieve this goal is to make the patient a full partner in charting the course of therapy. This entails discussing the purpose of meeting with

the therapist, the goals of treatment, and the types of methods that will be used to achieve these goals.

By exploring the purpose and goals of treatment, therapists take some of the mystery out of the process of change, and minimize the chances that mistrustful patients will view their therapists as playing mind games or being on power trips. If the therapist and patient determine that their respective goals are at odds, at least the problem will be on the table, and not a conflict of hidden agendas. They can then agree to find some common ground, and work toward shared goals until the thornier issues can be discussed and explored at greater length. Therapists can stress that the process of change requires teamwork, and that the therapist and patient are not adversaries.

Discuss the Issue of Confidentiality

Because illicit drug use is by definition illegal behavior, patients have learned to be very cautious in what they will divulge about their activities. Thus they often are highly motivated to be dishonest in reporting their substance abuse. Although the vast majority of therapeutic interactions represent privileged communications, drug-abusing patients may not understand or trust the extent to which their admissions of drug use will be kept confidential.

To facilitate more open communication and mutual trust, therapists should spell out the nature and limits of confidentiality from the very start. Patients may not be pleased to hear about the limits, but they will appreciate the explanation and the warning. Therapists will need to emphasize that their primary role is to help patients confront their drug use and improve the quality of their lives; therapists do not serve as society's watchdog, or punish, or oppress.

Avoid Judgmental Comments

A longstanding and well-known fact is that it is important for the therapist to communicate a sense of positive regard and respect for the patient (e.g., Bergin and Solomon 1970; Egan 1975; Truax 1963; Truax and Carkhuff 1967; Truax and Mitchell 1971). Nevertheless, it is all too easy for the therapist to fall into the trap of sounding accusatory and judgmental toward a patient who is abusing drugs. If this happens, the formation of a healthy therapeutic relationship is seriously hindered. Further, the patient may become less inclined to view the therapist as an effective professional when the therapist's comments resemble those heard from exasperated relatives.

Instead, therapists need to explain that they wish to ally with their patients in a mutual struggle against the patients' drug use and concomitant life problems. Patients need to be helped to understand that they are not viewed as bad people, but rather as people with a highly troublesome habit with which to deal.

Similarly, therapists need to take care not to spew forth judgmental or hostile comments about anybody else. For example, when a therapist treats a substance-abusing patient who is involved in a romantic relationship with another substance abuser, there is a great temptation for the therapist to criticize the significant other, especially when the significant other sabotages the patient's progress toward abstinence. However, by doing this the therapist runs the risk of triangulating the patient between the loved one and the therapist (in essence, putting the patient in the position of having to take sides). When this happens, patients frequently choose to be loyal to the significant other, which may precipitate a flight from treatment.

Even if the therapist makes judgmental comments about impersonal third parties, the patient may wonder whether this is also how the therapist truly feels about the patient when he or she is not around. This will impede the formation and maintenance of a positive therapeutic alliance. It is much more prudent to evaluate the relative merits and drawbacks of the behaviors and attitudes of people, rather than make pat statements about their characters.

Appeal to the Patient's Areas of Positive Self-Esteem

Although substance-abusing patients typically present with a host of problems, including chaotic lifestyles and skills deficits, it is important for therapists to assess their patients' areas of strength and competence. By doing so, therapists show that they have respect for their patients' individual talents and assets. Further, they can appeal to areas in which the patients feel a sense of pride, thereby eliciting greater cooperation in other therapy tasks.

For example, Walter (all names have been changed) was a patient who was very mistrustful of authority figures, and his collaboration in the process of therapy at the start of treatment was tenuous at best. Although he seemed to be quite hostile and resistant, he did prove himself to be rather intelligent (in spite of his limited education). When Walter would engage in high-risk behaviors (e.g., drive while intoxicated), the therapist would appeal to the patient's intelligence to get him to reconsider this maladaptive behavior. For example, the

therapist would say: "Walt, you and I have discussed how you have survived to this point, mainly due to your smarts. You seem to be someone who thinks fast under pressure. That's why I'm so perplexed that you would risk your safety and freedom by driving drunk. It just doesn't seem to fit. What's your opinion about all of this? I'm interested to hear your views."

Aside from noting the patients' intelligence, therapists can encourage patients to collaborate in the work of therapy by focusing on other attributes such as their survival skills, the love of their friends and family, their spirituality, their integrity, their potential abilities to be positive role models for others, their advanced vocational skills (when sober), and other legitimate personal attributes.

Acknowledge That Therapy Is Difficult

Therapists can help to build rapport with their patients by noting that it takes courage and hard work to participate fully in therapy. This stance can help to counteract patients' beliefs that it is a sign of weakness and incompetence to be in treatment. In essence, the therapist tries to help the patient to take the shame out of being a patient. Additionally, by establishing the baseline notion that therapy will be difficult, the therapist reduces the chance that a patient will bail out of treatment at the first sign of discomfort.

The therapist can liken the pain of going through therapy to the pain of receiving medical treatment for a wound or a broken bone. Although the procedures hurt, they enable the patient to heal and to be strong. The adage, "If it hurts, you know the medicine is working," is appropriate in this regard. By contrast, if the patient comes to learn that he or she actually enjoys and looks forward to therapy sessions, it will seem like a bonus benefit.

Ask Open-Ended Questions, Then Be a Good Listener

One of the defining features of cognitive therapy is the spirit of collaboration that the therapist attempts to foster in working with the patient (Beck et al. 1979). A central method for enhancing an atmosphere of collaboration is to encourage the patient to actively talk and think aloud in the session, and for the therapist to listen carefully and reflect accurately. Additionally, it is important to add structure to this process by asking clinically relevant questions that allow the patient to expound his or her feelings and thoughts. Open-ended questions serve this purpose well.

A common trap to avoid is lecturing the patients and/or bombarding them with yes/no questions that are reminiscent of interrogation. It is much more collaborative to employ a Socratic style (Overholser 1987, 1988, 1993) in which the therapist gently guides the direction of the session material by punctuating the patients' comments with thoughtful, open-ended questions. The following short dialog serves as an example.

Therapist: I see on your responses to the questionnaires that you haven't used any drugs or alcohol since our last session. What do you think has helped you to do this?

Patient: I don't go past that house no more.

Therapist: The crack house?

Patient: Yeah.

Therapist: What do you say to yourself—how do you manage to keep yourself from going to that house?

Patient: I just remind myself that my life falls apart whenever I start to go there. I just remind myself that I'm kidding myself if I think I can just stop in and say "hi" and shoot the breeze and then just go home. It don't work that way. I just have to stay away.

Therapist: So you remember the problems that you had when you used to go there, and how your life changes for the worse when you use drugs.

Patient: That about sums it up. (Frowns)

Therapist: You looked a little sad just then. What went through your mind?

Patient: Ahhh. I don't know. (Pause) It's a lonely feeling. I got friends who hang out at the house, and I can't see them no more.

Note that in the example above, the therapist gets a lot of useful information from the patient by asking open-ended questions and by carefully listening to the patient's responses. A good rapport seems

to be present in the interaction, with the patient implicitly acknowledging that the therapist understands.

MAINTAINING A POSITIVE ALLIANCE OVER THE COURSE OF TREATMENT

It is often difficult to establish rapport and a collaborative working set with substance-abusing patients; moreover, it is very easy to lose that rapport once it is there. Therefore, even when things seem to be going smoothly in the therapeutic relationship, the therapist must be vigilant in consistently doing what is necessary to maintain the positive feelings between therapist and patient.

The following are some general principles that therapists can employ throughout treatment to preserve a productive and healthy therapeutic alliance.

1. Ask patients for feedback about every session.
2. Be attentive. Remember details about the patients from session to session.
3. Use imagery and metaphors that the patients will find personally relevant.
4. Be consistent, dependable, and available.
5. Be trustworthy, even when the patient is not.
6. Remain calm and cool in session, even if the patient is not.
7. Be confident, but be humble.
8. Set limits in a respectful manner.

Ask Patients for Feedback About Every Session

The best cure for a damaged therapeutic relationship is prevention. One of the easiest and most reliable methods for avoiding misunderstandings between the therapist and patient is for the therapist to check on what the patient perceives and feels about the session. This can be done during the course of the session (e.g., "What do you think about what I've been saying so far today?") and/or at the completion of the session (e.g., "How do you feel about today's session? Is there anything I said that rubbed you the wrong way?") If the patient states that he or she is disgruntled, or demonstrates nonverbal reactions that seem to indicate discomfort (e.g., sighing, reticence), the therapist can address this immediately, providing a heavy dose of nondefensive empathy along the way.

For example, one patient misconstrued the therapist's discussion of high-risk situations as an attempt to plant the idea into the patient's head that he was going to succumb to his urges. Once the therapist asked for feedback and ascertained that the patient thought the therapist was trying to sabotage the patient's sobriety, the therapist was able to explain his actual intentions, which were to educate and help the patient. For good measure, the therapist apologized for not being more clear.

It is important for the therapist not to assume that everything is okay in the therapeutic relationship just because the patient hasn't openly complained. Patients who have mistrust issues and/or live in dangerous neighborhoods often conceal their negative feelings extremely well. They adopt a "street smile" that hides both their vulnerability and their desire to strike back without warning. Therefore, the therapist should make an effort to ask for feedback on a regular basis, as both a preventive and a reparative measure.

Be Attentive. Remember Details About the Patients From Session to Session

Although this point may be common sense in theory, it is not always easy to enact in practice. For example, some drug-abusing patients may use slang terms the therapist doesn't know. If the therapist doesn't ask for clarification, he or she may miss important information. This may further lead the patient to think that the therapist didn't care to understand, rather than that the therapist wasn't able to understand, and the therapeutic rapport may be harmed.

To accurately conceptualize the patient's life situation, the therapist must be able to mentally accumulate information about the patient from week to week. In this way, understanding increases. A simple, tried-and-true method to enhance this process is to take thorough, prompt therapy notes about every contact with the patient, and to review these notes religiously before each new session.

Use Imagery and Metaphors That the Patients Will Find Personally Relevant

Once the therapist facilitates the establishment of rapport by speaking "directly, simply, and honestly" (see first item, previous section), he or she can facilitate more sophisticated understanding by using images and metaphors to communicate important but complex points.

For example, a therapist wanted to discuss the patient's tendency to isolate himself from others, including those who purported to love him and to want to help him. The therapist conceptualized the patient's problem in terms of the patient's fear that he would inevitably hurt anyone who got close to him. Further, the patient saw himself as being very attractive and powerful, thus making his efforts to isolate himself from would-be admirers all the more difficult.

The therapist used the following metaphor in order to explain this formulation, while also appealing to the patient's narcissism: "Joe, you're like a shiny new Porsche with no brakes. You're coming down the road looking as cool and swift as you can be, and everyone wants to come up close to you to get a better look. Meanwhile, you know that you have no brakes. Therefore, you're afraid if that people get too close, you're going to run them down, and you're not sure you can live with yourself if that happens, so you drive away from everybody. Joe, I think we need to get you some brakes. What do you think?"

Then the therapist elicited feedback from the patient, who said he felt both understood and complimented. This facilitated the continued discussion of the important issue above.

Be Consistent, Dependable, and Available

Therapists typically do not earn their drug-abusing patients' trust through sudden, dramatic gestures. Rather, trust is gained through the therapist's consistent professionalism, honesty, and well-meaning actions over a long period of time.

Although drug-abusing patients often may arrive late for sessions, fail to show up at all, and otherwise demonstrate the lack of a serious involvement in the process of treatment, therapists (by contrast) need to demonstrate a steady commitment to helping these patients. Therefore, it is very important for therapists to arrive on time for their appointments, even in cases when the patients habitually come late. In like manner, it is important for therapists to be available for therapy sessions on as regular a basis as possible (and to make sensible alternative arrangements if necessary), to return their patients' phone calls promptly, and to be reachable in cases of emergency.

Another more powerful way that therapists can establish that they are well grounded and dependable centering points in their patients' lives is to unfailingly pursue patients who do not show up for their sessions. If the therapist establishes a pattern whereby he or she will almost always telephone a patient within hours of their missing a session, the therapist communicates a concern that goes beyond words. Along these same lines, it is advisable for therapists to be willing to continue to treat a drug-abusing patient when he or she returns after a drug lapse or other problematic hiatus from therapy. This strategy provides the most realistic means by which to treat a disorder whose course is often recurrent. Further, it provides a sense of hope for patients who otherwise might believe that they have burned their bridges with all benevolent and helpful others. Therefore, they may be more apt to return to treatment voluntarily and more quickly following future lapses.

Be Trustworthy, Even When the Patient Is Not

As explained above, therapists must demand a higher standard of behavior from themselves than they can expect from their substance-abusing patients. Patients who act and think in combative, passive-aggressive, and/or mistrustful ways in their everyday life often expect that others will treat them in like fashion. Therefore, it is a corrective experience for patients when they realize that their therapists will continue to demonstrate honesty and concern, even when the patients themselves have been less than friendly or truthful in return.

As difficult as it is to gain the trust of the substance-abusing patient, it can be impaired or lost quickly and with relatively little provocation. Therefore, the therapeutic relationship must be managed in a delicate, pains-taking fashion. In the process of accomplishing this

goal, therapists must recognize their own anger when patients lie to them, and must strive to keep such feelings in check. Instead, therapists need to find a diplomatic way to address the "apparent inconsistencies" in what the patients say and do, and to remain nonjudgmental (Beck et al. 1993).

Remain Calm and Cool in Session, Even If the Patient Is Not

When a patient becomes hostile, loud, intransigent, and/or verbally abusive, it does little good for the therapist to respond in kind (Beck et al. 1993). To deescalate a potentially dangerous situation, the therapist must stay calm, nondefensive, and matter-of-fact. It is important at such times for the therapist to express a genuine concern for the patient's well-being and best interests.

When the therapist and patient are at odds, it is extremely helpful for the therapist to call attention to their areas of agreement and collaboration. This helps to remind that patient that a single conflict with the therapist does not mean that the entire therapeutic endeavor is adversarial. Although a certain degree of confrontation between the therapist and the drug-abusing patient is almost inevitable during the course of treatment (Frances and Miller 1991), the therapist can minimize damage to the therapeutic relationship by calmly communicating a tone of respect and concern (Newman 1988).

Be Confident, But Be Humble

One of the most fundamental ways to help patients gain confidence and hope about the process of therapy is for therapists to show confidence in themselves. This involves such behavioral components as clarity of voice, relaxed posture, nondefensiveness, and an energetic optimism.

However, the therapist does not need to go to extremes to demonstrate confidence. In fact, it is actually ill-advised for therapists to portray themselves as omnipotent and/or omniscient. A certain degree of humility is necessary to create and sustain an atmosphere of collaboration and mutual respect.

For example, therapists must be willing to admit that they do not know (or were wrong about) something, if appropriate, rather than try to fake their way through. For example, one patient repeatedly referred to a "Reverend Percy" in his first therapy session. At one point, he asked his therapist, "You're aware of Reverend Percy's work

in the community, aren't you?" The therapist, not wanting to seem like he was ignorant about important civic leaders, was tempted to tell a white lie and answer "yes." Fortunately, the therapist humbly admitted that he hadn't heard of Reverend Percy, but that he was interested in learning more about him. The patient laughed, and stated that it was a good thing that the therapist didn't know Reverend Percy, because "I just made him up!" By showing a willingness to admit that he didn't know something, the therapist passed the patient's rather clever but devious test. Therefore, the therapist preserved his credibility.

Another way therapists can demonstrate humble confidence is to apologize at times. Therapists can do this in response to misunderstandings or minor errors, such as a miscommunication about the exact date and time of a scheduled session, or a harsh sounding comment (e.g., "I'm sorry if my last statement sounded rather hard on you. Really, I'm on your side, but perhaps I got a little carried away just then because I was very concerned about you."). The therapist communicates confidence by showing that he or she is not afraid to admit to a mistake, and that he or she is still optimistic about the course of therapy.

Set Limits in a Respectful Manner

While it is important that therapists work collaboratively with their substance-abusing patients, they must take care not to become so permissive that patients will know that they can take advantage of their therapists' good will. Limits must be set (Ellis 1985; Ellis et al. 1988; Moorey 1989)—for example, that a therapy session will not be held if the patient is intoxicated.

Therapists should establish ground rules during the first session so there will be no confusion or ambiguity later on. Therapists can set limits without sabotaging the therapeutic relationship if they adopt a respectful tone and emphasize their commitment to help patients with their problems (Newman 1988, 1990).

For example, Beck and colleagues (1993) describe the case of a patient who arrived intoxicated for a therapy session. The therapist asked the patient if he had been drinking, and the patient acknowledged that he had. The therapist thanked the patient for his honesty and then suggested that the session be postponed. When the patient protested, the therapist calmly stated, "We made an agreement that we would meet only when you were sober and able to

fully absorb the benefits of the session, and I think we should stick to our agreements." The therapist went further to point out the advantages of the patient's remaining in the waiting room for a couple of hours until it was safe for him to drive home. The patient was a bit disgruntled, but was mollified when the therapist gave him a newspaper to read to keep him occupied.

The lesson to be learned from the above vignette is to set limits, but be neither critical nor controlling. Emphasize that the patient's welfare is the primary concern, and that the therapeutic alliance is still active and strong in spite of the disagreement. Then, follow through.

THE THERAPEUTIC RELATIONSHIP AND THE CASE FORMULATION

Therapists who are most adept at accurately understanding their patients have the best chance of establishing and preserving positive alliances with their patients. In this sense, a good case formulation goes a long way toward helping the therapist and patient maximize their collaborative effort.

When conflicts arise between a therapist and a patient, and/or when unexpressed but problematic ill feelings exist in the therapeutic relationship, the therapist can explore aspects of the case conceptualization to make sense of the interpersonal tensions in session. Oftentimes, this strategy will not only shed light on the reasons for the problems in the therapeutic relationship, but will advance an overall understanding of the patient's life issues. As a result, important material is revealed, the patient feels better understood, and the therapeutic alliance is strengthened.

The following are some general guides for using the case conceptualization in the service of improving the therapeutic relationship.

1. Strive to understand the pain and fear behind the patient's hostility and resistance.
2. Explore the meaning and function of the patient's seemingly oppositional or self-defeating actions.
3. Assess the patient's beliefs about therapy.

4. Assess your own beliefs about the patient.
5. Collaboratively utilize unpleasant feelings in the therapeutic relationship as grist for the mill.

Strive To Understand the Pain and Fear Behind the Patient's Hostility and Resistance

Although the therapist may believe that change is a good thing, clients may have misgivings. Many patients, especially those with serious, longstand-ing disorders, cling tenaciously to the status quo in their lives, because to some extent it is familiar and safe (Beck et al. 1990; Layden et al. 1993; Newman 1994a; Young 1990). For many patients, it is frightening and disorienting to change patterns of cognition, affect, and behavior that they have long associated with their very identity. Additionally, many patients believe that significant change is untenable, due to further difficulties that they expect would arise.

For example, Ed and his therapist agreed that prostitutes were a high-risk stimulus for him. Whenever he would encounter a prostitute who liked to get high, he was vulnerable to seeking out drugs with which to pay the woman. Then, they would have sex and smoke crack cocaine together. In spite of this understanding, Ed still frequented prostitutes and used drugs. At first, this exasperated the therapist, who thought that Ed was deliberately sabotaging therapy because of an opposition to change. However, when the therapist probed for Ed's fears about giving up this maladaptive pattern, Ed was able to articulate that he felt he had nothing to offer a straight woman. He believed that because he was unemployed and not very handsome, his only means of finding female companionship would be in the context of drug use with a prostitute. In other words, underlying Ed's apparent resistance was a fear of being alone. This understanding helped the therapist to express empathy, and to encourage Ed to actively challenge the belief that he would be alone if he gave up drugs.

When patients become overtly angry in session, therapists can cope with this situation best by trying to provide empathy, and by reminding them-selves that no matter how aversive this situation is for therapists, the patients almost always feel worse. This stance helps therapists to decatas-trophize the situation, and to keep the therapists' attention squarely on the patients' needs.

For example, one therapist defused a patient's hostile outburst by asking, "Do you feel I've let you down in some way?" Another

therapist achieved the same end by saying, "I'm sorry if what I've said or done has upset you. That wasn't my intention. How did what I said hurt your feelings?" Yet another example is the therapist who "normalized" his patient's angry refusal to answer the therapist's questions by stating, "I can see that you're only trying to protect yourself. That's okay. Everybody has the right to do that."

Explore the Meaning and Function of the Patient's Seemingly Oppositional or Self-Defeating Actions

When substance-abusing patients do not appear optimally connected with the therapist or engaged in the process of therapy, it is useful to explore the factors that seem to make it in the patient's best interest to oppose the therapist.

Therapists can address this issue head on by noting that there are both advantages and disadvantages to changing one's behavior, and that it might be interesting to look at the pros and cons of attending therapy, as well as the pros and cons of using or abstaining from drugs. Therapeutic collaboration is facilitated when therapists show that they are willing to look at the cons of change (Grilo 1993). Patients then become more apt to cooperate in the exercise of reviewing the long-term costs involved in not changing. Thus, patient receptivity to change is enhanced.

Rita's behavior at the start of therapy was quite contentious. She contradicted or made sarcastic remarks about much of what the therapist would say. After experiencing much frustration and consternation, the therapist finally said: "Rita, given that you frequently disagree with me, my first guess would be that you don't like to meet with me—and yet, you always come to your sessions. What are you getting out of these sessions? How is therapy meeting your needs, given that we seem to be at odds so often?"

Rita didn't know what to make of this at first. Upon further reflection, however, she admitted that she gained a sense of power out of being able to intellectually spar with the therapist. In her view, it would take the fun out of therapy if she agreed with her therapist. This admission led to a fruitful discussion of power, control, and counter-control in relationships.

Assess the Patient's Beliefs About Therapy

An assessment of how patients idiosyncratically interpret various situations is part and parcel of the process of case conceptualization in cognitive therapy (Persons 1989). One such situation is therapy itself. Some patients expect that therapy will be an adversarial process, especially when they perceive their therapists to be from a more privileged socio-economic background. Here, they may perceive their therapists to be agents of the system who will continue to oppress them. Naturally, this viewpoint is laden with mistrust, and will need to be addressed in order for treatment to proceed in a collaborative and amicable fashion.

Another problematic belief about therapy to which some drug-abusing patients subscribe is that the process should always feel good. This belief ignores the fact that taking part in treatment is hard work, and often involves the discussion of emotionally painful issues. If this belief is unassessed and unaddressed, a patient may bolt from therapy at the first sign of discomfort, perhaps before a positive therapeutic alliance can even be established.

Yet another maladaptive cognitive stance that some patients adopt is that therapists cannot be of any help unless they have gone through the problem of substance abuse in their lives too. Therefore, instead of looking at their therapists as positive role models who have the personal and technical skills to help the patients with their problems, patients may discount the therapists' comments and reject their help because "they just don't understand."

Therapists need to be aware of some of these (and other) dysfunctional presuppositions that drug-abusing patients sometimes have about therapy and therapists. Towards that end, it is extremely useful in the first session for therapists to ask two series of questions, one during the early stages of the session and the other at the end of the session.

The first question is: "What are your thoughts about coming in to meet with me today? I'm not sure whether you feel good or bad about seeing me, and I'm not sure what your expectations or hopes about treatment are. But I'd like to know, if you're willing to share your thoughts with me."

The second question is: "What are your impressions about how things went in today's session? Was there anything that I said that you didn't like or didn't agree with? Was there anything about today's session that was particularly helpful? What should we make sure we

continue to talk about in our next session in order to get the most out of being here?"

Assess Your Own Beliefs About the Patient

Therapists are human beings, and therefore are subject to their own dysfunctional beliefs at times. This is most problematic when the therapist's maladaptive beliefs center on their patients, and the therapist fails to take stock of these beliefs. Some of the more commonly encountered therapist beliefs (cf. Beck et al. 1993) include:

- "This patient is a loser."
- "This patient is beyond help."
- "This patient will never listen to me."
- "Why can't I reach this patient? What am I doing wrong? I'm going to have to give up on working with this patient."
- "You can't be collaborative with this type of patient. If you give them an inch, they'll take a mile. Therefore, I will not budge from my position one iota."
- "This case is more trouble and responsibility than I can bear."

When therapists find themselves having such thoughts, it presents them with an excellent opportunity to use cognitive therapy techniques on themselves (Newman 1994*b*). This strategy can help therapists moderate their own hopelessness and frustration enough to still be able to provide good will and an earnest effort. The end result is that the therapeutic relationship will continue to have a positive effect on the process of treatment, rather than being a hindrance. Additionally, the therapist will have gained a deeper understanding of the nature of the patient's typical interpersonal difficulties in everyday life.

The following is a sampling of rational response flashcards that therapists can personally develop to help them modify counterproductive beliefs about drug-abusing patients (cf. Beck et al. 1993):

- "There have been a number of sessions in which the patient and I have worked very well together. Those were rewarding experiences that I must not forget."

- "Let me try to understand my patient's resistant thoughts and behaviors, rather than simply label her a troublemaker."
- "This power struggle is a great opportunity to get at some really hot interpersonal cognitions!"
- "If I keep my cool, present my point of view calmly, and also show that I'm willing to be flexible within reason, I'll probably get a lot more therapeutic mileage out of this conflict than I will if I become strident or stubborn."

Collaboratively Utilize Unpleasant Feelings in the Therapeutic Relationship as Grist for the Mill

Tension and conflict between a patient and therapist need not be gratuitously disruptive to the process of therapy. In fact, if handled skillfully, such episodes can shed light on the patient's negative beliefs and actions regarding interpersonal relationships (cf. Layden et al. 1993). This information, in turn, can be used to help the patient make important discoveries, and can inspire him or her to experiment with new adaptive behaviors.

For example, a therapist noticed that the patient was looking glum, not making eye contact, and sounding a little sarcastic. To explore the meaning of this behavior, the therapist forthrightly said, "Things seem a little tense between you and me today. Did you notice that?" This led to the patient's becoming uncharacteristically silent; therefore the therapist knew that she had hit home. She added, "Can we talk about it? If something is wrong I'd like to try to work it out, if that's okay with you."

Upon further discussion, the patient stated that the group therapy leader (in another setting, though still part of the patient's treatment package) had said something that "he could only have known if he spoke to you." In other words, the patient thought that his individual therapist was saying things about him behind his back to the group therapy counselor. This, in fact, was not the case at all.

The therapist and patient discussed all the possible alternatives to his mistrustful point of view, including the possibility that the group counselor and individual therapist were independently reaching similar clinical judgments about the patient. The therapist added that she would certainly talk to the patient directly about the prospect of sharing information with the group counselor if the need arose. Then she demonstrated empathy for the patient, stating, "It must have

been difficult for you, thinking that I betrayed your trust. I can imagine how disillusioned you must have felt. I'm glad we can set the record straight, because I have enjoyed working with you, and things seemed to be going well until this misunderstanding."

Furthermore, this episode became grist for the mill in that it highlighted one of the patient's characteristic patterns—namely, to jump to conclusions about the ill motives of another person, and then to keep these suspicions to himself. This would then prevent the possibility of talking things out and resolving or clarifying the matter with the other person, and the relationship would deteriorate. It was little wonder that the patient felt he had so few friends, and believed that he could never depend on anyone. Because the therapist succeeded in uncovering the nature of the rupture in the therapeutic relationship, the patient-therapist alliance was preserved, and an important aspect of the patient's dysfunction became a clinical topic for the session.

CONCLUSION

The treatment of substance-abusing patients poses a great set of challenges to therapists. One of the most fundamental and vital of these is the establishment and maintenance of a positive therapeutic relationship. If therapists succeed in communicating a spirit of acceptance, collaboration, respect, good will, and optimism to their drug-abusing patients, the process of treatment will be enhanced. If, by contrast, these goals are not achieved, the likelihood of the patients' demonstrating spotty attendance, poor punctuality, and premature termination will increase, thus diminishing the prospects that therapy will have an appreciable effect.

Therapists can facilitate the formation and maintenance of a positive therapeutic alliance with drug-abusing patients by consistently adhering to principles that are part and parcel of a cognitive therapy approach. Such principles include working with the patient as a team, giving clinical rationales in a clear fashion, eliciting feedback from the patient, exploring the belief systems of the patient, being aware of one's own belief systems and how they may impinge on the therapeutic process, and utilizing the case conceptualization and other strategies that require a thoughtful, empathic, and pragmatic approach.

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