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Part 1

Strategies for Enhancing Client Compliance

Practical Strategies for Improving Client Compliance With Treatment

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Erratic attendance, premature termination, and inadequate participation in treatment have been pervasive problems in the alcohol treatment field. Attrition rates for substance abuse treatment range up to 90 percent, and those clients who remain in treatment and participate more fully generally fare better than those who terminate prematurely.

This section presents several compliance-enhancement procedures that have proven effective from the first contact with the program through termination of treatment and, for research projects, through the followup phase. Some strategies do not apply to all settings—some may even change the nature of the treatment itself—and may therefore be impractical in certain programs. Using those that do apply, however, should enhance treatment for both the client and the therapist.

Note that the focus of this manual is on compliance with psychosocial treatments for alcohol problems; compliance issues with pharmacologic treatments for alcohol problems have been addressed elsewhere.[57,78,79]

Before Treatment Begins

Prospective clients may find a treatment program on their own or they may be referred by a clinical program, health-care professional (e.g., social worker, psychologist, psychiatrist, physician, nurse, employee-assistance counselor), social service agency, probation department, telephone hot line, or case manager of a health-maintenance organization. Often, an advertisement is

seen by a concerned spouse, family member, friend, or health-care professional who encourages the prospective client to call and learn more about the program.

Pretreatment contacts with clients and concerned others may involve various program personnel, and may or may not involve a therapist. Thus, all relevant staff should be prepared to conduct pretreatment activities in a manner consistent with the treatment model.

Initial Contact

The initial contact with the treatment site is often over the telephone. A staff member usually conducts a brief screening to identify those who may be appropriate for the treatment offered and give alternative treatment referrals to those who are not appropriate candidates for the specific treatment being offered.

Provide Rapid Response

To enhance compliance and the likelihood of the client's actually entering treatment, schedule the initial appointment as soon as possible after the call and provide adequate information about the program and the application procedures.

Since some clients may be most motivated for treatment when they first call the program, attempt to complete all steps necessary for entry into treatment promptly. Decreasing the time between application for treatment and the first appointment has been shown to significantly improve retention in treatment.[21,40,80,81] Timely scheduling of client evaluation is facilitated by having several staff members available to do interviews and by providing evening hours for appointments to increase flexibility.

Describe Pretreatment Meetings

When the first appointment is made, fully inform clients about the reason for the meeting and what they can expect. This should include who they will see, how long the meeting will last, and what kinds of information they are expected to provide (e.g., demographics, recent alcohol and drug use, psychiatric status, legal status) and why it is needed (e.g., administrative purposes, initial diagnosis, identification of areas of concern to the client).

Research Note: *In some situations, especially research programs or others where the program itself is being evaluated, interviews may be taped (e.g., videotaped or audiotaped). Clients should be informed in advance and told why this is important to the program. If clients are also to be breathalyzed, this should be explained and the consequences of elevated blood alcohol level readings during treatment should be reviewed.*

Pretreatment Meetings

Assess Client Expectations

Many clients have not experienced previous alcohol treatment and express some anxiety (and relief) at finally getting help for their drinking. It is important to assess their reactions to the prospect of treatment and any expectations they might have. The interviewer should listen attentively to the client and periodically reflect back and summarize what is heard in order to help the client feel understood without feeling judged.

A structured clinical interview or self-report can help clients identify their problems with alcohol. Then interviewers can indicate how treatment may help address those problems (e.g., treatment may help identify alternative ways to relax after work or suggest ways to cope with relationship issues related to drinking). This discussion may elicit any uncomfortable feelings or negative reactions to treatment. Reassure the client that expressing such feelings will positively affect treatment outcome. Eliciting reflection on treatment has been described as one strategy to help prevent premature withdrawal from treatment.[82]

Describe the Treatment Program

Treatment compliance is enhanced when the client's expectations match what the program can actually provide. Clients are more likely to drop out of treatment prematurely if misunderstandings occur between the practitioner and client regarding treatment.[83] Therefore, be sure to carefully describe details of the treatment program and the client's obligations.

During the first inperson assessment, give the client a brief overview of the treatment being offered and general ways in which it may be helpful. If the program offers more than one treatment approach (e.g., one-on-one, group, 12-step, behavior modification), explain the potential benefits and risks involved in each. Bring up other issues, such as whether family members will be involved and expectations regarding simultaneous attendance at Alcoholics Anonymous (AA) meetings. Table 2.1 suggests issues to review when preparing research clients for treatment.

Be sure that clients understand the different roles of the people they encounter in the program. Also provide them with names and telephone numbers of staff to contact about scheduling problems and other such concerns.

Clients may also be given an individually customized handout that describes the treatment, the therapist's name(s), the starting dates of treatment, the time of the first session, rules regarding attendance, and other matters of importance (see table 2.2). Ma-

Table 2.1. Preparing clients for treatment in an alcohol research setting

- ☐ Review differences between research (pretreatment, followup) and treatment phases of study, and give clients a project timeline sheet which provides an overview of the different phases over time.
- ☐ Review staff roles during all study phases. Indicate project staff to call in case of emergency (e.g., project coordinator, principal investigator).
- ☐ Review differences between study treatment and other nonresearch treatments potentially available:
  - — client will likely have no choice regarding treatment assignment, and cannot "switch" to a more preferred treatment group.
  - — study treatment will be manualized and protocol-driven, and may be less eclectic.
  - — review protocol requirements regarding family involvement or noninvolvement in treatment.
  - — attitudes towards involvement in AA or other self-help groups may differ from other treatment programs. For example, in MATCH III, we adopt a neutral stance towards self-help group attendance.
  - — interviews and treatment sessions will be audio- or videotaped. Explain why this is important, and who will be allowed to listen to these tapes.
  - — study treatment may be free to client because of research funding, but will require client's accurate completion of interviews and questionnaires, which can be lengthy.
  - — unlike some other treatment programs, clients who prematurely leave treatment will not be able to reenroll in study treatment at a later date.
- ☐ Review informed consent procedures, and give client a copy of form. Include review of:
  - — confidentiality.
  - — a description of procedures for assessment (e.g., interviews, questionnaires, breathalyzer readings, urinalyses), detoxification, and treatment (e.g., scheduling, assignment to treatment, brief description of possible treatments).
  - — client obligations during treatment. Describe possible problems which may emerge (e.g., arriving to treatment intoxicated, need for more intensive treatment) and how the project handles them. Review referral procedures for additional alcohol and nonalcohol treatment.
  - — payments for followup assessments. Remind clients that even if they choose to withdraw from treatment prematurely, we will still contact them to complete followup assessments.
- ☐ When clients are assigned to treatment, provide a handout which identifies the treatment to which they have been assigned, the therapist(s), session location, starting and ending dates and times, and expectations regarding attendance, completion of research forms during treatment, and followup assessments.

terial in writing reinforces the information provided in the initial contact and allows the client to review that information at home. However, this handout should never be used as a substitute for the personal, one-on-one discussion.

Table 2.2. Sample treatment handout to client

Interactional Therapy
Wednesdays
7:30 to 9 pm
8/20/97–2/4 98
(26 weekly sessions)

- ☐ For first session only (8/20), please arrive at waiting area by 7:15 pm for pregroup interview with therapists. Therapists: (name); (name).
- ☐ If you have any questions or concerns between group sessions, please contact (name), at (phone #), Monday through Friday, 9:30 to 5:30.

Additional sample items for research programs:

- ☐ *Anticipate that 1 or 2 questionnaires will need completion at the end of sessions 3, 12, and 14.*
- ☐ *Remember the 4/8 rules: If you miss 4 consecutive treatment sessions, or 8 or more sessions, we will consider dropping you from treatment, but not from the followup phase.*
- ☐ *Followups with your research assistant, (name), will begin in February 1998.*

Research Note: *Giving clients a project timeline (see figure 2.1), that provides an overview of their scheduled involvement in both the treatment and research aspects of the study over time is also helpful in preventing scheduling conflicts and missed appointments.*

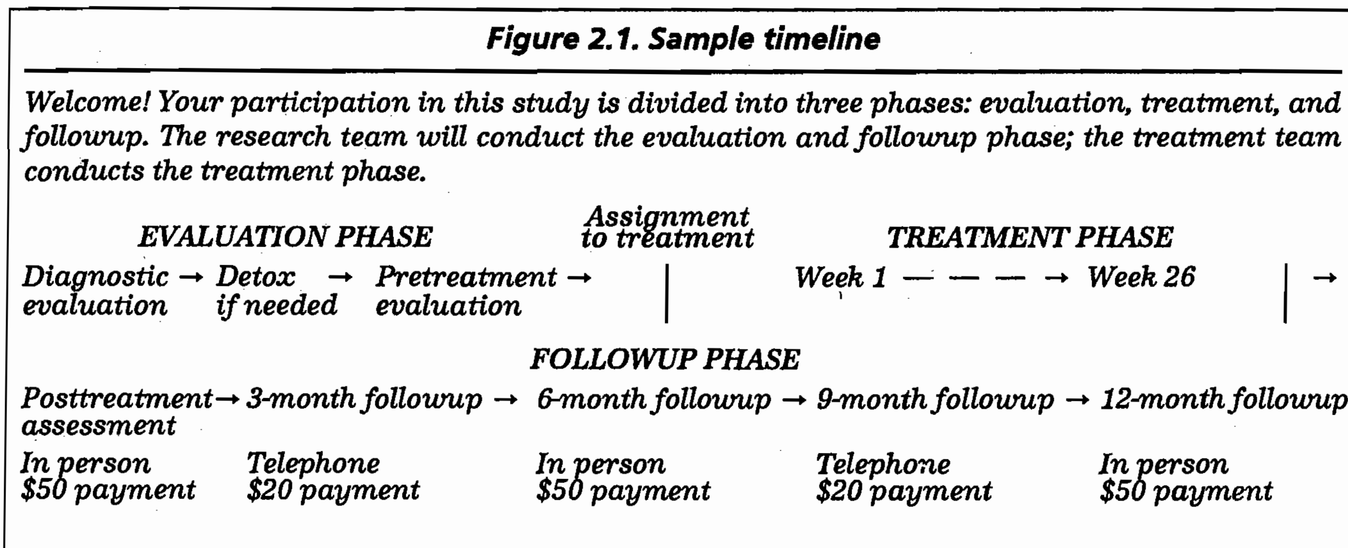

Figure 2.1. Sample timeline

Clarify Expectations

In research studies, the informed consent form (see sample in appendix) has been valuable in clarifying treatment parameters and thereby improving compliance. A similar form or contract in a nonresearch setting may serve the same compliance-enhancing role. Careful attention to this procedure can avoid misperceptions about treatment and thus prevent many potential problems.

To ensure that clients understand the form, read it aloud to the client or paraphrase its major points and answer any questions that arise. Key issues to cover include:

- *Confidentiality.* Assure clients at the beginning of the interview that confidentiality will be maintained at all times. Discuss your policies for ensuring this, such as not using last names in group meetings. Explain any potential exceptions to confidentiality (e.g., state-mandated reporting of child abuse); provide a handout describing confidentiality and these limitations if not covered in the informed consent.

  Where programs are required to report on their caseloads or provide aggregate client data, explain the procedures for protecting client identity. These could include identifying all client information by client number and storing information linking client numbers to names in a locked file cabinet. If relevant, inform clients that any taped interviews will not include their complete names and that personnel who listen to these tapes (e.g., for supervision purposes) will not know their names. In some cases, confidentiality of the videotapes may be further ensured by aiming the camera at the therapist so that the client cannot be seen.

- *Client obligations during treatment.* Clarity regarding the clients' obligations will help foster compliance. Explain all the program's rules and expectations and answer any questions that arise. Such obligations could include the following:

  - Clients are expected to attend all scheduled sessions. Spell out the consequences of irregular attendance.
  - Cancellations should be made at least 24 hours in advance.
  - Clients should arrive for all appointments on time.
  - Clients should inform staff of relapses involving alcohol or drugs and make a good faith effort to maintain abstinence during treatment.
  - Clients should always arrive sober for sessions. Consequences of showing up intoxicated might include not

being allowed to participate in the session and car keys being held by staff until the breathalyzer reading drops to a safe level or alternative transportation is arranged.

- Any plans to prematurely leave treatment should be discussed with the staff; clients should not drop out without explanation.

- *Involvement of significant others.* This will vary with the type of program. Some programs do not involve significant others. Some may depend on significant others for support, information, or involvement in treatment.

Research Note: *Two specific types of outside contacts may be required for tracking clients:*

- *Locator. Clients may be asked to identify at least one person (who does not live with them) whom the program can contact if it loses touch with the client. If called, this person will be asked to help contact the client but will not be told about the nature of the program.*
- *Collateral. Clients may be asked to provide the name of someone whom staff may call at various times during treatment to obtain additional information regarding the client's functioning. Any information obtained through these interviews will be confidential and will not be shared with client.*

Review Potential Barriers

Discuss potential barriers to full compliance, such as transportation and childcare problems, work or school schedules, court involvements, and planned vacations (table 2.3) in detail before starting treatment. For example, the provision of childcare while attending treatment appointments may be critical for women clients. For less socially stable clients, it may be necessary to provide bus tokens, bus schedules, and perhaps taxi service. Clients who drive to the clinic should be given specific directions to safe and convenient parking.

Research Note*: In a research study, the protocol may require random assignment to treatments that meet at fixed times (e.g., groups). If it appears that scheduling conflicts will prohibit clients from attending the particular treatment to which they are assigned, determine the flexibility of their schedules and explore strategies that would support attendance (e.g., obtain consent to talk to the client's employer or family). Research subjects should be reminded during the pretreatment phase that they cannot switch their treatment assignment to another study treatment or group time because of a change in schedule or desire for alternative treatment. Clients should not be accepted if they are unwilling to attend any treatment to which they may be assigned or if they are strongly opposed to the goals of the program (e.g., abstinence). Ignoring these rules can lead to premature dropout, sometimes even before treatment begins.*

Table 2.3. Potential barriers to treatment

- ☐ *Traveling distance to treatment facility.* Clients are more likely to leave treatment prematurely if their drive is lengthy.
- ☐ *Reliability of transportation.* This is particularly important for clients who live in more rural areas not accessible by a local bus line. Clients who have no driver's license or who are awaiting sentencing regarding a DWI charge need to brainstorm alternative, feasible ways to get to treatment.
- ☐ *Legal difficulties* that may interfere with choice of treatment.
- ☐ *Flexibility of schedule* and absences due to upcoming vacations from work or school.
- ☐ *Family support for client involvement in treatment.* Clients who live with substance-abusing or physically abusive partners may require additional referrals and support during treatment.
- ☐ *Childcare arrangements.* If the program cannot provide childcare, consider arranging appointments in the evenings or on weekends when other caretakers may be available.
- ☐ *Psychiatric or medical problems* that would significantly interfere with participation.

Additional issues for research programs:

- ☐ Access to client by phone, *or access to someone who can reliably contact the client.*
- ☐ Alcohol treatment history. *Limitations regarding recent prior treatment or concurrent treatment*
- ☐ Adequate cognitive ability *to understand assessment questionnaires.*
- ☐ Client willingness to accept assignment *to any of the treatments offered in the study.*
- ☐ Client willingness to be audiotaped or videotaped *during treatment sessions.*

Physical Dependence

Significant withdrawal symptoms can present a number of barriers to outpatient treatment and hence lead to compliance problems. Therefore, screen potential clients regarding the need for medically supervised detoxification. Have complex cases reviewed by a medical team (nurse, physician's assistant, internist). Provide referrals to clients who cannot safely self-taper gradually from alcohol or who are not appropriate for outpatient detoxification. Unfortunately, clients who require inpatient detoxification before treatment (because of serious medical or psychiatric problems or a history of seizures or DTs) often do not complete it. On the other hand, clients who can safely undergo outpatient detoxification tend to progress more quickly toward treatment assignment.

Ask clients who can safely self-taper from alcohol to negotiate a realistic target date for sobriety so they will be medically stable and no longer experiencing withdrawal symptoms when treatment starts. The target date helps clients progress through the pretreatment phase so they may more quickly be assigned to treatment. A sample contract for outpatient detoxification is included in the appendix.

Comorbid Psychopathology

Indications of psychopathology, such as significant depression or anxiety, should be assessed and addressed before beginning treatment to maximize retention. Although some clients' symptoms may improve after several weeks of sobriety, others may require medication or referral for psychotherapy. These clients often require more contacts with the program for referrals and support.

For clients who already have a relationship with a therapist, consider recommending that they schedule more frequent sessions (e.g., see their psychiatrist every other week rather than once per month) if there appear to be significant concurrent psychiatric problems. This gives clients the clear message that their clinical needs are of primary importance. Clients should also be encouraged to contact program staff if their existing symptoms begin to worsen or if new symptoms develop.

Introduce Group Therapy

An induction interview that prepares clients for group therapy can help reduce premature dropout.[82] Have clients in group treatment meet with their therapists individually before their first group session for a role induction interview. This should supplement information already provided by the staff regarding the treatment. A sample guideline for meeting with new members of a coping skills group is provided in table 2.4.

The role induction interview may be conducted by the group's therapist or a cotherapist, with one or more clients who are beginning group at the same time. After introductions, provide some general information about the group's composition and meeting schedule. Elicit some of the client's more salient problems at this time to identify them as part of the agenda for working with the clients and to impart the message that this therapy will be relevant to their particular needs. Material elicited during the role induction can later be used in therapy sessions. One approach is to give clients a list of typical problems and ask them to check off those they have experienced in each area.

Discuss the general philosophy of the treatment approach that will be used, making specific reference to the client problems that were just identified. For example, in the case of a coping skills training approach, explain the process of identifying trigger situations that may lead to relapse, the benefit of developing skills for

Table 2.4. Guidelines for role induction interview for cognitive-behavioral group therapy

- ☐ General information
  - Number of other clients in the group
  - Name of cotherapist
  - Weekly meetings for ______ weeks
- ☐ Identify current problem areas
  - Usual drinking situations
  - Social pressure to drink
  - Marital/family problems
  - Negative moods: depression, anxiety, anger, loneliness, boredom
  - Other problems
- ☐ Coping-Skills Training approach
  - Difficulty handling problems can lead to a relapse.
  - To stay sober, you will learn new ways to cope with problems.
  - Opportunities will be provided to practice what you learn, so that the new skills will become easier and more natural to perform.
  - Practice exercises will be distributed each week, to help you practice new skills at home.
  - Do not abandon a skill until you have tried it several times.
- ☐ Therapist and client roles
  - Therapists' job is to assist you, but not tell you what to do.
  - Client's role is to participate actively in group and complete homework exercises.
- ☐ Stumbling blocks
  - Explore instances when client previously dropped out of treatment. If client is considering dropping out, discuss it with the group—unlikely to be the only one who feels this way.
  - Most clients experience hopelessness, anger, frustration, and other negative feelings about group at times. Client should come to group and discuss these feelings, even if they may be embarrassing to the therapists.
  - In spite of efforts to maintain abstinence, some clients will slip. Client should come sober to group and let the group support efforts to get back on the wagon.
- ☐ Group members' contract
  - Review and obtain client's concurrence.

avoiding or managing these triggers, and the need to practice the new coping skills to become proficient in them.

Next describe the roles of the therapists and clients. For example, therapists provide information and support without making decisions for clients or telling them what to do. Clients are expected to participate actively in the group, attempt to abstain from drinking, and complete assignments between sessions. Explore potential obstacles to compliance, and encourage clients to come to group to discuss the problems they are encountering, rather than allowing them to interfere with their recovery or serve as a pretext for dropping out of treatment.

During Treatment

A number of compliance issues arise when treating clients with drinking problems, but the major focus is often on preventing dropouts. Even when valiant attempts are made to persuade clients to stay in treatment, they may still withdraw prematurely for various reasons (e.g., a change in their priorities or schedule, feeling cured and in no further need of treatment, dislike of the treatment or setting, need for more intensive alcohol or non-alcohol treatment, embarrassment about relapse, desire for a group with a greater number of abstinent members). Moreover, clients may leave treatment without ever disclosing their reasons.

When the reason can be determined, sometimes clients can be persuaded to return if they appear ambivalent and client concerns are listened to and addressed. For example, when clients complained of the heat and lack of space in a group meeting room, adding a fan and removing a table solved the problem. Clients who are more emphatic about dropping out may be less amenable to staff persuasion to attend another treatment session and may complain that they feel they have been pressured too much. Staff need to use clinical judgment when deciding the best approach to take with a particular client.

The following suggestions come from a variety of treatment approaches and settings. All have worked in their particular programs and may be equally effective in other circumstances.

Engender Trust

Successful implementation of compliance-enhancement strategies is facilitated if the client learns to trust the therapist and other program staff. Developing the necessary degree of trust requires a satisfactory working relationship with the client. Only then may

the client be willing to divulge personal material in therapy and cooperate with assignments.

A number of steps can help to improve the therapeutic relationship. The primary goal is to foster a sense of active partnership and shared responsibility between therapist and client. Specific techniques include probing for the client's worries and concerns, attending to and reflecting what the client is saying, discussing all diagnoses and treatment alternatives, exploring the client's expectations about treatment, and discussing potential adherence problems openly with the client.

Therapists should use a friendly, empathic, nontechnical communication style and encourage the clients to express any doubts or misgivings they may have. Deemphasizing use of the term "alcoholic" may enhance the therapeutic relationship, especially among clients who acknowledge an alcohol problem but ascribe the alcoholic label primarily to others who appear less socially stable or more physically dependent than themselves.

Provide Support and Advocacy

Sometimes clients are more likely to continue attending treatment if they can contact the staff to share uncomfortable feelings about the treatment or to discuss a troublesome slip. Clients who are dissatisfied with the treatment can be encouraged to bring it up with their individual therapist or group. For example, one client who had just begun interactional group therapy told the staff that she thought the type of therapy was wrong for her, in part because she was concerned that in her current group she would care more for others than herself. At the staff's suggestion, she agreed to give her group another try and discuss her concerns there. As a result, she continued to attend her original group and was able to request more support for herself.

Encourage Clients to Share Concerns

Concerns that clients may want to discuss with staff during treatment (and which may affect treatment attendance) include difficulties with the therapists, difficulties with other group members, need for letters of participation for court, and requests for additional treatment referrals for alcohol or nonalcohol disorders. Sometimes a client can be persuaded to discuss interpersonal concerns with the therapists or other group members, but at other times, the distressed client's concerns may require contact with more senior staff (e.g., a supervisor or project coordinator).

For example, one group member almost dropped out of treatment after one session because of a great fear of becoming infected with HIV by another group member. After speaking to the project coordinator several times and gathering additional information from trusted friends regarding HIV transmission, she was able to

manage her fear well enough to attend group consistently but did not discuss her fear with the group nor with this particular member. Her therapist was informed of this situation and helped the client feel more comfortable with the other group member by engaging them in role plays together.

Sometimes a staff member (e.g., nurse, project coordinator) can assist a client without involving the therapists or other group members. For example, when one client with bipolar disorder noticed an increase in manic behavior but had difficulty reaching her psychiatrist to request more medication, she phoned the program for help. After some reassurance and problem solving, she was able to reach her psychiatrist and obtain the medication she had previously found helpful, thereby preventing further deterioration. This client also reported concerns about spending sprees, for which she received additional treatment referrals. She continued to attend regularly and do well in the study treatment and updated the staff periodically about her progress.

Explore Ambivalence

Clients may be more inclined to reconsider their resistance to change if they believe that the therapist understands their reasons for being hesitant to change (e.g., lifestyle changes can be difficult, it may be unpleasant to give up old drinking buddies, it may seem easier to handle various feelings and problems by using alcohol). Therapeutic collaboration may be facilitated when therapists empathically examine resistance and are willing to look at the disadvantages and difficulties of change.

Maintain Relevance to Clients Needs in Research Protocols

Research Note: *During the course of treatment, clients experience numerous problems, as well as cravings and actual slips, as they struggle to achieve sobriety. It is crucial that clients perceive the treatment they are receiving as relevant to the major issues they are confronting. The therapy manuals employed in clinical research studies often require that the focus of sessions be limited to prescribed topics. However, if therapists ignore the real-life problems that clients are experiencing and probably want to talk about, they risk having the clients view the treatment as peripheral or even irrelevant to their current needs.*

A compromise is therefore necessary between the demands of the protocol and being responsive to clients' perceived needs. A limited amount of time can usually be allocated at the outset of each session for discussing current problems. The general rule is that these opening discussions should be structured in a way that is consistent with the therapeutic protocol being employed in the study.[84]

For example, at the beginning of a coping skills group, a male client may describe difficulty with a high-risk situation such as a recent conflict with his wife. Although the topic scheduled for discussion in this session may be

"increasing pleasant activities," the therapists would still attempt to identify cognitive and behavioral antecedents of the conflict. If the conflict relates to his having difficulty expressing anger with his wife, therapists and clients might suggest principles from past groups (e.g., anger management, feeling talk and listening skills, giving and receiving criticism), if he has already been exposed to these topics.

If not yet exposed, the group could still problem-solve options, such as asking the client to more often discuss his concerns with his wife as they emerge rather than stuffing his feelings and becoming increasingly angry. Examples of ways to frame his concerns nondefensively might be given or role played. If the client agrees to try the suggestions, his progress would be assessed at the beginning of the next group. Engaging in pleasant activities also might be used as a possible way to manage moods and deal with future conflicts with his wife.

Some problems, however, may only receive relatively brief attention at the beginning of a session. It may become necessary to inform clients with special needs that, given the limitations imposed by the research protocol, not all problems can be dealt with fully. Clients with issues that require interventions beyond the study treatment can be given referrals for additional therapy. For example, if despite group suggestions, the client described above continues to report relapses related to ongoing conflicts with his wife, he might be given referrals for individual or couples therapy.

Another potential relevance issue that can affect compliance relates to the presentation of didactic material. If therapists present new information by reading from a manual, they may give the appearance of being more concerned with following a predetermined protocol than with the needs of their clients. Therefore, when presenting new material, therapists should not read verbatim from a treatment manual but rather should paraphrase the major points in their own words and include illustrative examples derived from what they have learned about their clients' particular problems or needs. In addition, only relatively small amounts of information should be imparted at any one time to prevent overloading the clients. The information should be presented simply, using short sentences and nontechnical language. Therapists should check for client understanding during the course of any presentations they make.

Involve Significant Others

Significant others can provide information and encouragement and can help the client to secure material aid, develop realistic goals, identify and express feelings, find meaning, and develop a sense of belonging.[3] Socially stable problem drinkers are more likely to remain in treatment if their spouses are involved in the sessions.[85,86] Moreover, favorable treatment outcomes are more likely if positive ties existed between spouses before treatment.[82,87]

Inviting spouses or partners to one or two treatment sessions allows the significant other to learn more about the clients' treat-

ment and followup, ask questions, express concerns, and participate in future treatment planning. This involvement may help the significant other become an ally and prevent sabotaging of treatment.[23] Significant others can be encouraged to help motivate the client for change and identify possible obstacles to such change. They can also give the client feedback regarding drinking-related consequences and support their positive efforts.

Depending on the treatment approach, it may also be useful to discuss ways to decrease significant others' enabling behaviors, increase appropriate detachment and Al-Anon attendance, use problem solving during high-risk situations, and enhance communication skills. For some clients, couples counseling may be recommended.

Enlist Other Social Supports

Regardless of whether a spouse or significant other participates in treatment, clients should routinely be encouraged to consider how their friends and possibly other people could support their efforts to maintain sobriety. This may be particularly important for those clients with unsupportive spouses or families. The availability of social supports helps assure treatment compliance, decreases client denial, mitigates against the occurrence of slips, and supports reintegration into treatment when relapses occur.

Clients can be specifically taught how to use AA to develop a social support network and other ways to enhance social supports (e.g., by joining a church or club or by generally engaging in more mutually beneficial relationships). Specific training in interpersonal skills can help clients enhance their social supports by improving their ability to interact effectively with others (e.g., through training in starting conversations, assertiveness, drink refusal skills, and dealing with criticism). Social support research suggests that it is not the number of social contacts per se but rather the quality of the relationships that influences the individual's ability to cope with distress and adhere to treatment.[3]

Clients in group therapy often give one another support, as well as suggestions for maintaining sobriety. Group therapy clients can occasionally call each other between group sessions to obtain additional support, or provide it to a fellow group member who appears particularly distressed. This contact between members outside of the formal group sessions can help maintain their involvement in treatment and is acceptable providing this is agreed upon in formulating the group rules, members discuss this contact during the next group, and subgroups do not form.

Increase Motivation to Change

Eliciting statements that indicate client recognition of an alcohol-related problem and a commitment to deal with the problem may help retain ambivalent clients in treatment. Motivational enhancement therapy was designed around this concept. It is based on elements that appear to be the common and active ingredients in effective brief interventions, and its principles could be applied with other types of therapy.[61] Several specific strategies for implementing this approach have proven helpful:

- Give clients personalized, objective feedback of drinking-related consequences.
- Emphasize that the responsibility for change rests with the client.
- Clearly advise clients to make a change in their drinking.
- Provide a menu of alternative strategies from which a course of action can be selected.
- Employ an empathic rather than a confrontational approach.
- Reinforce clients' self-efficacy to enhance their belief that they can successfully make changes.

Case History: Resistance to Assigned Treatment

This separated female in her early 40s participated in a 12-step treatment. She was encouraged to maintain her sobriety by attending AA meetings; enlisting support from AA members (e.g., obtaining phone numbers and using them when experiencing urges); keeping a journal of experiences with AA, treatment, and sobriety; reading recovery literature; and beginning to work steps 1 through 5 of the AA program.

The client reported no previous alcohol treatment or any drug problems and no significant problems with anxiety or depression. Before starting treatment, she drank about a half pint of vodka, 5 or 6 days per week. She agreed to a treatment goal of abstinence.

The client was hesitant to become involved in the AA program, in part because of her difficulties with its spiritual aspects. The therapist first praised the client when she tried suggestions in the book "Living Sober" and when she wrote in her journal.

The client was then reinforced for successive approximations to AA attendance, since she was anxious about actually sitting in a meeting. Initially, the client was praised for driving to an AA meeting several times, even though she stayed in the car. In later weeks, she was praised for actually sitting in on a meeting. Obstacles to meeting attendance and ways in which other AA members might help her remain sober were repeatedly discussed. The therapist obtained commitments to comply with further meeting attendance. The client reported few slips during treatment.

During the second half of treatment, the client canceled her 7th session because of personal business out of town. She spoke with her therapist and a staff member and was reminded of her treatment end date. Her therapist supported her plan to attend AA meetings at her destination, and it was agreed that the client would call the therapist upon her return. When this did not occur, the therapist mailed her a letter inviting her to reschedule before her treatment end date. However, the client did not call to reschedule.

Although this client withdrew from treatment prematurely despite staff outreach by phone and letter, she did appear to respond to her therapist's praise for completing successively more difficult recovery tasks, despite her initial resistance to the AA approach.

- Use reflective listening, summarizing, and reframing.
- Explore discrepancies between client goals and current problem behaviors.
- Avoid argumentation and direct opposition of client resistance.

Other strategies for enhancing client cooperation and motivation include the use of open-ended questions (e.g., What concerns you about your drinking? How has your drinking changed over time?), periodic questioning about drinking-related problems, and reviewing the pros and cons of changing versus not changing. A decisional balance worksheet (table 2.5) designed for clients examines the benefits and the costs of continuing to drink at pretreatment levels as well as the benefits and costs of changing drinking habits.[88]

Give Feedback

Objective feedback about the negative consequences of drinking that the client is personally experiencing right now is an effective way to clarify the problem and motivate clients to change. This information can come from a variety of sources:

Table 2.5. Decisional balance worksheet

CONTINUING TO DRINK AS BEFORE		MAKING A CHANGE IN MY DRINKING	
Benefits	Costs	Benefits	Costs

- Data obtained from intake assessments (e.g., DRINC questionnaire, Alcohol Use Inventory). A percentile measure can be computed comparing the client's drinking to American adults in general (controlled for gender).

- Estimates of blood alcohol peaks during a typical week of drinking and on a heavy day of drinking, based on their own reports of amounts consumed.

- The results of liver function tests. These can be provided at various times (e.g., pretreatment, midway through treatment, and at followup) to inform clients of how their drinking has affected their bodies.

- The outcome of cognitive assessments.

Following this feedback, ask clients to comment on whether they perceive themselves as having alcohol-related problems and how formal treatment could help deal with these difficulties. The motivation-enhancing effect of this strategy may prepare the client for compliance with a change plan.

Help Clients Set Goals

Engaging clients' active participation in setting goals for change and selecting treatment components is likely to facilitate treatment compliance.[89] One structured process for training clients in goal-setting[90] emphasizes that goals be clearly formulated and described in terms that are measurable so there will be no question as to when they have been met. If goals are framed in terms of abstract concepts or cannot be objectively assessed, it will be impossible to ascertain how successful one has been in achieving them.

Specify the steps required to reach a goal in terms of behaviors that the client is likely to perform, and determine a timeframe within which the various steps are to be completed. If goals entail some risk, clients are more likely to experience a sense of accomplishment if they are successful, but they should not be so risky, unrealistic, or difficult that failure is a certainty.

Individualize Client Goals

In cognitive-behavioral treatment, some treatment contracts outlining the rules for therapy participation include specific behavioral goals identified by the client. Such goals might involve learning to relax, dealing with depression without drinking, changing nighttime routine to improve sleep habits, and developing more friendships.

In some programs, clients also help determine which elective topics are covered after a number of core topics are completed.

For example, some clients choose to focus more on assertiveness and anger management, while others choose to focus on managing negative thoughts or moods and enhancing social support. The topics chosen are influenced by client goals. For example, a client interested in developing more friendships would be exposed to topics such as enhancing social supports and increasing pleasant activities.

Therapists and clients should actively collaborate on establishing goals. A change plan worksheet (table 2.6) helps to identify steps that could be employed outside of the therapy sessions to reach these goals. Clients can keep a copy of this change plan, which also provides a way to assess their progress.

Reassess Goals

Midway through any treatment, reassess goals that were set at the beginning. Clients' perspective or outlook may undergo changes during the course of treatment; certain problems that appeared overwhelming initially may assume more realistic proportions over time. Values may shift, perhaps returning to those that were more prominent before drinking became a serious problem. These changes can be identified and incorporated into the overall goals of treatment.

Some clients who commit to abstinence during the pretreatment phase become ambivalent about it during the course of treatment. Remind clients that the goal of abstinence applies to the treatment period and that later they can decide whether to maintain it. Always remember the importance of nonjudgmentally discussing client ambivalence toward treatment or the goal of making changes. Some clients may need to first agree to reach intermediate goals, to make their task seem less overwhelming.

Focus on Strengths

Emphasize the client's strengths to increase client involvement in goal setting and resource utilization.[91] Ask clients, "What is healthy about you and how can you use your strengths to get what you need?" Help clients identify their strengths (e.g., intelligence, competence, and problem-solving abilities) and ask for their collaboration in setting goals, planning strategies to accomplish them, and identifying supports such as self-help groups, neighbors, and friends that can provide assistance to them in achieving their goals. Act as a consultant to clients and assist them in the processes of identifying their personal strengths; formulating broad goals, specific objectives, and strategies to accomplish them; and developing the behaviors needed to carry out the various aspects of their plan.

Case History: Enhancing Motivation

At pretreatment, this alcohol-dependent, married professional man in his mid 30s reported drinking from a pint to a fifth of vodka 2 or 3 times per week, and noted that his drinking first became problematic when he was a teenager. His drinking led him to receive several charges of driving while intoxicated and contributed to marital difficulties. This was his second outpatient treatment for alcohol problems. He also reported significant problems with anxiety and depression, but denied drug use.

The client participated in all four motivational enhancement therapy sessions. To increase his motivation for change, he received feedback during his first session that he had a high level of negative consequences related to drinking and that he regularly consumed more alcohol than 95 percent of other American males. His Alcohol Use Inventory scores also suggested that, relative to other adults seeking treatment for alcohol problems, he reported significantly more marital problems and a lack of control over drinking. He also was informed that his pretreatment liver function tests were within the normal range, and his brief neuropsychological tests suggested no drinking-induced cognitive impairments. The client received this information well and reported motivation for continued sobriety.

Social support for maintaining positive change was enlisted by having the client's wife attend the next two sessions. During both appointments, the client reported a drinking episode, and the client's ambivalence toward complete sobriety was discussed. The therapist also examined the effects of the client's use of alcohol on his marital relationship, and specific ways for the client and wife to support one another were discussed. The client's ambivalence about making further changes in his drinking also was examined by having the client complete a decisional balance sheet.

A detailed change plan also was developed to help the client further specify behavioral goals, build motivation to achieve these goals, and specify steps needed to achieve them. For example, the client wanted to learn how to better manage his anxiety without alcohol, improve his relationship with his wife, get in better physical shape, and begin to see himself as a nondrinker. He was well able to identify reasons for these changes and elucidated steps he planned to take to make these changes (e.g., reinforce his decision to continue sobriety, seek specific help from family and from professionals). He planned to continue receiving biofeedback treatment to help reduce his anxiety and to take time off from work to get more rest.

During the development of his change plan, the client reported feeling better able to make positive changes and more ready to accept help from others. The client and therapist reviewed specific obstacles that could interfere with his attainment of goals and how he might surmount these obstacles. When the client was asked to identify ways to assess how well his plan was working, he reported that he would have more sober days, be more optimistic, less negative toward himself, and more in control of his anxiety.

To increase the client's commitment, he was given a copy of the change plan, and the therapist asked for a commitment to comply within the next 6 weeks. The therapist was warm, empathic, and nonjudgmental, communicated respect for the client, and expressed some understanding for his ambivalence about change. She also gently and persistently focused on the discrepancies between his behavior and stated goals.

During his last session about 6 weeks later, the client reported another drinking episode, but also reported his longest period of sobriety. His therapist noted that, relative to earlier sessions, he seemed more motivated for positive change and displayed less discrepancy between his behavior and stated goals.

Table 2.6. Change plan worksheet

The changes I want to make are:

The most important reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

Person	Possible ways to help

I will know that my plan is working if:

Some things that could interfere with my plan are:

Source: Miller et al.[61]

Give Assignments

All therapies expect clients to make some efforts to change outside of the sessions. Many provide homework assignments, which present an ongoing compliance challenge throughout the course of treatment. Although the nature of the assignments may vary widely across different types of therapy, nevertheless certain general approaches to the assigning of homework may serve to enhance compliance across various situations. These are summarized in table 2.7.

Table 2.7. Checklist for giving homework assignments

- ☐ Provide a rationale and a clear description of the assignment.
- ☐ Give clients an active role in developing, or selecting aspects of, the assignment.
- ☐ Explore any fears about, or attitudes toward, the assignment.
- ☐ Model and/or practice the assignment during the session.
- ☐ Ask clients to try something once, rather than setting an expectation that they do it "from now on."
- ☐ Encourage clients to make an appointment with themselves to do the assignment and to consider what cues may help remind them to do it.
- ☐ Anticipate what sorts of things might get in the way of completing the assignment.
- ☐ Find out how the clients motivate themselves to do things.
- ☐ Help clients anticipate the possibility of failure and how to react to it.
- ☐ Self-reinforcement techniques:

  Whenever homework is assigned, clients should be asked to indicate how they will reward themselves for completing it. If they have trouble coming up with rewards, suggest that they brainstorm to identify something specific from among these general categories:

hobbies	reading	food/beverages
sports	socializing	shopping
exercise/walking	music/dancing	movies

Provide a Rationale

Compliance is more likely if clients understand how the assigned task will help to address their goals and if they play an active role in developing or selecting the assignment.[92] As a general rule, the temptation to attempt too much too soon should be resisted; assignments should be kept brief and simple at first, only gradually increasing in difficulty and complexity over time.[89,92]

When giving homework assignments, it is crucial that the instructions be clear and include sufficient details regarding what is expected. The assignment should indicate the circumstances under

which it is to be performed, exactly what is to be done, and for how long. However, care must be exercised that while providing enough detail, clarity and simplicity should not be sacrificed, for this too would increase the likelihood of noncompliance. Providing written instructions can help overcome the common tendency to forget the assignment or important aspects of it. The use of videotaped instructions and demonstrations can also be helpful.[93]

Explore Resistance

Explore the clients' fears or attitude toward the assignment and help them anticipate possible roadblocks, negative effects of compliance that could interfere with completing the assignment, or problems that have arisen in similar situations in the past. Consider physical obstacles such as lack of transportation, childcare problems, or insufficient money and interpersonal obstacles such as lack of support or outright negative reactions to the new behavior. Attempt to anticipate these when the assignment is developed with the client, and make plans for coping with potential obstacles or working around them.

Anticipating obstacles will make them seem an expected part of the overall recovery process that requires application of a problem-solving approach, rather than an indication of failure of the treatment or the client. It is helpful if the client can view a problem with an assignment as a natural part of the learning process and not as a sign of total failure and an excuse to abandon efforts to change.

Identify Reminders and Reinforcers

Encourage clients to use cues to remind them of the need to comply with assigned tasks. These might include calendar prompts, written reminders to oneself, strategic placement of critical items, asking others to provide reminders or to participate in the activity, coordinating new activities with established daily routines, and scheduling specific times to practice skills.

Self-reinforcement may enhance the likelihood of compliance with homework exercises and may also increase the likelihood that the new behaviors will continue to be used after treatment has been terminated.[89] The possibilities for self-reinforcement are limited only by the collective ingenuity of the therapist and the clients. When homework is assigned, clients should be helped to plan how they will reward themselves for completing it. If they have trouble coming up with specific rewards, suggest that they identify something from among the general categories listed in table 2.7.

Verbal self-reinforcement may be used in addition to more concrete rewards but should not be the sole consequence of the desired behaviors. As a general strategy, clients should deny

themselves access to the selected reinforcer until the homework is completed and then reward themselves as soon as possible.

Rehearse

Most homework assignments are designed to provide practice of new skills in order to strengthen them so that they will be readily available whenever they are needed. However, practicing skills requires at least a minimal ability to perform them in the first place. Therefore, rehearsal in the therapy session is necessary to assure that the instructions have been understood and that the task can be performed with at least a minimal level of competence.[92] This may involve both modeling by the therapist and active role playing by the client. Rehearsal by the client during sessions also provides opportunities for giving feedback and differential reinforcement of successively closer approximations to the desired behavior.

Monitor and Follow Through

Therapists' checking on homework compliance at each session has been demonstrated to have a salutary effect.[94] This monitoring may take the form of a simple verbal report by the client, ongoing data recording by the client, or observations by significant others. Client involvement in selecting the method of monitoring is also likely to enhance compliance with the assignment. Clients should be praised/reinforced for compliance, initially even for approximations of compliance. If no efforts were made to attempt the assignment, or there was only partial compliance, the reasons for this should be explored in a nonjudgmental, problem-solving manner, and plans formulated for improving compliance with the next assignment. In fact, early dropout from treatment may be more likely if noncompliance is ignored.[95] Table 2.8 provides a checklist of items to cover when reviewing homework compliance.

Obtain Commitments To Comply

Therapists should ask whether the client intends to comply with an assigned activity and obtain a commitment to do so. Clients in outpatient behavior therapy who give a verbal commitment are more likely to comply than those who are merely given the assignment without a request for commitment. Those who sign a form indicating that they will comply have the highest compliance rates of all.[96] If clients are unwilling to make a commitment to comply, explore this unwillingness and problem-solve ways to possibly increase commitment (e.g., through adjusting the assignment). Therapists (and sometimes other clients in a group) also could try to obtain a public commitment from clients who have a record of noncompliance with prior assignments.

Table 2.8. Checklist for reviewing homework assignments

- ☐ Each week ask directly who did and did not complete the previously assigned homework.
- ☐ Reinforce adherence by praising all approximations to compliance.
- ☐ Discuss problems that clients may have had with the homework, but keep the main emphasis on the positive aspects of performance.
- ☐ For those who did not do an assignment, ask "What could you do to ensure that you will be able to complete the next assignment?"
- ☐ Emphasize that adherence to assignments is up to the individual. The therapist only wants to help clients get what they want.
- ☐ Collect written assignments and return them at the next meeting to improve compliance.

Additional issues for research programs:

- ☐ *Keep the discussion of homework compliance within the bounds of the treatment protocol.*

Use Contracts

Many programs make contracts with their clients that cover a variety of issues—attendance, confidentiality, behavior, assignment completion. Signing such a contract signifies a commitment to the therapist, group, or program that encourages the client to comply. Table 2.9 shows a group members' contract that describes expectations such as attendance, confidentiality, and commitment to sobriety during treatment.

This contract encourages the client to attend at least four sessions before withdrawing from treatment and to discuss plans to prematurely leave treatment with staff. One client who had maintained abstinence since treatment onset remained in treatment longer because, when reminded of the contract to which he had agreed, he returned to the group to discuss his plans to leave. The group then persuaded him to continue in treatment longer because of his helpfulness to other members.

Behavioral Contracts

Behavioral contracts during treatment may also enhance adherence to treatment. The negotiations to develop a contract increase clients' involvement in goal setting, provide them with a sense of control over treatment planning, and develop a working collaboration with the therapist(s), factors that are likely to enhance cooperation with treatment. In addition, the contract's specification of agreed-upon target behaviors provides criteria for moni-

Table 2.9. Client contract for group therapy

- ☐ I agree to participate in this group for six months. Although I do retain the right to withdraw, I agree to attend at least the first 4 sessions to give the group a chance. After that, if I want to leave, I will discuss my thoughts with the group before making my final decision.
- ☐ I agree to attend all group meetings and to be on time for them. If something urgent forces me to be late or absent, I will call (phone #) in advance to notify the group leaders.
- ☐ I accept the goal of total abstinence from alcohol and all drugs of abuse. I promise to talk in the group about any drinking or drug use that occurs, and about any cravings or fears of relapse that I experience. I agree to give a breath sample prior to group sessions.
- ☐ I agree that I will not reveal any names or details about the personal lives of fellow group members. Although it is all right to talk in general terms about my experience in the group, I will protect the privacy of other group members.
- ☐ I agree to discuss outside contacts that I may have with other group members. I realize that secrets or cliques among group members can impede the progress of all group members.

For interactional group therapy only:

- ☐ I understand that it is important for my own progress in therapy to talk about my feelings and my reactions to what happens in the group. Doing this will help me better understand my interpersonal relationships and problems.

toring and reinforcing compliance and for assessing client progress.

A written copy of the contract, in the client's hands, can be an effective reminder of exactly what behaviors are required and can help cognitively impaired or impulsive clients to organize and focus their activities. Behavioral contracts should be renegotiated periodically as a means of responding to problems that develop along the way, maintaining clients' sense of continuing involvement in the treatment process, and providing a mechanism for gradually shaping increasing levels of adherence.

Sobriety Contracts

One aspect of substance abuse treatment that lends itself to a contract, either written or verbal, is the issue of client sobriety during treatment. This issue arises most frequently with alcohol and marijuana. Clients who are unwilling or unable to commit to long-term

abstinence can be problematic in abstinence-oriented treatment programs, especially where contact with other clients is likely. One way to deal with this is to ask the client to agree on a certain period of abstinence as a condition of treatment—for the duration of treatment if possible. In some cases, even shorter durations of abstinence may need to be negotiated, in successive steps.

Most clients are willing to agree to some period of abstinence; many of them view it as a demonstration to themselves that they are not hopelessly addicted and can control whether they use or not. If the program is not abstinence oriented, then some acceptable level of use should be agreed upon at which clients can function satisfactorily and safely and are not impaired during treatment sessions.

Contracting for sobriety was employed successfully with a client in abstinence-oriented group therapy who continued to have two or three lapses a week and who did not appear invested in treatment. Based on negotiation with his therapists, the client agreed to strive for one full week of abstinence and to practice the coping skills that he was learning in group. If he complied with these, he would be allowed to continue in treatment. The client met this goal, and his functioning both within and outside of his treatment group improved noticeably. The contract appeared to help him focus his efforts and provided a concrete goal to work for.

Contracts for People With Dual Diagnosis

Similar agreements may be useful in dealing with the problems of clients with dual diagnoses. For example, a client was so depressed that he made no attempt to utilize any of the coping strategies discussed during treatment sessions. Furthermore, he was taking medications that were being prescribed over the phone by a former doctor in a distant state and was not seeing anyone locally about his depression. His primary response to feeling depressed was to sleep, which he would do for most of the day on many occasions.

A treatment contract was negotiated with him specifying that, in order to remain in treatment, he needed to obtain a psychotherapist locally (a number of suggestions were provided) and that he get prescriptions only from a local psychiatrist associated with the selected therapist. For their part, his group cotherapists agreed to work with him in group on more appropriate ways of coping with depression other than sleeping and also on anger management skills.

Be Aware of Safety Issues

The issue of commitment to comply is critical when discussing safety precautions to be taken by a client expressing suicidal ideation. Such a client must be willing to take certain safety

Case History: Alcohol Dependence and Severe Comorbid Psychopathology

A widowed female in her mid 50s sought treatment because of problems related to drinking up to a fifth of wine per day for several months. She reported a long history of drinking and other psychiatric problems, with previous inpatient and outpatient alcohol and psychiatric treatments. She also reported numerous trials with a variety of psychotropic medications. She was seeing a psychiatrist on a monthly basis, which she planned to continue.

During her initial interviews, the staff discussed her participation in treatment and provided her with a timeline sheet that chronologically described her involvement. The staff explained that this particular treatment might differ from her past experiences and described ways in which this kind of treatment might help her.

She seemed to understand the various roles of staff and her responsibilities. She was willing to assume the client obligations during treatment, including the treatment goal of abstinence, the need to attend treatment regularly, and to be honest about any alcohol or drug use. Potential barriers to her participation were reviewed, and most were deemed nonproblematic.

The client required extra time to complete her pretreatment assessments because of the complexity of her psychiatric history. Her interviewers were empathic regarding her difficulties, and she was praised for her patience and cooperative attitude during the assessments. In addition to Alcohol Dependence, she also met diagnostic criteria for Bipolar Disorder, Panic Disorder with Agoraphobia, and Obsessive Compulsive Disorder. Her prescribed medications at pretreatment were Zoloft and Ritalin. Due to the extent and recency of her psychiatric symptoms, she agreed to the recommendation that she see her psychiatrist more frequently than once per month and that she obtain other additional support/therapy if her symptoms significantly worsened.

Because of recent sobriety, she did not require detoxification before treatment assignment. She was given a treatment information handout to help orient her to the treatment, and she denied any negative reactions. She accepted our rules of group attendance and was shown the location of the group room.

Before her first group session, her therapists conducted a role induction interview with her to further prepare her for treatment. The philosophy of the treatment approach was described in more detail, and a group contract specifying expectations regarding attendance, participation in group, maintenance of confidentiality, completion of homework assignments, and commitment to sobriety during treatment was reviewed. It also was explained that desires to leave treatment prematurely should be discussed with the therapists and the group and that she should attend at least four treatment sessions before making a final decision to drop out. She verbalized acceptance of the group contract.

The client's compliance was good in the beginning of treatment. Her breathalyzer readings were all negative and she reported nearly continuous sobriety. She initiated numerous contacts with the staff regarding a variety of concerns, including occasional desires to withdraw from treatment (e.g., because of inadequate time to discuss nondrinking concerns, therapists weren't sufficiently caring, her work schedule was too tiring). Occasionally she called to express ambivalence about attending a particular session because of other tasks she stated were important (e.g., her laundry), but allowed herself to be persuaded to attend (e.g., she was told she would be missed and that staff enjoyed seeing her).

The client kept the staff informed when she noticed increased manic or anxiety symptoms and was able to articulate the kind of support she found most helpful. Phone contacts required patience, limit setting, problem solving, and empathic listening, and she responded well to suggestions. Referral options were discussed to help her better address other issues which became more problematic with sobriety (e.g., overspending, anxiety over family issues, reemergence of traumatic memories). The frequency of her use of additional therapeutic supports continued to be monitored. (continued)

Case History: Alcohol Dependence and Severe Comorbid Psychopathology (continued)

The therapist noted that her cognitive status fluctuated during sessions. At times she appeared confused and disorganized, and the therapists tried to keep her focused when she became tangential. At one point the therapists had her change her seat so she could better concentrate on the new topic displayed on the chalkboard. Concrete behavioral suggestions were made to help her deal with high-risk situations, and weekly contracts were sometimes negotiated to help her follow the suggestions. Enlisting family support was downplayed because it was deemed unhelpful in her case; indeed, she sometimes needed help setting limits on them. Her therapists, who routinely checked for completion of homework assignments at the beginning of each session, praised her for her frequent compliance in this area. Problem solving was initiated when she reported occasional difficulties practicing new coping skills, and she participated in role plays to help reinforce the new skills.

When the client did not come to a session without a prior cancellation, she was telephoned by one of her group therapists the same night. Since her attendance was more sporadic in later months, staff outreach efforts were increased, with reminders regarding the date of her last treatment session, her positive contributions to the group, and the achievement associated with completing the treatment. Her attendance subsequently improved, such that she attended 18 out of 26 sessions, and she received her certificate of treatment completion at her last group session.

measures (e.g., giving a weapon to someone for safekeeping, disposing of a supply of pills) and to allow verification of compliance, such as by checking with a significant other. The client must also express willingness to seek professional help if at some later time the suicidal ideation intensifies or escalates to actual intent, and the therapist must feel confident that the client will comply. If this is not the case, the client may need a formal psychiatric evaluation, or to be taken to an Emergency Room for assessment.

Table 2.10 shows a sample safety contract. If there are repeated episodes in which clients are unable to provide convincing assurances of their willingness to comply with recommended safety measures, it may be necessary to remove them from the study and refer them for more intensive treatment.

Reinforce Compliance

Initially, clients should be reinforced for all approximations to compliance. Shaping of the client's performance can then occur by reinforcing gradually closer approximations to full compliance. Table 2.11 lists several strategies which may be used to reinforce client compliance.

Negative reinforcement involves the withholding or reduction of a desired item or event as a consequence of behavior. It has been used effectively in some instances, although it sometimes leads

Table 2.10. Safety contract

I, ______, deny that I have any intention to harm myself at the present time. If I begin to feel like hurting myself, I agree that I will make no attempt to harm myself and will follow recommendations to remain safe by:

1. Telling my group therapists or other staff (phone #) about any suicidal thoughts.
2. Phoning my outside therapist or psychiatrist (Dr. ______).

During evening hours, weekends, or holidays, I can deal with suicidal thoughts by:

3. Going to a nearby emergency room
4. Calling a crisis intervention line (phone #, phone #)

Signed ______________________________

Date ______________________

the client to focus excessively on avoiding the negative consequences, rather than developing the desired behavior.

Use Incentives

In one program, clients who complete 6 months of weekly group therapy are given a certificate of completion signed by the therapist and staff. This can be a very meaningful token for some clients. Clients' completion of interactional therapy is also commemorated during their last session by cake and beverages brought in by the therapists or group members. In another program, within one week of each appointment attended, a reward

Table 2.11. Potential therapist reinforcers for treatment compliance

☐ Positive reinforcers (for compliance):

- Verbal praise
- An extra therapy session
- Refund of monetary deposit
- Food (snacks, soda)
- Modest prizes (restaurant coupons, movie tickets)
- Tokens or points that can be exchanged for goods or services
- Special privileges within the treatment setting
- Certificate of completion

☐ Negative reinforcers (for noncompliance):

- Reduced session length
- Send monetary deposit to least favorite charity

(e.g., special meal or recreational activity) was provided by the significant other or the client himself.[97]

Recognizing client progress with stars and modest prizes for performing specific behaviors has been effective in increasing clinic attendance rates and reducing illicit drug use among clients in a community-based methadone treatment program. The stars were exchanged for food, gas coupons, or bus tokens.[98] In another program, three severely alcoholic methadone clients significantly decreased alcohol intake and improved clinic attendance when continuation of methadone maintenance was made contingent upon daily disulfiram consumption.[99]

Attendance among dually diagnosed clients in a day treatment program was assessed for successive 4-week periods before, during, and after an incentive intervention. The incentive consisted of modest rewards (e.g., coupons from a local restaurant) offered at the end of each week to all clients who attended the program for at least 5 hours a day, on 3 days per week. The results suggested that modest incentives can enhance attendance.[100]

Incentives have also been shown to improve attendance and outcome when added to outpatient behavioral treatment of cocaine dependence. Some clients earned points, recorded on vouchers, for negative urine specimens. Points were used to purchase retail items in the community, such as YMCA passes, continuing education materials, fishing licenses, gift certificates to local restaurants, and camera and bicycle equipment. Clients in the reward group were significantly more likely to complete the 24 weeks of treatment than clients who could not earn points and were also more likely to remain cocaine-free longer.[101]

Money Deposits

Another strategy to reinforce treatment compliance is to ask clients to submit a money deposit before treatment, which is returned upon completion of treatment. Clients are informed before treatment onset that noncompletion of treatment would result in forfeiture of the deposit to a "least favorite charity." Alternatively, a money deposit obtained before treatment could be returned only after the clients complete all between-session assignments to which they agreed, or a small amount could be returned to the client after each successful completion of an assignment. This contingency should be specified in a written contract.[92] However, use of a money deposit to enhance compliance may be contraindicated for clients with significant financial problems.

Inpatient Incentives

Alcohol treatment conducted in inpatient settings could also improve compliance by employing a contingency management sys-

tem. In one setting, an accumulation of nine specified accomplishments resulted in the acquisition of special privileges. Accumulation of 3 demerits, given for inappropriate behaviors, led to a status reduction that was restored only by completing 10 additional positive behaviors. Improvement in clients' program participation was seen in several areas, with a decrease in resistance to treatment.[102]

Dealing With Absences

Use Reminders

Programs with individual therapy formats allow for some flexibility in scheduling, as the client and therapist can find mutually satisfactory times. They are able to schedule appointments during the early mornings, evenings, and on Saturdays, in addition to regular daytime hours. However, scheduling may be problematic for group therapy clients. This may provide a reason or an excuse for absence.

Letters and telephone calls have been successfully used to remind clients of scheduled appointments. Some programs have given clients a calendar with session dates circled to help them schedule their activities around their treatment appointments.[47] It also helps to have the client identify a visible place to keep the calendar (such as a refrigerator) as a prompt to remember appointments.

Use a Contract

Negotiating an attendance contract has been shown to improve treatment attendance. In one program, after male veterans had completed 28-day inpatient treatment, attendance in aftercare was nearly doubled for those clients who received a calendar prompt and an attendance contract.[97] The calendar prompt consisted of a wall calendar on which eight scheduled appointments over a 6-month period were circled in red. The contract specified that the calendar be posted in a prominent location, that the client attend aftercare, and that he call the alcohol program at least one hour in advance of the scheduled appointment if unable to attend a session. When possible, contracts were negotiated between clients and a significant other, with therapist guidance.

Follow Up

When clients miss a session without canceling it, call them the same day to check on their status. If it is necessary to leave a message and the client does not return the call, follow up with another call to the client a day or two later. Phone calls are generally more effective in retaining clients than letters, because concerns can be dealt with more immediately and directly. This may require calling at odd hours, such as early in the morning or on Sundays, to catch the client at home. If a client is especially

difficult to reach, it may be necessary to contact an identified collateral informant to get word to the client to contact the therapist or other project staff.

If repeated efforts to reach clients by telephone are unsuccessful, and the clients continue to miss sessions, a personalized letter may be sent inviting them to contact the staff and return to treatment by a specified date. Telephone contacts and personalized letters can significantly, and cost effectively, facilitate clients' return to treatment.

The approach to the client in such instances should not be heavy handed, but rather exploratory and combined with offers of assistance. It may turn out that conflicts, such as a work schedule or childcare needs, are preventing attendance. In such instances, initiate efforts at problem-solving with the client. It may be helpful to discuss the relevance of the treatment approach to the client's problems. The approach to such clients should communicate concern and that they are missed. Some clients have returned to treatment when reminded of their positive influence on the group and of their specific end date (e.g., only two or three more sessions to go).

When absences are due to slips, be respectful, empathic, and nonjudgmental and encourage the client to return to treatment in a sober condition to process the experience. Strategies to help address client absences from treatment are listed in table 2.12.

Table 2.12. Dealing with absences

- ☐ Call client soon after the absence (during evenings or weekends, if necessary).
- ☐ If client repeatedly cannot be reached by phone, send a personalized letter asking client to respond by a certain date.
- ☐ If client can be reached, explore reasons for absence.
- ☐ Communicate concern and support. Assist client with problem-solving regarding obstacles to attendance.
- ☐ Suggest relevance of treatment to the client's current problems.
- ☐ Indicate that the client is missed by the group. Inform clients of their positive influence on the group.
- ☐ Remind clients that their involvement in this treatment program is for a limited time.
- ☐ If the absence was due to a slip:
    - — Be empathic, nonjudgmental.
    - — Encourage return to treatment to process the experience.
    - — Identify specific coping skills that could be used to help maintain sobriety until next session.
    - — Recommend involvement of a significant other to enhance support for client.
    - — Recommend additional treatment or AA attendance (if consistent with protocol), as needed.
    - — Maintain phone contact until client returns to group.

Case History: Labile Client

A married female in her early 40s reported drinking at least a pint of vodka up to 4 days per week before seeking treatment. She worked part time and reported numerous financial concerns. Past alcohol treatments included an inpatient detoxification and two extended inpatient stays. She reported alcohol problems for nearly 20 years and had nearly 4½ years of sobriety up to 2 years ago. She also reported numerous marital problems that greatly distressed her, especially her husband's physical abuse. Before seeking treatment, she and her husband were summoned to court for mutual assault charges that occurred while she was drunk.

The client was educated about participation in the study, and potential barriers to participation were reviewed. She completed outpatient detoxification before further assessment and treatment assignment. She appeared to meet diagnoses of Major Depressive Disorder, single episode, and Dysthymic Disorder, as well as possible Borderline Personality Disorder. During her pretreatment assessments, additional treatment referrals for her depression and marital difficulties were discussed, within the limits of her financial constraints. She also signed a suicide contract which further specified possible low-cost treatment options when in crisis (e.g., crisis intervention hotlines, services for battered women). She later followed up on several of these options.

The staff noted her strengths (creativity, artistic talent) during her pretreatment interviews and pointed out how her creativity and ability to express feelings would aid her in group. Staff also suggested how the group would help provide support with her various problems. She seemed to develop a good relationship with the staff, accepted her treatment assignment, and was given a descriptive treatment handout.

She agreed to the group contract that was presented during her induction interview with the therapists. Her attendance in interactional therapy was fairly regular during her first 2 months but became problematic thereafter. Early in treatment, she reported sobriety but expressed discomfort with the group's feedback. She perceived herself to be verbally attacked, and repeatedly felt interrupted and not listened to, even though her therapists had a different impression. For example, sometimes group members felt she spoke too rapidly and dominated the group. When she later tearfully told the group how she felt about their feedback and her thoughts of dropping out, she got some positive feedback and was encouraged to stay. On several occasions, the therapists and staff (during phone contacts) attempted to help her view the troubling group feedback in a broader, more positive context, and to help her see some of the similarities she shared with other group members.

After she missed several groups, it was learned that after nearly 3 months of sobriety, she had a relapse and returned to AA. She reported no further problems with physical abuse. She was invited to return to group the following week, but she resisted because she was now embarrassed. She also was encouraged to contact some of the treatment referrals for her depression that had previously been discussed.

Although she chose to drop out of the interactional group after seven sessions, she did follow through on one of the referrals recommended for treatment of her depression, and at her request, clinical information was faxed to the therapist. Subsequently, she completed all research followup appointments and reported significant improvement, but not total abstinence.

Suggest Referrals

Discuss options with clients who may require referrals for additional treatment (detoxification, partial hospital program, additional therapy for depression, anxiety, or couple's issues). Spouse or family involvement may also be appropriate at this time to provide support and help the client secure additional treatment. To help maintain the client's connection with the program, staff should provide clinical information for outside treatment, and

may even initiate personal contact with clients during their additional treatment.

The use of appropriate flexibility regarding additional, outside treatment may help retain clients in the program. Client involvement in any additional treatment and in self-help groups should be monitored during the treatment period. If the absence from the study treatment is more than a few sessions, staff should periodically phone such clients until they return.

Termination

For individual therapy or closed groups (in which all clients complete treatment at the same time), termination must be anticipated and discussed a number of sessions in advance so that clients' anxiety over it does not lead to noncompliance and other forms of acting out. Clients who report continued problems with drinking, anxiety, depression, relationships, and so forth should be informed about possible referrals for additional treatment to help them deal with these issues in the immediate posttreatment period.

In open groups with rolling admissions, termination is an ongoing process as individual group members approach their completion date. In this case, keep in mind which clients are approaching their final sessions and begin preparing them and the rest of the group for the separation. The continual process of terminating members, as well as the loss of members who drop out prematurely, could be a negative experience for group members. The leaders should help clients identify and manage their reactions. In this way, the experience can be used as a growth opportunity, to learn how to cope appropriately with losses.

Care must be taken to avoid prolonged farewells that would make it difficult for the ongoing group to continue without the departing members. To avoid this, put the emphasis on gains made by the departing member since starting treatment, on recovery tasks that remain to be accomplished, and on strategies for working on them. Continuation of the old group through outside contacts with former group members who have terminated could be destructive to the remaining group and should be discouraged.

Research Note: *At the end of treatment, therapists should remind clients that they will be contacted by research staff to begin the research followup phase. When possible, the research staff should schedule the clients' first followup appointment at the end of their last treatment session. The project coordinator also should remind clients about the followup phase, as well as praise them for their treatment involvement, and elicit their reactions (both positive and negative) to the treatment. In this way, the clients are prepared, at the conclusion of the treatment phase of a clinical research protocol, for compli-*

ance with the continuing research aspects of the study. Clients who did not complete treatment are reminded of the followup phase by letters or phone calls.