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Improving Compliance With Alcoholism Treatment

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Introduction

The goal of this manual is to provide a compendium of strategies for enhancing client compliance to psychosocial treatments, as well as therapist compliance with treatment protocols, in treatment and research programs involving alcohol-using populations. The authors recognize multiple determinants of compliance and emphasize methods of enhancing treatment programs to meet the needs of a variety of clients, thereby improving compliance.

The volume consists of two parts. Part 1 is directed to both clinicians and clinical researchers, with points of particular interest to researchers shown in italics as research notes. In this section, Kabela and Kadden focus on strategies for enhancing client compliance throughout treatment. These are, for the most part, generic client compliance strategies that can be used across a range of treatment types and modules. Particular types of treatment approaches also have specific strategies for enhancing compliance. (Examples of treatment-specific compliance enhancing techniques can also be found in the Project MATCH treatment manuals—Vol. 1–3 of the Project MATCH Monograph Series.)

Part 2 focuses on strategies for enhancing therapist compliance in treatment delivery through the use of treatment manuals and careful supervision of the therapists delivering the intervention. Both are important ingredients in ensuring that the therapies are of high quality, evaluable, and consistent. Thus the concept of "compliance" is equally relevant to the behavior of the therapist and the client. Carroll and Nuro review the development and use of manuals as a clinical tool. By defining exactly what clients and therapists should be complying with, treatment manuals have revolutionized the field of treatment research and made it easier to define and therefore monitor compliance by both clients and therapists. Witte and Wilber draw upon the experience of Project MATCH and provide a range of strategies for promoting therapist compliance with treatment protocols through close therapist supervision.

Many of the strategies described in this manual were used in Project MATCH, a multisite collaborative study sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The primary goal of Project MATCH was the evaluation of client-treatment interaction, that is, whether treatment outcomes can be improved by matching

particular types of clients to particular types of treatments. Because of a number of special considerations regarding matching research, achieving adequate treatment compliance by both clients and therapists was particularly critical. The study also required that treatments be as distinct as possible in order to determine whether different clients will respond to different treatments; that treatments be delivered as described in the protocol and clients be exposed to a sufficient dose of their treatment; and that attrition remain low in order to maintain adequate power to detect matching effects.

Overall, treatment compliance was unusually good in Project MATCH, with clients completing approximately 75 percent of their scheduled treatment sessions (see table). Rates of compliance were fairly consistent across treatments, reflecting, among other factors, the careful efforts of the therapists to deliver high quality therapy that engaged the clients. It is important to recognize, however, that while the investigators emphasized compliance throughout the planning and implementation of Project MATCH, the project was not a study of compliance per se. While the strategies presented here are drawn from experience with Project MATCH and several other clinical trials, comparatively few have been evaluated empirically. Thus, it is not possible to state whether these strategies actually improved compliance, whether the high rates of compliance were related to other factors, or whether other strategies would have produced the same or better results. Moreover, it is not

Treatment compliance in Project MATCH: Session attendance by treatment

	Treatment weeks[1]	# Treatment sessions[2]
Outpatient study		
Cognitive-Behavioral Treatment (n=300)	9.28 (4.02)[3]	8.28 (4.18)
Motivational Enhancement Therapy (n=312)	8.50 (4.24)	3.29 (1.18)
Twelve-Step Facilitation (n=334)	8.30 (4.35)	7.49 (4.08)
Aftercare study		
Cognitive-Behavioral Treatment (n=258)	8.21 (4.62)	8.08 (4.51)
Motivational Enhancement Therapy (n=256)	7.99 (4.66)	3.11 (1.36)
Twelve-Step Facilitation (n=240)	7.81 (4.73)	7.31 (4.56)

1 Range is 0 to 12.
2 Range is 0 to 12 for CBT and TSF, 0 to 4 for MET.
3 Standard deviation in parentheses.

certain which particular strategies may have enhanced or even diminished compliance. Experimental research in this area is needed and would be likely to have broad clinical utility, as strategies that enhance compliance are also likely to enhance outcomes.

We describe these strategies merely as suggestions to clinicians and as ideas for enhancing adherence to particular treatment regimens by therapists in research settings. We believe but do not guarantee that these strategies will actually improve compliance.

Compliance and Alcohol Treatment: An Overview

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One of the few universal problems in the delivery of health care is treatment compliance. Across a wide variety of disorders and treatment regimens, research consistently indicates that a substantial minority, and sometimes a majority, of clients do not adhere to their prescribed regimen (see reviews[1–3]). For example, rates of adherence to pharmacotherapy regimens in general medical practice have been estimated at only 50–55 percent.[4]

A recent meta-analysis of 164 studies evaluating methods of improving patient's keeping medical appointments indicated that the average rate of compliance was 58 percent.[5] Most individuals referred for psychotherapy do not follow through on that recommendation.[6] As many as 50 percent of hypertensive individuals in the United States drop out during the first year of treatment, and of those who remain in treatment, most do not comply adequately with their prescribed medication regimen.[7,8]

Noncompliance raises profound problems from both clinical and research perspectives. Clinically, compliant clients generally have better outcomes than noncompliant clients,[9–12] although this relationship is not uniform and may be quite complex.[13]

Moreover, the strong relationship between compliance and outcome holds even when placebo treatments are being evaluated.[10] This suggests that compliant behavior may tap important beneficial processes other than active ingredients of the treatment itself, such as the instillation of hope, self-efficacy, and enhanced health-promoting behaviors.

Noncompliance leads to need for additional services (clinic visits, hospital admissions, emergency room visits) and for increased provider time, thereby reducing access of other patients to needed services, and

increases health care costs and the risk of complications and even patient death.[5,14,15]

From a research perspective, noncompliance is problematic because it reduces statistical power to detect treatment effects, leads to the need for larger sample sizes, increases sample bias, undermines the internal validity of a study, and is associated with a host of other methodological and statistical concerns.[16–19] In clinical trials, differential compliance across treatments leads to compliance bias,[20] where differences in outcomes between treatments may be due to differences in the level of compliance across treatments rather than effects of the treatments themselves.

Noncompliance and the Treatment of Alcohol Use Disorders

Compliance is a prominent issue in the treatment of alcohol and substance abuse and dependence, where rates of treatment dropout range from 25 to 90 percent.[21–22] That alcohol abuse poses special problems for compliance is illustrated by the frequency with which trials evaluating treatments for disorders other than substance abuse refuse to accept substance users into their protocols in order to improve compliance.[23] Similarly, substance abuse is often cited as a correlate of noncompliance in other populations.[24–28]

Like the broader field of compliance with medical recommendations, compliance with alcohol treatment recommendations usually results in improved outcome. Compliance with psychotherapy (treatment attendance) and pharmacotherapy (medication compliance) has been associated with improved outcome in several studies.[29–32]

Table 1.1 presents rates of one type of noncompliance in alcohol treatment—dropout—defined broadly (and oversimply) here as the proportion of clients who do not complete treatment. The table summarizes attrition rates across several recent uncontrolled studies and randomized clinical trials which include a range of client populations, settings, treatment types, and length of prescribed treatment.

Review of the attrition rates among the uncontrolled studies is for the most part similar to that reported in 1973 by Baekeland and colleagues,[56] where:

- 17.5 percent were immediate dropouts (i.e., failed to return after the first visit).
- 26 percent were rapid dropouts (after 1 to 4 weeks of treatment).
- 30 percent were slow dropouts (leaving between 2 and 5 months of treatment).

Table 1.1. Rates of dropout from alcohol treatment: Selected recent studies

Study	Treatment studied	Sample size	Rates of dropout
Single-site studies			
Allan 1987[33]	Outpatient community	112	64% drop out by 4 weeks 93% by 6 months
Brizer et al. 1990[35]	Outpatient	178	52% drop out before 9 visits
Castaneda et al. 1992[36]	Inpatient & outpatient	109	54% don't follow through on referral
Fink et al. 1984[37]	Extended inpatient	258	41% noncompleters
Huselid et al. 1991[38]	Female halfway house	30	47% drop out
Jones 1985[39]	Residential	34	71% drop out
Leigh et al. 1984[40]	Outpatient	172	72% drop out (15% don't start)
Noel et al. 1987[41]	Outpatient couples	105	35% don't start 22% drop out
Pekarik & Zimmer 1992[42]	5 settings	3240	52.7% average across programs
Rees 1985[43]	Outpatient	117	77% drop out by 6 months
Verinis 1986[44]	Outpatient	121	38% don't start 36% drop out
Randomized clinical trials			
Chick et al. 1988[45]	Advice vs treatment	152	45% of treatment group drop out by 10 appts.
Fuller et al. 1983[30]	Disulfiram	128	78% keep less than 85% of scheduled appointments
Ito et al. 1988[46]	Aftercare psychotherapy	39	25% don't start, 20% drop out at 6 months
Kadden et al. 1989[47]	Aftercare psychotherapy	96	19% drop out after 2 sessions
Kranzler et al. 1994[48]	Outpatient, buspirone	61	18% don't start, 31% drop out by 3 months
Kranzler et al. 1995[49]	Outpatient, fluoxetine	101	22% don't start, 6% drop out by 3 months
Mason et al. 1994[50]	Outpatient, nalmefene	21	76% drop out by 3 months
Murphy et al. 1986[51]	Lifestyle modification	60	20% don't start, 35% drop out by 4 months
Monti et al. 1993[52]	Cue exposure + coping	40	21% drop out by 3 months
Naranjo et al. 1995[53]	Outpatient, citalopram	62	37% noncompleters
O'Farrell et al. 1993[54]	Outpatient couples	59	19% drop out
O'Malley et al. 1992[55]	Naltrexone/ psychotherapy	97	26% don't start 35% drop out
Powell et al. 1986[31]	Outpatient	100	30% drop out by 6 months

- 26.6 percent persisted in treatment longer than 6 months.

Rates of dropout tend to be somewhat lower in the recent randomized trials than the uncontrolled studies, but this may in part reflect inclusion of more select samples in clinical trials, research procedures which may have enhanced retention, or the treatments evaluated. Similarly, rates of alcohol clients' compliance with aspects of treatment other than retention, such as medication compliance, have also been poor in many studies.[57]

High rates of dropout and noncompliance suggest that no matter how effective a treatment is, its success will be constrained by its ability to retain clients. In other words, compliance may be a necessary, but not sufficient, component of treatment effectiveness. Furthermore, available treatments for substance abuse are often considered effective to the extent that they demonstrate the ability to retain clients.[23]

For example, methadone maintenance, despite its drawbacks, is the most successful pharmacologic strategy for opioid dependence, in large part due to its power to retain clients over extended periods. On the other hand, naltrexone, which is an elegant, safe, long-acting, and theoretically perfect antagonist treatment for opioid dependence, is infrequently used and often perceived as ineffective largely because of its historically poor record of retention.[58] Similarly, the combined voucher and CRA approach described by Higgins and colleagues[59–60] has generated a great deal of excitement because several trials evaluating this approach have shown unusually high retention and abstinence rates among cocaine abusers. In part, the failure of many alcohol and drug abuse treatments to retain clients beyond a few weeks has led to increased emphasis on developing and evaluating brief treatments, such as motivational approaches.[61–62] These treatments, which typically involve only a session or two, have been found to have durable effects on alcohol use as well as low rates of attrition.[63–64]

Defining Compliance in Alcohol Treatment

The broad definition of compliance is "the extent to which a person's behavior (in terms of taking medications, following diets, or executing lifestyle changes) coincides with medical or health advice."[65] However, specific definitions of compliance vary with the treatment prescribed and research questions asked in particular studies.

In treatments involving the administration of medications, compliance is usually defined as the person's taking the prescribed dose of medication, at the prescribed schedule, for the prescribed duration of therapy, and also refraining from using other medications or substances that may interact negatively with the medication prescribed. Here, compliance can be measured by a variety of mechanisms, including monitoring medication plasma levels, pill counts, markers introduced

into the medication, MEMS caps and other monitoring devices, client self-reports, and so on.[14,57,66,67]

The bulk of alcohol treatment consists of psychosocial treatments, principally group, family, or individual counseling or therapy, with pharmacotherapies such as disulfiram or naltrexone typically delivered as adjuncts to a primarily psychosocial approach. Thus, compliance is defined and measured differently in psychosocial treatments for alcohol abuse, usually falling into one of two broad categories: retention-related and treatment-specific (table 1.2).

Table 1.2. Indicators of compliance in psychosocial treatments

- Retention-related indicators
  - Number of prescribed sessions attended
  - Number of sessions missed
  - Lateness to sessions
  - Repeated rescheduling of sessions
  - Failure to call to cancel sessions
  - Attending sessions while intoxicated
  - Use of other psychoactive substances
- Treatment-specific indicators
  - Failure to complete homework assignments
  - Incomplete homework assignments
  - Failure to attend AA meetings
  - Involvement in non-study treatments
  - Failure or refusal to bring in spouse or family for family therapy
  - Overt resistance (e.g., silence, hostility)
  - Failure to provide breath/urine/blood samples

Retention-Related Indicators

In psychosocial treatments, the most important indicator of compliance is treatment attendance; that is, whether or not the client attends the sessions prescribed. Retention is particularly important because it is often closely related to outcome in alcohol treatment.[67] In addition, a variety of secondary indicators are related to retention, including lateness to sessions, missed sessions, and rescheduling of sessions.

Treatment-Specific Indicators

Psychosocial treatments for alcohol abuse typically include a number of specific recommendations or tasks for clients, and the degree to which clients adhere to these prescribed activities is another indicator of compliance. Depending on the specific treatment, these might include completion of homework assignments (e.g., practicing a skill taught during therapy), attending self-help meetings or getting a sponsor, practicing skills learned during therapy, or bringing in one's spouse or family members for recommended family meetings.

It is important to note that different indicators of compliance may not converge; for example, high attendance does not always imply that clients have fully complied with treatment. Thus, multiple indicators of compliance may be needed to fully assess compliance and its effects on process and outcome in a clinical trial. Some aspects of treatment compliance, particularly treatment attendance, are frequently monitored and reported on in clinical trials and reports on treatment outcome. However, other aspects of compliance are less frequently evaluated. For example, client compliance with key aspects of therapy, such as homework completion, is rarely monitored.[68]

Client Characteristics Associated With Noncompliance

Traditionally and persistently, the causes of noncompliance and attrition have been conceived as client driven. That is, investigators have focused their efforts on searching for client characteristics associated with poor compliance, such as demographic characteristics, social instability, and low motivation.[33,34,36,39,41,44,56,69–71]

The search for universal client characteristics associated with compliance has met with mixed success, in large part because findings of client characteristics associated with dropout in one treatment setting are frequently not replicated in other settings with differing treatment approaches.[42]

Although there is little consistency across studies and treatment settings in terms of characteristics of clients who comply with or drop out of treatment, there is a good deal of consistency across studies suggesting that the bulk of attrition occurs early, with the majority of dropouts usually occurring during the first month of treatment.[21–72]

Furthermore, in both clinical and research settings, client heterogeneity has often been met with treatment homogeneity. That is, regardless of clients' backgrounds and preferences, the nature or severity of their alcohol abuse and related problems, or the factors that precipitated treatment-seeking, many treatment programs offer only a single type of treatment. With this "one size fits all" model, variations in compliance and outcome have traditionally been ascribed to client factors and characteristics.[73] Thus, clients who are a good "fit" for a given approach are more likely to remain in treatment, and those who are less well suited to the treatment may be more likely to drop out.

Again, in treatment settings that offer only a single approach, it may not make sense to ask clients what they need, desire, or expect out of treatment. If clients want something other than the services the center provides, very often staff can do little to accommodate them. In addition, clients often have only an uncertain idea of what treatment will entail until it begins. Thus, early attrition may reflect self-selection, where clients may find themselves in the wrong treatment setting,

wrong group, with the wrong therapist, or participating in a treatment geared to a stage other than the one they are in. It is thus not surprising that dropouts usually seek treatment again elsewhere.[74]

Treatment as a Partnership

The emphasis on identifying client correlates of noncompliance is shifting, and current efforts to reduce attrition and enhance compliance reflect increasing awareness that compliance is related to a combination of conditions and efforts contributed by therapists, investigators, and research staff, as well as clients.[23,32,75–77] Thus, in this manual, compliance is conceived as a partnership relationship among client, therapist, treatment, and setting. In other words, compliance may have more to do with what investigators and treatment providers do than who their clients are.

Furthermore, the implications of seeking client characteristics associated with noncompliance or dropout are quite different, depending upon whether one sees noncompliance as solely client driven or as the product of a partnership. If seen as client driven, identification of client characteristics associated with dropout or noncompliance could be used to identify a profile of clients who are less likely to continue or have good outcomes in the treatment program. This strategy could be used to direct costly treatment resources primarily to those clients who are most likely to benefit from the program and not 'waste' resources on those who will derive little benefit. However, characteristics usually associated with dropout and noncompliance are frequently those associated with the greatest need for treatment (e.g., low socioeconomic status, more psychiatric impairment, and fewer social supports). Treatment programs using this strategy might thus be faced with the unpleasant prospect of refusing treatment to those who need it most. Moreover, given the inconsistent findings linking client characteristics to outcome and the heterogeneity in alcohol outcomes, some clients, who might in fact do well in the treatment program, could be turned away merely because they have the wrong "profile".

Conversely, if one sees compliance and retention as the product of a partnership, information about client characteristics associated with noncompliance or dropout can, and should, be used to make treatment programs more responsive to the special needs of these clients, broaden the scope of services offered to meet heterogeneous needs of clients, and identify treatment practices or therapists which discourage compliance.

This manual is organized to reflect this latter strategy, which recognizes multiple determinants of compliance and emphasizes methods of enhancing treatment programs to meet the needs of heterogeneous clients, thereby improving compliance.

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). Material in writing

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.

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.

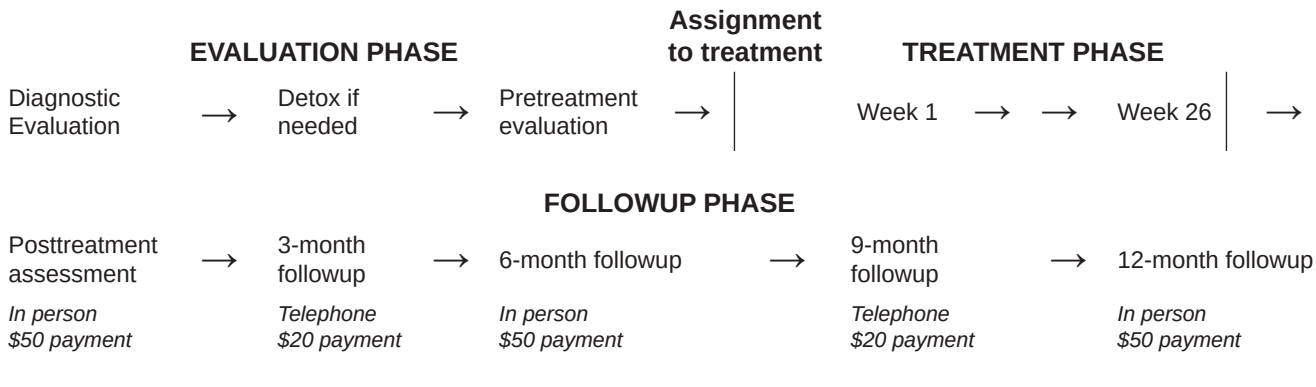
Additional sample items for research programs:

- ☐ *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

Welcome! Your participation in this study is divided into three phases: evaluation, treatment, and followup. The research team will conduct the evaluation and followup phase; the treatment team conducts the treatment phase.



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 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

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.

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 anyone 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' treatment 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.
- 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]

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 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 not appear to respond to her therapist's praise for completing successively more difficult recovery tasks, despite her initial resistance to the AA approach.

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:

- 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.

Table 2.5. Decisional balance worksheet

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

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 al1.[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 monitoring and reinforcing compliance and for assessing client progress.

Table 2.9 Cient 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.

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 Diagnoses

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 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

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.

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

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 _____

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

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

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 system. 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 compliance 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.*

Part 2

Strategies for Enhancing Therapist Compliance

The Use and Development of Treatment Manuals

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Overview

Treatment manuals that specify and discriminate treatments as well as provide guidelines to therapists for their implementation have revolutionized psychotherapy and treatment research.[103,104] Therapy manuals have become a virtual requirement in clinical treatment research in that they define the independent variable.[105] They are becoming increasingly important in clinical practice as changes in the health care system put greater pressure on clinicians to define and evaluate the effectiveness of their services. They also help meet the increasing demands on training programs to evaluate their methods for training therapists for clinical practice.

Psychotherapy manuals also serve many other purposes. These include providing a means for objective comparisons of different psychotherapies, setting standards for training and evaluation of therapists, establishing clear treatment goals and clinical care standards, fostering replication of clinical trials to other settings, facilitating transfer of promising treatments from research to clinical settings, providing a means of linking treatment processes to outcome, and reducing variability in outcome due to therapist effects.[103,104,106–108]

Manuals and Treatment Compliance

A major function of manuals is to define what therapists and clients should and should not do in the course of treatment. Defining and clarifying client expectations is very important in facilitating compliance, and the use of manuals can assure a clear understanding between client and therapist about their respective roles and all aspects of the protocol.

Manuals define the theoretical underpinnings of a treatment, the goals of a treatment, the strategies the therapist uses to reach those goals, and how that treatment is different from other treatments. They also articulate a set of guidelines that steer the therapist through the conduct of that treatment. Thus, manuals define behaviors prescribed and proscribed for both therapist and clients in the course of a treatment.

Manuals also sharpen distinctions between specific and nonspecific aspects of a given therapy. Nonspecific ingredients refer to aspects of treatment that are common across most psychotherapies, including education, support, attention, a convincing rationale, expectations of improvement, the skill of the therapist, and the quality of the therapeutic relationship.[109,110]

Specific components refer to a treatment's active ingredients—those techniques and interventions that are unique to or characterize particular psychotherapies. Examples of specific ingredients include skills training in cognitive-behavioral approaches, transference interpretations in psychoanalytic approaches, eliciting self-motivational statements in motivational approaches, and fostering the client's involvement in Alcoholics Anonymous (AA) in 12-step facilitation.

Therapist Compliance

Therapist compliance can be defined as the degree of adherence to the guidelines specified in a treatment manual. Treatment manuals define standards by which therapist adherence may be monitored along several dimensions.

- *Structural.* The ideal or minimal number, duration, or frequency of sessions. Group, individual, or family format. How topics are introduced and processed. How the session flows.

- *Goals and subgoals*. Is the treatment goal abstinence or reduced drinking? The process by which the client and therapist will reach their goals (e.g., skills training, increased insight, involvement with self-help). Other target symptom and problems that might be addressed by this treatment.

- *Active ingredients*. The characteristic or unique aspects of the treatment through which therapeutic effects are expected to occur. The process through which these active ingredients are expected to affect drinking behavior and other target problems.

- *Treatment boundaries.* The range of topics, interventions, or processes that would be expected to define this treatment. Topics, interventions, or processes that would be proscribed or discouraged in this treatment.

- *Nonspecific aspects.* Nonspecific aspects (e.g., providing education, a supportive relationship) that are important to the outcome of this treatment. How the therapeutic relationship is to be characterized. Aspects this treatment shares with other treatments. How therapists should handle the balance between specific and nonspecific elements of therapy. Whether sessions are primarily didactic or collaborative and how structured they are.

Compliance Versus Competence

There is an important distinction between adherence/compliance, that is, the degree to which the therapist follows the guidelines laid out in the therapy manual, and therapist competence, which refers to the therapist's level of skill in delivering that treatment. Adherence and competence are not necessarily closely related. A therapist can follow a treatment manual word for word and not deliver that treatment competently or skillfully (e.g., with an appropriate level of flexibility and understanding of a particular client, using appropriate timing and language).

In some cases, extremely high adherence (e.g., a wooden, mechanistic, rote repetition of material in the manual) may be indicative of very low competence in a therapist. High compliance and low skillfulness may also occur when a therapist delivers a technique perfectly but at an inappropriate time that is insensitive to the needs of a particular client.

Conversely, cases of high skillfulness and low competence can exist, for example, when a therapist empathetically responds to the client and provides incisive interpretations at the precise moment they are most likely to be helpful, but rarely touches on material described in the manual.

Moreover, a therapist's adherence and competence are not necessarily static entities. For example, adherence may vary across time, where some therapists may start a treatment with high adherence but drift away from following manual guidelines during the course of treatment. Similarly, a therapist's competence may vary across clients, for example, with client difficulty, psychopathology, or the therapist's liking for the client.

Furthermore, competence is not necessarily a generic factor that is uniform across different types of therapies. Instead, competence should be conceived and assessed relative to the specific treatment the therapist is expected to deliver.[111] Although traditional nonspecific aspects of therapy (e.g., empathy, warmth, support) have been assumed to be universal indicators of therapist skillfulness, these nonspecific indicators may not be accurate nor even adequate proxies for skillfulness in all therapies. For example, empathy and warmth may be important

indices of competence in some therapies (e.g., Rogerian) but may be superfluous to others. Therefore, manual developers should lay out guidelines for determining competence that are specific to their type of therapy.

Linkage of Client and Therapist Compliance

Therapist adherence and client compliance are inextricably linked. A client cannot be expected to comply with a given suggestion or intervention unless the therapist complies with the treatment manual by delivering that intervention. Several dimensions of client compliance are linked with treatment integrity and therapist adherence. For example, whether clients comply with an intervention depends entirely on whether the therapist asks them to do it and to a large extent on whether or not the therapist specifies exactly what the assignment or suggestion would entail, asks the clients if they would comply, makes clear how complying with the intervention or suggestion might be helpful, works through possible obstacles and resistances, and follows through by asking the clients whether they did comply.

This implies that complete assessment of client compliance entails a several-step process that emphasizes linkage of client and therapist compliance. First, did the therapist prescribe the client behavior (e.g., ask the client to go to a 12-step meeting, ask the client to record his cravings for alcohol during the next week)? Second, did the therapist prescribe the client behavior adequately and competently (e.g., did the therapist provide a rationale for 12-step meetings or self-monitoring, discuss the steps that would be necessary to locate, select, and go to a meeting or do the self-monitoring, ask the client whether s/he was likely to comply with the prescription, was the prescription appropriately timed for that particular client). Finally, did the client follow through on the prescription? Thus, assessment of client compliance for some aspects of treatment would be predicated on assessment of therapist adherence.

This also suggests that an important strategy to foster client compliance would be clearly specified expectations for client compliance (e.g., number of sessions, policy around missed or canceled sessions, extra-treatment assignments, in-session behavior). Strategies and techniques to address client noncompliance are important as well.

Manual Content

While the specific content of a manual will vary with each treatment and with each population, a number of generic features are common to most manuals. Table 3.1 provides a checklist for domains that should be considered in developing a new treatment or describing a standard one. Not all of them will apply to a given manual, but they should all be considered when attempting to thoroughly define a treatment. The more comprehensive and specific the manual, the easier it will be for

Table 3.1. Treatment manual checklist

- ☐ Overview, description and rationale
  - — General description of approach
  - — Background and rationale for treatment
  - — Theoretical mechanism of action (what makes this treatment work?)
  - — Empirical evidence supporting the effectiveness of this approach
  - — How is the treatment described to the client?
- ☐ Conception of alcohol abuse/dependence
  - — Etiological factors
  - — Factors associated with cessation of use
  - — Agent of change (e.g., client, therapist, group affiliation)
  - — What is the conceptual framework around which cases are formulated and understood?
  - — How are alcohol use and associated problem assessed by the therapist?
- ☐ Goals and goal-setting
  - — Overall treatment goal (abstinence, harm reduction)
  - — Evaluating client goals
  - — Identification of other target behaviors and goals
  - — Negotiation of changes in therapeutic goals and contracts negotiated?
- ☐ Contrast to other treatments for alcohol and related disorders
  - — Approaches which are most similar to this approach
    - • How does this approach differ from similar approaches?
  - — Approaches most dissimilar to this approach
- ☐ Specification of active ingredients, therapist behaviors prescribed and proscribed
  - — What are the specific active ingredients that are unique and essential to this treatment?
  - — What interventions are essential to this treatment but not unique?
  - — What interventions or processes are recommended but not essential or unique?
  - — What interventions or processes are prohibited or not characteristic of this treatment?
  - — What interventions may be harmful or countertherapeutic in the context of this treatment?
- ☐ Client-counselor relationship
  - — What is the ideal therapist role in this treatment (educator, collaborator, teacher, peer, adviser)
  - — How important is the therapeutic relationship to the outcome of the treatment?
  - — Strategies the therapist uses to develop desired relationship
  - — Strategies the therapist uses to address poor or weak therapeutic relationship
- ☐ Format
  - — Variations for individual, group, family, other formats
  - — Variations for different settings: inpatient, outpatient, residential, aftercare, other
  - — Recommended frequency and duration of sessions
  - — Variations for closed and open-ended formats

Table 3.1. Treatment manual checklist (continued)

- ☐ Session format and content
  - — What is the format of a 'typical' session?
  - — How does the session begin and end?
  - — Are there a series of topics or themes to be covered?
  - — Are there required versus elective sessions?
  - — How are session topics or sequences selected?
  - — How structured are the sessions? Is level of structure important to outcome?
    - Who talks more?
    - How directive is the therapist?
    - Is an explicit agenda set? How is the agenda set?
  - — Is the client given extra-session tasks?
    - What is the purpose of these tasks?
    - How are assignments selected?
    - How are assignments given to the client?
    - How does the therapist respond to the client's completion of an assignment? How is it integrated into the work of therapy?
    - How does the therapist respond to the client's failure to complete an assignment?
  - — Session by session content (e.g., Session 1):
    - How does the therapist introduce him/herself?
    - What information does the therapist collect about the client? What does s/he especially listen or probe for?
    - How is the disorder (usually alcohol abuse or dependence) characterized to the patient?
    - How are treatment goals negotiated?
    - How is the treatment strategy introduced to the client?
    - Do the therapist and client agree on a treatment contract? What does it consist of (e.g., number and type of sessions, policy about canceling and lateness, extra-treatment phone calls)?
    - What, if any, extra-session tasks are assigned? What rationale does the therapist provide about extra-session tasks?
  - — Troubleshooting: What problems are usually encountered in the first session? What are some methods the therapist might use to avoid or address these problems in a manner consistent with the general theory of this treatment?
  - — Session 2 – Session N
    - How does the therapist greet the client?
    - How does the therapist assess substance use since the last session?
    - How does the therapist review completion of any extra-session assignment?
    - What is the second session topic and goals? How is it selected? How is it introduced?
      - How is it introduced in the context of the client's current concerns and problems?
      - What are the key ideas to be introduced in the second session?

Table 3.1. Treatment manual checklist (continued)

- — Managing transitions
  - How does the therapist determine the client's readiness to move on to a new stage of therapy?
  - How does the therapist judge the core issues to be covered in the treatment?
  - How does the therapist decide whether to work through or repeat old material or move on?
  - How does the therapist determine the client's readiness for termination? How is termination introduced and discussed?
  - How does the therapist time key interventions or activities to maximize their usefulness to the client?

☐ Compatibility with adjunctive treatments (e.g., pharmacotherapy, family therapy)

- — How are adjunctive treatments integrated and monitored?
- — Role of AA and other self-help groups

☐ Clinical care standards

- — How does the therapist assess substance use that may have occurred since the last session?
- — How does the therapist assess treatment progress?
- — How does the therapist respond to lack of progress or clinical deterioration?
- — How does the therapist assess and respond to expressions or hints of suicidal or homicidal ideation?
- — How does the therapist respond to a contradiction between a client's self-report of alcohol use and a collateral source?

☐ Troubleshooting: Strategies for dealing with common clinical problems

- — Therapist response to lateness
- — Therapist response to missed sessions
- — Strategies for dealing with low motivation
- — Strategies for dealing with recurrent crises
- — Therapist's response to slips and relapses
- — Therapist's response to clients who come to sessions while intoxicated
- — Strategies for clients who appear to understand but don't follow through on agreed upon suggestions
- — Strategies when the client's significant others convey disagreement with goals of therapy or interfere in the client's progress.

☐ Target population

- — Characteristics of individuals who are well-suited for this approach
- — Characteristics of individuals who might be poorly suited for this approach

Table 3.1. Treatment manual checklist (continued)

- ☐ Meeting the needs of special populations. Suggested variations in the treatment for clients who have the following common comorbid problems
  - — Depression
  - — Anxiety and posttraumatic stress disorders
  - — Antisocial personality disorder
  - — Concurrent drug use
  - — Psychotic disorders
  - — Cognitive impairment
  - — Medical problems
  - — Unstable living situations
- ☐ Therapist characteristics and requirements
  - — Training, credentials, and experience required
  - — Therapist recovery status (essential, helpful, irrelevant)
  - — Ideal personal characteristics of counselor
- ☐ Therapist training
  - — Components and goals of training, training materials available
  - — Training cases required
  - — Common problems encountered in training
  - — Standards for determination of therapist competence
  - — Availability of ratings and assessments of therapist competence
- ☐ Supervision
  - — Recommendations of type (group, individual) and intensity of supervision
  - — Common problems involved in training novice therapists to use this approach
  - — Common problems involved in training more experienced therapists to use this approach
  - — Strategies to address therapist drift in treatment delivery
  - — Strategies to help therapists balance adherence and competence
  - — Strategies for supervision sessions; use of videotapes and rating systems

therapists to follow and the less likely a therapist will deviate from the intentions of the program when faced with a clinical situation or problem not specified in the manual.

Treatment Definition

- *Overview and theoretical rationale.* The background or rationale for the treatment, how it works, how and when the therapist explains the treatment to the client. Include empirical evidence that supports the effectiveness of the treatment with the given population.
- *Conception of the disorder.* How the treatment conceives the etiology of alcohol use disorders, the essential steps or processes needed to reduce alcohol use and alcohol-related problems, and the agent of change for this treatment—the client, the therapist, particular treatment processes, group affiliation?

- *Goal setting.* Whether the treatment is abstinence oriented or focuses on the reduction of alcohol use and how this is introduced to the client. How the therapist should respond to a client who does not share the treatment goal; how goals relating to other target behaviors and problems (e.g., psychopathology, marital discord) are defined; and how treatment goals are determined, monitored, and renegotiated as well as how important transitions in the treatment are negotiated.

- *Differentiation from other treatments.* Other types of treatment that are most similar and those that are most dissimilar to this treatment. Exactly how this treatment differs from similar treatments for this disorder. See table 3.2 for a sample chart that highlights differences between the treatments used in Project MATCH.

- *Therapist behaviors prescribed and proscribed.* Specific ingredients that are unique to or characterize this treatment. Interventions or processes required to be delivered to each client. Interventions or processes that are recommended but not unique. Proscribed interventions or processes. Interventions that might be counter-therapeutic to deliver in the context of this treatment. Are there interventions that might have a negative effect on some clients?

Treatment Implementation

- *Client-therapist relationship.* Therapist's role, client's role, optimal client-therapist relationship. Importance of relationship issues relative to other aspects of the therapy and to the outcome of the therapy. Strategies a therapist might use to develop the desired relationship and to address poor or weak therapeutic relationships.

- *Treatment format.* How the treatment is delivered (individual, group, self-guided, family). The recommended length and frequency of sessions, the recommended duration of treatment, and variations of the treatment that would be required for different settings (inpatient, outpatient) or formats (group versus individual).

- *Session format and content.* How typical sessions begin and end, whether a series of topics are to be covered, and how the therapist determines what issues are to be covered in each session. Whether the treatment involves a set of required topics to be delivered and if there are elective topics or sessions. The specific goals or aims of each topic. How the therapist decides which elective sessions are to be delivered to the client. Whether sessions are structured. If clients are given extra-session tasks, how these are introduced and monitored.

- *Adjunctive treatments.* Compatibility with other treatments, such as family therapy or pharmacotherapy. How these are integrated

Table 3.2 Contrasts between Project MATCH therapies

	Twelve-Step Facilitation	Cognitive-Behavioral	Motivational Therapy
Goals of treatment	Encourage person to accept his/her alcoholism and understand it as a progressive fatal disease. Facilitate integration into AA.	Help person master coping behaviors as effective alternatives to alcohol use. Increase self-efficacy.	Maximize the person's motivation and commitment to change his/her drinking.
Therapy approach	Disease oriented.	Cognitive-behavioral.	Motivational.
Agent of change	Treatment Fellowship/Higher Power	Treatment Mastery of skills	Patient
Labeling	Labeling the patient as "alcoholic" is encouraged, as this label provides the framework for treatment. Acceptance of the diagnosis is necessary; it determines a set of symptoms (e.g., lack of control, denial) and the steps required for recovery.	Labeling discouraged; alcohol abuse/dependence is conceived as over-learned behavior that can be broken down into a finite set of discrete problem situations and behaviors.	Labeling is strongly discouraged. Alternative conceptions of alcohol-related problems are accepted and encouraged.
Control	Emphasis on loss of control. The patient cannot control drinking, has the disease of alcoholism and is powerless to control. Patients can control whether they have the next drink, use AA or accept the idea that drinking can be controlled.	Emphasis on self-control. Patients make decisions regarding drinking over which they have control. Patient can learn to understand and better control the decisionmaking process. Patient can exert self-control by choosing alternative behaviors and cognitions.	Emphasis on choice. Patient has full control over the decision to alter drinking.
Responsibility	Patient is not responsible for disease of alcoholism but is responsible for own sobriety, by "working" the 12-step program.	Patient responsible for own behavior. Emphasis on enhancing self-efficacy through skills training.	Patient responsible for own choices. Emphasis on autonomy.
Conception of craving	Because of disease process, patient's body will crave alcohol periodically. First drink will trigger craving: "one drink, a drunk."	Craving as conditioned response. Craving can be coped with and reduced through stimulus control, urge control, etc.	Patient free and capable of developing strategies for dealing with craving on his/her own.
Strategies for addressing ambivalence and motivation	Remember last drunk. Alcoholism is a disease that motivates denial; educate patient about "sinister" aspects of the disease. Current problems attributed to disease.	Positive/negative consequences of decisions to drink or stay abstinent. Instill belief that effective coping will provide alternatives to drinking.	Acknowledge validity of patient's feelings; elicit self-motivational statements. Provide feedback. Empathic listening, primacy of patient's choice. Deploy discrepancy.
Therapist's response to alcohol use	External, uniform approach. Use AA social network (call sponsor, go to meeting). Remember and use slogans.	Individualized approach. Examine antecedents, behaviors and consequences. Develop and use individualized set of coping strategies (challenge cognitions, problem-solve, etc.)	Internal, individualized approach. Review progress, review/evaluate initial plan, renew motivation and commitment. Reevaluate decision and plan based on new information gained from drinking.
	"Do not think you can control the consequences of use."	"You can learn skills to avoid lapses and prevent lapses from becoming relapses."	"It's up to you whether you drink or not."
Coping behaviors	AA fellowship/network constitute a ready-made set of strategies and the one preferred solution.	Individualized set of strategies, generalizable problem-solving approach. Specific training in drink refusal skills, urge control, altering cognitions, emergency planning, social skills, affect management, job seeking skills, etc.	Patient free to develop own coping strategies. Development of strategies encouraged, but these are *not provided* by the therapist. Encourage to use personally effective coping strategies.
Negative cognitions	Generally interpreted as evidence of rationalization and denial (e.g., "stinking thinking").	Identified, examined and challenged; encourage alternative perceptions/cognitions.	Accepted as valid; met with exploration, reflection and feedback.
Phone calls/crises	Refer patient to AA/sponsor. "Use the fellowship."	Encourage patient to implement coping strategies.	Meeting patient's concerns with reflection and elicitation of client's plan of action.
	Two permissible emergency sessions.	Two permissible emergency sessions.	Two permissible emergency sessions.

Source: Donovan et al. 1994.[121] Reprinted with permission from *Journal of Studies on Alcohol, Supplement* No. 12, pp. 138–148, 1994. Copyright by Alcohol Research Documentation, Inc., Rutgers Center of Alcohol Studies, Piscataway, NJ 08855.

into the treatment and monitored. The role of AA or other self-help groups.

- *Clinical care standards.* How, and how often, alcohol and other substance use is monitored (e.g., breathalyzers, urine toxicology screens). How contradictions between client self-reports and collateral sources are discussed with the client. How the therapist responds to a client who is suicidal or homicidal. How the therapist determines the need to refer the client to a more intensive level of care.

- *Troubleshooting.* How the therapist should respond to common clinical problems that arise in the course of alcoholism treatment, e.g., missed sessions, lateness, frequent crises, coming to sessions while intoxicated, other forms of noncompliance. Whether these strategies are largely generic or specific to the type of treatment being delivered.

- *Variations for special populations.* How the treatment is adapted to meet the needs of client types typically encountered in alcohol treatment settings. Variations or changes necessary for clients who may be depressed, antisocial, anxious, cognitively impaired or have posttraumatic stress disorder, few social resources, and so on. Particular client types or characteristics for which this treatment is ill-suited. Limits on the flexibility therapists may use in tailoring the treatment to meet individual client needs.

Therapist Training and Supervision

- *Therapist characteristics and training.* Any training or education required for therapists to conduct this treatment effectively. Procedures used to train therapists to conduct this treatment. Available training materials (e.g., trainers manuals, videotaped examples). Standards that must be met before a therapist is certified to deliver this treatment.

- *Therapist competence.* What determines how well the therapist performs the treatment. The characteristics that would describe a therapist performing this treatment optimally and how this is assessed. The characteristics that would identify a therapist performing this treatment poorly. Relevance of generic therapist skills (e.g., empathy, spontaneity, warmth) to the conduct and outcome of this treatment. Any assessment instruments available for evaluating therapist adherence and competence.

- *Supervision.* Training or education required for supervisors. Level and intensity of supervision recommended or required for therapists delivering this approach. Important aspects of treatment delivery for supervisors to monitor. Any aspects of treatment delivery or

competence that are particularly difficult for novice therapists to master. Common mistakes made by more experienced therapists, and some strategies a supervisor would use to address therapist drift in adherence.

Manual Style

An important general strategy to enhance therapist compliance and adherence with therapy guidelines is to make it easy for therapists to understand and thus to follow the manual. Because a manual is more or less a set of instructions for undertaking a highly complex task, the clearer, more specific, and detailed those instructions, the more likely the treatment as practiced will reflect the manual writer's intentions and the greater consistency across therapists (see table 3.3).

Table 3.3. Therapist-friendly manuals

- ☐ Anticipate common clinical problems
- ☐ Anticipate client heterogeneity
- ☐ Provide troubleshooting guidelines
- ☐ Cover process as well as technique
- ☐ Build in flexibility and clarity
- ☐ Include summaries and outlines
- ☐ Provide guidance around therapeutic choice points

Anticipate Real-World Problems

Manuals should anticipate that some clients will be poorly motivated, ambivalent, psychiatrically unstable, inarticulate, cognitively impaired, involved in abusive relationships (or all of the above) and should provide explicit guidance for addressing these issues. Similarly, if a treatment is contraindicated for a particular client type, the manual should say so explicitly.[107] This is particularly important when a manual might be used by novice or inexperienced therapists.

Manuals are often written around the ideal client, but there are few ideal clients in actual clinical practice. Manuals geared only to such clients are likely to have limited usefulness to therapists. Moreover, while therapist adherence is likely to be high with easy clients, adherence is less likely with more impaired or difficult clients. Therapists may be most likely to drift from manual guidelines with more difficult clients, as they struggle to address complex clinical issues.

Include Troubleshooting Guidelines

Just as there are few ideal clients, few treatments proceed without some snags and difficulties along the way. Therapists are most likely to deviate from manual guidelines and borrow from other approaches when they encounter such clinical problems. Therapist-friendly manuals anticipate and provide guidance for handling common clinical problems encountered in alcohol treatment in a manner consistent with the theoretical background of the treatment.

Issues where specific guidelines are most likely to be helpful include:

- Lateness to sessions
- Missed sessions
- Clients who come to sessions while intoxicated
- Clients whose lives are so consumed by alcohol-related crises that they cannot settle down to do the work of therapy
- Clients with little or no intention of stopping substance use
- Client's whose self-reports of substance use do not match those of collateral sources
- Spouses or significant others who are substance abusers
- Clients who say their sponsors told them not to be compliant with treatment

Manuals should also provide some guidance to the therapist in determining when these problems have eclipsed the benefits the treatment might provide, that is, when it is time to refer the client to another type or more intensive form of treatment.

Cover the Basics

Point out that adherence to the manual should be balanced with clinical judgment. Therapists are frequently anxious about their performance when working with a manual. Although this anxiety usually abates during training and as they become more confident in the treatment and their own experience, the manual itself can attempt to directly confront this apprehension.

No supervisor would encourage a therapist to plunge ahead with difficult therapeutic tasks without first establishing rapport, formulating the case, agreeing on treatment goals, and building a working alliance.

However, few manuals explicitly point out the importance of these more fundamental tasks of treatment as a prerequisite for moving ahead to other, treatment-specific tasks. The central importance of clinical competence and nonspecific elements of therapy should not be ignored when developing treatment manuals.

Thus, a therapist-friendly manual should:

- Stress and articulate definitions of therapist competence (as well as adherence) in the conduct of the specific treatment
- Specify the role of nonspecific aspects of treatment and how they are to be balanced with treatment-specific techniques
- Define the fundamental requirements and indicators of progress that must be present before each new stage or technique is undertaken
- Discuss techniques that therapists might use to address problems in nonspecific aspects of therapy, particularly the therapeutic alliance.

Required Versus Optional Elements

Manuals should have built-in flexibility rather than giving the impression that all interventions are created equal and that they should be delivered frequently or in all sessions. Treatment developers usually expect some interventions to be present in all sessions and some in only selected sessions, as appropriate. Thus, therapist adherence may be facilitated to the degree that there is clarity regarding the essential, key, active ingredients of the therapy that must be delivered and those that are optional or indicated only for specific clients or in particular circumstances.

Specification of which interventions fall into the following categories will make the treatment developers' intentions clearer to the therapists and thus easier to follow:

- Interventions, behaviors, or processes that are unique and essential to that treatment
- Interventions, behaviors, or processes that are essential to the treatment but not unique to it
- Interventions, behaviors, or processes that are acceptable within the therapy but are not essential or unique
- Interventions, behaviors, or processes that are proscribed.[111]

Tailor the Treatment

Specifying the strategies by which the therapist can tailor the treatment to meet the needs of specific clients is important. Examples include the distinction between core versus elective sessions in the Cognitive Behavioral Therapy (CBT) and Twelve-Step Facilitation (TSF) treatments in Project MATCH, and the four problem types of Interpersonal Psychotherapy (IPT).[112]

Manuals should also make clear the range of interventions and therapist styles that are acceptable practice within the confines of the treatment and which interventions or behaviors are proscribed in the therapy. If a commonly used therapeutic intervention is proscribed, then the manual should suggest an alternate intervention.

A clear statement regarding possible negative effects or countertherapeutic interventions is likely to enhance the helpfulness of a manual to therapists.[107] In other words, clarity about what not to do or what might actually hurt the client is a key aspect of treatment definition and is particularly important if a treatment is to be taught to relatively novice therapists.

Summaries and Outlines

Therapists may find it helpful to refer to brief session summaries or outlines to remind them of a few key points to be conveyed. This may be particularly useful in treatments with a more didactic focus, where a number of points are to be covered in a single session. An example of a therapist reminder sheet used in Project MATCH is given in table 3.4. Similarly, treatment outlines to which therapists may refer just before a session may be extremely helpful in cuing them to key elements to convey during the session.

Decision Points

Therapists conducting manual-guided treatments are often faced with a wide array of possible interventions and strategies, with comparatively little guidance about which intervention to select at different phases of treatment. Manuals should define important transition points in therapy (e.g., early to late abstinence, focus solely on alcohol to greater focus on psychiatric symptoms, when to focus on termination-related issues) and provide clear guidance to therapists about moving through them. Decision trees for determining a client's stage in treatment and readiness to move on may also be helpful and may minimize excessive drift at these decision points in clinical practice.

Providing rules of thumb or general strategies the therapist can use to organize complex treatments and maintain appropriate treatment goals is likely to enhance the usefulness of a manual. An excellent example of this approach is the use of the Core Conflictual Relationship Theme method[113] to focus dynamically oriented therapies.

Table 3.4. Twelve-step facilitation checklist

Form ____/____
CRU ____/____
Client ID ____/____/____/____
Therapist ID ____/____/____/____
Date____/____/____/____/____/___
Treatment week (1-12) ____/____
Session number ____/____

PLEASE COMPLETE THE FOLLOWING BASED ON THIS SESSION WITH THE CLIENT— Do not complete if this was an emergency session or if the session was truncated due to client intoxication.

1. Was this a core or elective session?
   1=Core 2 = Elective

2. What session topic was covered this week?

   1 = Introduction
   2 = Step 1 / Acceptance
   3 = Steps 2 & 3 / Surrender
   4 = Getting Active
   5 = Genogram
   6 = Enabling
   7 = People, Places, Things
   8 = HALT
   9 = Steps 4 & 5 / Moral Inventory
   10 = Sober Living
   11 = Conjoint Session 1/Enabling
   12 = Conjoint Session 2/Detaching
   13 = Termination

Approximately how many minutes of this session were devoted primarily to discussion of the manual session topic for this week? ____ ____ minutes

3. Did you check completion of last sessions's recovery tasks?
   1=No 2=Yes 9=N/A none assigned last session

4. How many AA meetings (any type) did the client attend since the last session? ____ ____

5. Did the client make journal entries since the last session? 1=No 2=Yes 9=N/A

6. Did the client read assigned AA literature since the last session? 1=No 2=Yes 9=N/A
   If so, from what source(s)?
   1=Big Book 2=12/12 3=Living Sober 4=Other:_____

7. To what extent did you review the client's REACTIONS TO LAST SESSION'S RECOVERY TASKS (e.g., 12 Step meetings, assigned readings, obtaining a sponsor, using the telephone to contact AA peers, written assignments)?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

8. Did you ASSIGN A RECOVERY TASK for next week?
   1=No 2=Yes. Please describe._____

Table 3.4. Twelve-step facilitation checklist (continued)

9. To what extent did you discuss the client's acceptance of his/her disease, its implications, or its symptoms or discuss the DISEASE CONCEPT OF ALCOHOLISM?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

10. To what extent did you explore the client's DENIAL/resistance (e.g., avoiding meetings, minimizing negative consequences), OR discuss the client's resistance to following 12 Step recovery in terms of his/her denial OR discuss the client's need to surrender?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

11. To what extent did you encourage the client to BECOME ACTIVE (e.g., 12 Step meeting attendance, getting a sponsor) OR plan specific AA-related activities for the week (e.g., speaking or helping at a particular meeting, use of the telephone) OR encourage the client to use AA involvement as a means of coping?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

12. To what extent did you explicitly refer to 12 STEP RECOVERY OR interpret or explain a particular step to the client OR invoke a particular step concept during the session OR discuss the client's progress through the steps?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

13. To what extent did you explicitly invoke the concept of SPIRITUALITY or a HIGHER POWER as a source of strength, hope, and guidance in the client's working a recovery program (e.g., invoking the Serenity Prayer, reference to Steps 2 or 3)?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

14. To what extent did you ASSESS THE CLIENT'S DRINKING since the last session?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

15. To what extent did you discuss or address the client's current COMMITMENT TO ABSTINENCE?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

16. To what extent did you discuss, review, or reformulate the client's GOALS FOR TREATMENT?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

Criticism of Manuals

As influential as treatment manuals have been to both research and clinical practice, they have also been subject to a number of criticisms. Those which are relevant to issues of therapist adherence and compliance are summarized briefly below, while broader issues have been reviewed elsewhere.[114] These are included here to heighten awareness of individuals interested in developing treatment manuals to their common pitfalls and problems and to encourage attempts to address these limitations.

Form Versus Substance

A frequent, and important, criticism of psychotherapy manuals is that they emphasize the form rather than the substance of therapeutic competence.[114–116] That is, manuals emphasize specific techniques over competent delivery of those techniques in the context of a positive therapeutic relationship. Part of this view of manuals arises from the recency of manuals as a methodological development in psychotherapy research. Most of the pioneering manuals written in the 1980s were developed for use in large-scale psychotherapy research studies, which used experienced and closely supervised therapists. Thus, these manuals were designed not to teach basic psychotherapy process skills to novice therapists, but to efficiently convey the specific techniques to be integrated into the repertoire of seasoned clinicians as a means of reducing variability in the treatment variable. However, the more recent proliferation of manuals into clinical practice and their more widespread use in the training of therapists[107,117–119] has led to a greater emphasis on the need to address more fundamental therapist skills in the training process. While there is emerging consensus that adherence can be enhanced through the use of manuals, whether manuals can teach competence is much less clear. For example, a recent study found that although manual-guided training did enhance therapist adherence, it may have led to unanticipated and potentially negative changes in other aspects of therapist interpersonal behavior.[120]

Thus, rather than a complete repudiation of manuals, this criticism should drive home the point that manuals are merely a tool. Manuals were not intended to be substitutes for training and supervision of therapists, nor are they in and of themselves sufficient to train therapists. This highlights that manuals should be used as adjuncts to, but not substitutes for, careful, thorough training and supervision of therapists as well as careful therapist selection. Thus, it is strongly urged that manuals include a section on recommended procedures for training and supervising therapists to use the approach, as well as specification of basic educational and experience requirements for therapists.

Mechanization of Therapy

As discussed above, manualization of a treatment involves defining, specifying, and distinguishing it from other treatments. Thus, a frequent criticism is that manuals emphasize the codification of often

artificial differences between treatments at the price of nonspecific beneficial aspects of therapy, such as spontaneity and flexibility. In other words, the aspects of psychotherapy that are more "art" than "science" are frequently omitted or underemphasized in the process of manualization, which can render manualized treatments as rigid, mechanistic "cookbooks" devoid of reference to important therapeutic processes. Moreover, some of the complex processes of therapy may not be adequately captured in manualized form, and therapies that are less prescriptive or behavioral lend themselves less well to specification in manuals.[104]

In practice, rigidity in manuals is often offset by an emphasis on flexibility and competence in training and supervision. However, manual developers might do well to try to take on the task of building greater flexibility and sophistication into manuals, for example by including detailed case examples, stressing the importance of therapist responsiveness at key therapeutic choice points, and developing videotaped training aids that illustrate therapists exhibiting effective therapeutic versatility while adhering to manual guidelines.

Update Often

It is very useful to develop second-generation manuals that incorporate the clinical wisdom that is accumulated gradually by conducting and supervising therapy in clinical practice but is rarely articulated and reflected in manuals. Psychotherapy manuals, particularly those used in clinical trials, are often constructed quite quickly, often in the first few months of a trial. Thus, they do not reflect the clinical sophistication and richness that is gained during the course of the study, as the treatment is implemented with a wide variety of clients and as omissions in the original manual are identified and filled in.

Supervisors, therapists, and other involved personnel should keep notes that can be used to broaden and enrich subsequent versions of the treatment manual. It should be considered a work in progress rather than a finished product.

A Case Study in Clinical Supervision: Experience From Project MATCH

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This chapter describes the rationale, practice, and outcome of the supervision in Project MATCH, where compliance was a critical component of the research design. The primary and most important aim of the supervision was to ensure the delivery of high-quality, effective treatment services in a professional and ethical manner to all clients. Maintaining the consistency of treatment obviously is vital to making sense of outcomes in psychotherapy research: poor therapist compliance to the treatments being assessed is a major factor contributing to inconclusive results in large clinical trials. Thus, a second primary goal of the supervision was to assure the homogeneity of treatment across time, across settings, and across therapists: to make certain that a given treatment replicated, as closely as possible, the treatments detailed in the manuals, and that it did so for the duration of the research project.

Levels of Supervision

Prior to starting the treatment phase of the research, two levels of supervision were established. Responsibility for on-site clinical and administrative overview was delegated to the site directors, who were responsible for daily details of the project. Typically, site supervisors met weekly for supervision with therapists and were available as needed for urgent clinical and procedural questions.

Each therapist also had a central supervisor, not based at the local site. Having a central supervision team in addition to the site supervisors was a component of the project explicitly designed to ensure compliance with the treatment manuals across sites, and to prevent "drift" either within a site or across sites over time.

This goal was accomplished through several procedural and structural details. Each central supervisor was responsible for only one treatment type, for example, cognitive-behavioral therapy, but was assigned a number of therapists to supervise, from more than one site. Thus, any divergence of practice for that treatment, from either a particular therapist or site, would be immediately evident.

The central supervisors themselves met regularly as a group to discuss common themes or problems emerging in the individual supervision and worked as a team to standardize supervision for the project as a whole. This had the aim of reducing variability in the advice given to therapists, within and across treatment components, and ensuring consistent supervision across all sites for the duration of the project. Whenever a project has a central supervision group, that team should meet regularly to discuss problems in the overall study.

Pilot Phase Therapist Training

Following training, each clinician was assigned at least two training cases and treated these cases following the manuals, under close supervision. During this pilot phase, supervision from both the local site and central supervision team was conducted weekly. Every session was videotaped and reviewed to ensure detailed coverage of techniques and the structure of the entire sequence of each protocol. After two cases were completed to the satisfaction of the site and central supervisors, the clinician could be certified as a study therapist. A small number of clinicians is expected to decline participation at this stage, due to the constraints of manual-guided therapy and the demands of close supervision.

Main Study Supervision Procedures

During the main phase of treatment, individual telephone supervision was conducted every other week between the central supervisors and therapists about specific sessions and general clinical issues related to each case. Procedurally, the centralized supervision involved having the site therapists videotape every session with every client. Of interest to the supervision was the requirement that the camera be directed at the therapist, not at the client. This allowed supervision of the nonverbal aspects of treatment and helped maintain client confidentiality.

Once a given session was recorded, a tape was sent to the central supervision site. The central supervisor viewed approximately one-quarter of

the sessions, taking a sample from the beginning, middle, and end of therapy. The supervisor also rated each tape using several scales—one to assess specific techniques in each treatment manual and others to rate general therapist skillfulness and therapeutic alliance.

These ratings gave the supervisors specific behaviors and techniques that therapists would be expected to demonstrate over the course of treatment sessions, and provided a ground for discussion of technique in supervision, in addition to the manuals. The central team supervisors discussed these ratings frequently to assure consistency in ratings across supervisors and treatment conditions.

A formal reliability check midway through a study in which supervisors rate a sample of tapes from different treatment conditions is recommended to establish levels of interrater reliability and ensure that the ratings are applied similarly across therapists and treatments.

Telephone supervision, based at a central site, entailed benefits to the project, some not immediately apparent at the outset. At a basic level, it afforded the therapists a private discussion focused entirely and purely on therapeutic issues: the central supervisors were unconnected with the local questions of hiring, administration, and evaluation at the sites. This gave the therapists scope to engage freely with the supervisors on clinical questions, with license to admit and correct mistakes, without fear of the effects on performance evaluation. However, giving site supervisors some feedback about the performance of site therapists, whether in the form of a summary of objective ratings or informally, appears necessary to redirect local supervision or review training.

In addition to individual supervision, sites were also given periodic group supervision for each treatment condition, usually via a conference call, on a monthly basis. The purpose of these exchanges was to discuss compliance or treatment issues that had risen for the site in general, and to review the objective feedback provided to the sites by the central supervisors.

Site supervisors participated in the group supervision for each treatment condition, to ensure that important issues were clearly understood between the local and central teams, thus easing potential frictions or miscommunications. For example, supervisors did not initially have an explicit policy for managing clinical deterioration (defined as a client needing a high or more intensive level of care, whether urgently or subacutely). Group supervision provided a forum for free discussion of this problem in a way that addressed the needs and concerns of the clinicians, the research needs of the site supervisors, and the compliance issues of the central supervision team, leading to an explicit policy that had the support of all involved.

The general quality of the treatment was monitored over time as well as compliance with the manuals. If a therapist's performance deviated either from good levels of competence or adherence to the manual, as measured by the central supervisor's ratings, for more than two sessions, that clinician was "redlined" for special attention. These therapists received no new clients, and the frequency of supervision increased from monthly to weekly until performance again returned to a satisfactory level. At times, tapes from other therapists who were more successful at a particular treatment were used to supplement the training of a redlined therapist. If these measures failed to change a therapist's performance, decertification was used to prevent problems for the research or harm to clients.

General Issues in Supervision

Central supervisors attempted to observe a number of basic principles to ensure the effectiveness of supervision (table 4.1). For example, supervisors clearly defined their roles relative to the site directors and within the research program. Given the possibility of confusion, with two types of supervision, central supervisors strove to maintain consistency at basic levels such as regularity of appointments and structure of the supervision, as well as in presenting a consistent approach to supervision. Supervision was presented as a collaborative endeavor, with mutual respect and a positive emphasis on the clinician's strengths, and competence was highlighted whenever feasible.

Table 4.1. Checklist for effective supervision and enhancing therapist compliance in manual-guided therapies

- ☐ Define participants' roles and parameters of supervision.
- ☐ Clarify goals of supervision.
- ☐ Discuss limits of confidentiality in a research project.
- ☐ Clarify the role of measures of therapist performance in treatment research.
- ☐ Keep supervision concrete and structured.
- ☐ Use examples from session videotapes and audiotapes.
- ☐ Refer frequently to the manual.
- ☐ Provide supervision as soon as possible after sessions are conducted, at a consistent time and date.
- ☐ Update therapists with newsletters and memos describing interesting examples, clarification of materials in manuals, and creative strategies for handling clinical problems.
- ☐ Provide effective alternate interventions for proscribed techniques.

A crucial clarification the supervision team addressed early in the project involved the constraints of therapy and supervision in treatment research. The limited goal of research supervision—to enhance therapist compliance with the treatment manuals while providing quality care—was openly stated, in contrast to more typical aims of supervision, such as preparation for licensure, advanced training, and so forth.

As a corollary, the limited parameters of the supervisor relationship within the confines of a research study, and for a limited time period, were explicitly described as well. The limited role of the therapists themselves in conducting time-limited therapy for a circumscribed set of problems was another theme constantly reinforced, particularly given the natural tendency to expand the scope of treatment for those accustomed to open-ended therapy. Together, these reminders tended to keep the supervision tightly focused on the treatments and the clients, and reduced digressions.

All supervision shared a commitment, insofar as possible, to provide specific behavioral feedback ("use this technique here"). In part, this was a reflection of the structure and detail of the treatment manuals themselves, but it also derived from a belief that behavioral feedback was more useful to clinicians and would be likely to increase compliance as well. A review[122] of evaluations of trainees and supervisors noted that trainees rate supervision as better when it is structured and provides clear feedback, the most effective feedback being that which embodies clearly stated objectives.

Increasing structure in supervision through outlines of techniques or other adjunctive material appears to lead to more change in trainees as wel1.[122] Moreover, others[108] have suggested that the use of manuals with explicit techniques can facilitate mastery in trainees, even as rated by clients, in addition to supervisors. Central team supervision generally tried to refer to the treatment manual in every supervision session to emphasize its centrality, especially as the study continued and clinicians assumed that they knew and remembered the manuals perfectly, without checking. This constant return to the manuals served as a check on the tendency of even well-trained and committed therapists to drift over time.

On the other hand, overly strict adherence to the manuals represented a clear problem in supervision, especially with less experienced therapists (table 4.2). For example, some clinicians would become so focused on the suggested topics or interventions in a specific model that client concerns would not be addressed, or material relevant to the client would not be offered. The problem tended to diminish as the therapists became more familiar with the treatment protocols, and viewed them more as "second nature".

Table 4.2. Common problems in therapist compliance with manual-guided therapies

- ☐ Overly strict conformance to the manual
  - — Failure to select interventions appropriate to client
  - — Giving the impression that the manual, rather than the client, determines the course of therapy
- ☐ Failure to adapt treatment to client
  - — Use of inappropriate language or terms
  - — Failure to attend to client concerns
- ☐ Looseness in conforming to the manual
  - — Covering manual material only at end of session
  - — Failure to fully cover core interventions
- ☐ Contamination
  - — Using techniques from other treatments
  - — Using language and terms associated with other treatments

A crucial function of supervision in this respect was to reframe client problems and characteristics within the terms of the respective models of treatment and to search for alternate, appropriate interventions that were congruent with the model. More subtle problems, such as using language and concepts appropriate to the client, were also addressed within the models. Thus, the therapists were gradually led, through supervision, to view the treatment manuals not only as collections of distinct techniques, but as embodying concepts and principles that had the flexibility to meet the needs of each client.

Variants in the clinicians themselves also required changes in supervision. Pertinent individual differences included level of training and experience, level of skill, defensiveness, resistance, and openness to change, to mention only the characteristics most striking to supervisors. Differing skills and experiences led supervisors to alter the content of supervision to best meet the needs of the clinicians. For example, relatively inexperienced or less well-trained therapists clearly required, and wanted, intense work on developing specific skills such as role-playing or relaxation training. More advanced clinicians, who had shown mastery of these skills, were more interested in discussing formulations, or relationship issues. Supervisors attempted to respect these interests by acknowledging competence, but keeping the discussion within the parameters of the particular model. For example, cognitive-behavioral therapy (CBT) supervisors would contain discussions of formulations or transference within the behavioral model, and would discourage examining cases from other theoretical perspectives not in the manual.

Therapists also differed considerably in their defensiveness or resistance to structured feedback, with those who had worked previously in research settings generally being more receptive to direct feedback.

Clearly, having one's performance as a therapist videotaped rendered certain kinds of resistance more difficult, and on a more subtle level, gave therapist and supervisor something concrete to which both could refer in making comments. Using detailed and highly structured manuals as a basis for supervision also appeared to make clinicians less defensive and more receptive to direct feedback, since this structure was an acknowledged fact that limited the scope of clinician judgement and exposure.

The highly structured, time-limited nature of the interventions also served to alter the classical model of supervision. From a psychodynamic perspective, supervision develops in a parallel process to therapy, and an exploration and resolution of relationship issues, such as transference, in the supervision affects the outcome of the therapy as well. The clear structure, and emphasis on concise, immediate behavioral feedback in manual-driven therapy, minimized these issues for supervisors and clinicians alike.

So much was structured and focused, not by the supervisor, but by the research requirements and manuals, that transferential elements had limited scope. Supervisors did not view this as a problem, since the aims of supervision were not to explore these issues, but to ensure therapist compliance. This is not to say that relationship issues were unimportant, but they did not form the central focus of supervision. An objective assessment of the quality of supervision by the study therapists suggested that even in structured, manual-guided therapy, empathy remained an important aspect of effective supervision nonetheless.

Another issue in supervision, more unique to treatment research, concerned the problem of perceived mismatches between the client and the treatment modality. Experienced clinicians in particular often quickly noticed that some clients were not the best fit for a certain therapy; a natural response in this case would be to alter one's treatment to best meet the needs of the client. However, such alterations, if they deviated substantially from the manual and particularly if they overlapped with a comparison condition, would adversely affect treatment integrity. Supervisors thus were faced with the task of reconciling the needs of the clients and the therapist's inclination with the restrictions of treatment-matching research. In part, this problem was addressed by the treatment manuals themselves, which had incorporated some flexibility. For example, the CBT manual offered the clients a choice of topics or issues once the core six sessions were covered; often a client's requests could be accommodated by simply promising to discuss the issue soon, when the essential materials had been reviewed.

In other cases, the supervisors and therapists faced more difficult choices. If, in the judgement of the central and site supervisors, a client's problems could not be addressed with the treatment outlined in the manual, therapists could deviate from the protocol. Even in these instances, supervisors attempted to preserve treatment integrity by

suggesting interventions consistent with the model that underlay the manuals, for example, a 12-step intervention rather than a dynamic or behavioral intervention for a 12-step client. In cases of clinical deterioration, clients were referred immediately to the most appropriate type and level of care. Clinicians choosing not to abide by the manuals were a relatively rare occurrence in this study, and in the opinion of the supervisors, represented less of a threat to treatment integrity than gradual drift.

Treatment-Specific Issues in Supervision

Cognitive-Behavioral Therapy

The cognitive-behavioral treatment manual contained a number of possible interventions and a choice of elective sessions in contrast to the 12-step and motivational enhancement interventions. A frequent problem that emerged in CBT as a consequence was a failure to select appropriate electives and interventions that suited the client's problems. Supervision attempted to address this problem by helping the therapist develop a comprehensive formulation of the client in CBT terms, and an overall treatment plan, rather than simply responding to the client's symptoms in a piecemeal fashion.

Other problems encountered in CBT included neglect of homework assigned to clients and failure to use role plays. These simpler problems tended to diminish over time with reminders and with practice as the therapists became more familiar with the interventions.

Other common mistakes involved the use of incompatible terminology, such as Alcoholics Anonymous phrases or family systems terms, but these were easy to illustrate and correct with videotapes. Future supervision efforts with manual-guided treatments might achieve even greater compliance by addressing pitfalls explicitly during training and the early phases of supervision.

Twelve-Step Facilitation

Although the 12-step facilitation manual was clearly written and easy to follow, several consistent problems with 12-step facilitation therapists had to be addressed early in the process of supervision. A frequent problem with this group of therapists was too much self-disclosure. Approximately one-half of this model's therapists were themselves in recovery, and there was the tendency to slip into personal anecdotes sometimes unrelated to what the client was discussing. While some self-disclosure might be helpful in establishing a positive relationship, as a general rule, self-disclosure can foster further resistance and shift the focus away from the client and should be avoided.

A second problem frequently seen in the 12-step therapists was being too rigid about clients' completion of between-session assignments. Some of the therapists would become anxious and frustrated by non-compliance in the early sessions as they began to introduce the 12-step material, rather than being more facilitative. Directing supervision to the needs of the client rather than the therapist typically was effective in addressing this problem.

Measures of Supervision

To assess the quality and consistency of the supervision itself, researchers might consider using objective measures of supervision effectiveness in treatment outcome studies. A review of current questionnaires in the research literature revealed no available questionnaires that could be adapted to a model of supervision that was based on treatment manuals and videotape.

The Psychotherapy Supervision Questionnaire (table 4.3) is a brief, 32-item survey designed specifically to assess the process of supervision in manual-guided therapy. Several study supervisors devised items, following four dimensions frequently discussed in the literature as important in the supervision process:

- *Level of Comfort* with a supervisor
- *Level of Congruence* between the therapist and supervisor on interventions, goals, and strategies that could be utilized in psychotherapy with particular clients
- *Rapport* (i.e., openness, honesty, and respect)
- Supervision that is *Consistent* with a particular theoretical model.

The scale items were evaluated using standard reliability and validity procedures and then were employed to evaluate supervision in the project.

Table 4.3. Psychotherapy Supervision Questionnaire

Below are a series of statements on the quality of supervision in psychotherapy. Please rate each statement about your psychotherapy supervision by circling a number after each statement indicating the degree to which your supervision reflected that statement. Please base your ratings *only* on the past *90 days* of supervision.

1. My supervisor taught me specific therapy skills or techniques as related to the treatment manual.

Never		Sometimes		Always
1	2	3	4	5

2. My supervisor helped me understand my client's personality and how this affects the treatment process.

Never		Sometimes		Always
1	2	3	4	5

3. My supervisor helped me understand better my feelings, thoughts, and behaviors toward my clients.

Never		Sometimes		Always
1	2	3	4	5

4. My supervisor helped me understand better my clients' style of relating to me as their therapist.

Never		Sometimes		Always
1	2	3	4	5

5. My supervisor helped me understand how my own personal characteristics or behavior helped or hindered my effectiveness as a psychotherapist with a particular client.

Never		Sometimes		Always
1	2	3	4	5

6. My supervisor was overly critical of me.

Never		Sometimes		Always
1	2	3	4	5

7. My supervisor was direct and clear in informing me of my strengths as a therapist.

Never		Sometimes		Always
1	2	3	4	5

8. My supervisor expected me to do most of the problem solving in supervision rather than give me the answers.

Never		Sometimes		Always
1	2	3	4	5

9. During supervision, my supervisor helps me focus on the goals of the treatment sessions as described in the treatment manual.

Never		Sometimes		Always
1	2	3	4	5

10. My supervisor explored my personal background to help me overcome problems I was having.

Never		Sometimes		Always
1	2	3	4	5

Table 4.3. Psychotherapy Supervision Questionnaire (cont.)

11. My supervisor reviewed with me specific selections of the videotapes of my therapy.

Never		Sometimes		Always
1	2	3	4	5

12. My supervisor and I agree on the appropriate treatment plans for my clients.

Never		Sometimes		Always
1	2	3	4	5

13. My supervisor gave me immediate feedback on my cases.

Never		Sometimes		Always
1	2	3	4	5

14. My supervisor expressed reservations about the style in which I interacted with my clients.

Never		Sometimes		Always
1	2	3	4	5

15. My supervisor was open to critical feedback regarding my satisfaction with supervision.

Never		Sometimes		Always
1	2	3	4	5

16. My supervisor was supportive of me when I made mistakes.

Never		Sometimes		Always
1	2	3	4	5

17. My supervisor was direct and clear in informing me of my weaknesses as a therapist.

Never		Sometimes		Always
1	2	3	4	5

18. My supervisor gave me a clear idea of how he or she really regards my work.

Never		Sometimes		Always
1	2	3	4	5

19. My supervisor provided supervision that challenged me to rethink my psychotherapeutic approach.

Never		Sometimes		Always
1	2	3	4	5

20. My supervisor's basic approach to therapy is different from mine.

Never		Sometimes		Always
1	2	3	4	5

21. My supervisor encouraged me to express my thoughts and feelings regarding his/her supervision of me.

Never		Sometimes		Always
1	2	3	4	5

22. My supervisor made me feel anxious when talking with him or her.

Never		Sometimes		Always
1	2	3	4	5

Table 4.3. Psychotherapy Supervision Questionnaire (cont.)

23. My supervisor was honest with me.

Never		Sometimes		Always
1	2	3	4	5

24. My supervisor kept to the plan about content of supervision.

Never		Sometimes		Always
1	2	3	4	5

25. My supervisor and I thought similar about the ways of intervening with clients.

Never		Sometimes		Always
1	2	3	4	5

26. During the process of supervision, my supervisor adhered to the model of therapy presented in the treatment manual.

Never		Sometimes		Always
1	2	3	4	5

27. During the course of the supervision, my supervisor frequently referred back to the treatment manual when explaining a point.

Never		Sometimes		Always
1	2	3	4	5

28. During supervision time, my supervisor and I were able to resolve any differences that arose between the two of us about the client's treatment plan.

Never		Sometimes		Always
1	2	3	4	5

29. My supervisor related to me more as a colleague during our supervision time rather than as someone who had authority over me.

Never		Sometimes		Always
1	2	3	4	5

30. My supervisor gave me suggestions about my cases that were confusing.

Never		Sometimes		Always
1	2	3	4	5

31. Because of my supervisor, I have a better understanding of how my therapy style can become more consistent with the treatment manual.

Never		Sometimes		Always
1	2	3	4	5

32. My supervisor helps me adapt my therapeutic interventions into interventions that fit the treatment manual.

Never		Sometimes		Always
1	2	3	4	5

Relationship Between Supervision and Therapist Compliance

Our final impression of the videotaped model of supervision is that, within particular parameters, this model can be an efficient and effective alternative to the more classical model of sit-down, face-to-face style of supervision, particularly in a large multiple-site psychotherapy study. We confirmed, through our own internal quality assurance survey, that the guidelines we adhered to increased therapist compliance and appeared to reduce resistance to the particular treatments and improved therapist-supervisor congruence during supervision.

We established that compliance-resistance could be managed in four ways: by using the manual, using videotapes, providing immediate feedback on ratings, and developing rapport and empathy in the telephone supervision.

Our final conclusion is that a videotape-based type of supervision can work provided that it is frequent, focused on the manual, and uses the above guidelines to increase compliance and deal with therapist resistance. Supervision delivered in this way may also contribute to client compliance and improvement in retention in psychotherapy studies.

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Appendix
Overview of Project Match

Many of the strategies described in this manual are those used in Project MATCH,[123] an NIAAA-sponsored, multisite collaborative study evaluating patient-treatment matching in alcohol-dependent individuals. As described in detail elsewhere,[124] Project MATCH involved two independent but parallel matching studies, one with clients recruited from outpatient settings (N=954), the other with clients receiving aftercare treatment following inpatient treatment (N=774). Treatment was provided in 10 sites affiliated with 8 clinical research units (5 outpatient, 5 aftercare) to provide geographic as well as client heterogeneity.

Subjects

Inclusion and exclusion criteria were used to define a heterogeneous sample of alcohol patients who were treatable within the limits of weekly outpatient or aftercare therapy, and thus were comparatively broad. Inclusion criteria included:

- Current DSM-III-R diagnosis of alcohol abuse or dependence
- Alcohol as the principal drug of abuse
- Drinking during the 3 months prior to study entry
- Minimum age of 18
- Sixth grade reading level
- Absence of legal or probation/parole requirements that might interfere with participation in the protocol.

Exclusion criteria included:

- Current DSM-III-R diagnosis of sedative, stimulant, cocaine, or opiate dependence
- Intravenous drug use in the past 6 months
- Current danger to self or others
- No clear prospects for residential stability

- Inability to identify at least one locator for assistance in followup tracking
- Severe organic impairment or acute psychosis
- Planned involvement in a more intensive form of treatment for alcohol problems than that provided by MATCH.[123]

Subjects were assessed at baseline and at 3-month intervals after randomization to treatment (i.e., 3, 6, 9, 12, and 15 months).

Forms

Subjects were screened to determine their need for medically supervised detoxification before entering treatment. Those who agreed to outpatient detoxification were required to read and sign a contract (see sample) that spelled out the details of the agreement. All subjects were required to read and sign consent forms (see sample) before participating in treatment.

Treatments

Subjects were randomly assigned to one of three manual-guided psychosocial treatment conditions: Twelve-Step Facilitation (TSF), Cognitive-Behavioral Coping Skills Training (CBT), or Motivational Enhancement Therapy (MET). Treatments were delivered in individual sessions over 12 weeks, with weekly sessions for CBT and TSF. MET consisted of four sessions, occurring during the first, second, sixth, and twelfth weeks.

Treatments were selected on the basis of their meeting several criteria,[124] including:

- Documentation of clinical effectiveness
- Potential for revealing matching effects
- Applicability to the existing treatment system
- Distinctiveness from comparison treatments
- Feasibility of implementation within the constraints of a clinical trial.

Cognitive-Behavioral Therapy

CBT[125] is based on the principles of social learning theory and views drinking behavior as functionally related to major problems in the individual's life. It posits that addressing this broad spectrum of problems will prove more effective than focusing on drinking alone. Emphasis is placed on overcoming skill deficits and increasing the individual's

Sample outpatient detoxification contract

Patient's Name: _____

Physician: _____ Clinical Coordinator: _____

Nurse: _____

I have already agreed to participate in the _____alcoholism treatment program. I understand that I am to be medically detoxified from alcohol on an outpatient basis. I am being treated with _____ for signs and symptoms of withdrawal. I understand that this medication may cause drowsiness and/or impair my ability to operate machinery or a motor vehicle. I also understand that it can be dangerous to drink alcohol while taking this medication.

Some of the following symptoms may occur during the withdrawal process:

shakiness or trembling excessive sweating

extreme nervousness restlessness

Other more serious symptoms of withdrawal are:

recurrent vomiting

diarrhea—more than three loose bowel movements in 24 hours

persistent or severe headaches

any change in: vision, hearing, skin sensations

If you begin to experience any of these symptoms, contact the Program Staff immediately. Dial xxx-xxxx and ask for (nurse). If she is unavailable, call Dr. (Project Coordinator), at yyy-yyyy. If it is after the hours of 8 a.m. to 5 p.m. Monday–Friday, a weekend, or neither of the other two contact people are available, please dial zzz-zzzz and ask the operator to page Dr. (name). If you feel that your medical symptoms need immediate attention, please go to the nearest Emergency Room.

I agree to identify another person _____, phone number _____ who will assist me in monitoring the prescribed medication. Alternatively, I agree to come in for daily appointments for evaluation of withdrawal and medication monitoring, if this is deemed medically necessary. I agree not to ingest any alcohol during detoxification period.

I understand that should my medical condition worsen, I will be asked to seek admission to an inpatient alcohol detoxification facility where my medical status can be monitored more closely and appropriate treatment provided.

I have read and understand the above statements and I agree to abide by them.

Client's Signature_____Date_____

Physician Signature_____Date_____

Sample informed consent form for participation in treatment-matching outpatient study

I, _____, agree to participate as a subject in a research project studying how different people benefit from two different types of outpatient treatment for problems associated with the use of alcohol. I understand that the study will involve treatment consisting of 26 weekly group sessions. Treatment will be based on one of the following approaches: (1) group therapy to foster insight into the way that I relate to other people, or (2) group therapy based on learning new coping skills. Which type of treatment I receive will be decided by the investigators on a random basis, but I understand that I will not be told which method of assignment is being used in my case.

I understand that if detoxification appears necessary I will receive a medical evaluation and may be detoxified on an outpatient basis prior to entry into the study; I will be responsible for the cost of medications for outpatient detoxification. If inpatient detoxification is recommended, the costs for that will be my responsibility. I understand that I will also be responsible for the cost of any medical care recommended by the Project's Medical Director or for the cost of more intensive treatment that would be recommended if my condition worsens in spite of the treatment I receive in this study.

As part of the research evaluation, I will be asked to give samples of my breath and blood for analysis at the beginning of the study. I will also be interviewed and asked to fill out questionnaires concerning many different aspects of my personal history and pattern of alcohol and drug use. This will require a few hours of my time, on two different occasions. In order to be assigned to treatment, I need to be sober during the evaluations.

Each week, before group therapy, I will be given a breath test and sometimes a brief questionnaire. At the end of the study I will be asked to fill out some more questionnaires and be interviewed again. This will take about two hours. Additional followup interviews will be conducted at 3, 6, 9 and 12 months after the end of my treatment. I will also be asked to give samples of blood and urine at some of the followup visits.

I have been told that I will receive compensation for the followup visits according to this schedule:

Interview at the end of treatment $50

Telephone interview 3 months later $20

Interview 6 months after treatment $50

Telephone interview 9 months after treatment.....$20

Interview 12 months after treatment $50

I hereby give my consent for the audiotaping of treatment sessions for the sole purpose of evaluating the treatment I receive.

I understand that a person identified by me (e.g., spouse, child, parent, or other relative or friend) will be asked about my well-being by a member of the evaluation staff. This individual will be called and asked about the presence or absence of any problems with alcohol and about my social adjustment. I understand that the purpose of these contacts will be to have an ongoing assessment of the effects of treatment in my case. I also agree to provide names of several people who will know my whereabouts over the next 18 months so that they may help the research staff to locate me if I change my address without notice. If no one knows my whereabouts, I agree that public information sources, such as motor vehicle records, telephone directories, Social Security Office information, or public access locator services, may be used to locate me. I am providing my Social Security number for later use in locating me, if necessary. I understand that this will be handled in a confidential manner, like all other information I provide.

Risks. We can foresee very few risks that might occur if you decide to participate in the study. The treatment you will receive will not differ much from what you would receive at this clinic if you decide not to participate in the study.

(continued)

Sample informed consent form (continued)

There is minimal risk associated with giving blood samples. Your blood will be drawn by trained technicians. It may hurt slightly or leave a black and blue mark from the needle stick. The amount of blood taken (2 vials) will be that usually required for regular medical laboratory tests.

We will make every effort to ensure your confidentiality. Your name will not appear in any publication or be released to anyone without your written consent. Information provided to the research staff will be kept strictly confidential and will not be shared with the person who provides the treatment to you. Also, the content of the interviews with you will not be revealed to your family, and the content of the interview with your family member or friend will not be revealed to you.

Benefits. Your participation in this study may benefit you in several ways, such as continued abstinence from alcohol and/or other improvements in your life. Another benefit is that the normal fees for the treatment program will be waived. Even if there are not specific benefits for you personally, this study might provide information that can be used to help other subjects in the future.

Subject Obligations. We would like you to tell us about any times you use any alcohol or other psychoactive drugs while in the study. We know that people are not perfect and that stopping alcohol use can be quite hard. In order to be helpful to you, we simply need to know about your alcohol use. The urine and breath tests enable us to be certain of our results. The only ways you might be dismissed from the study is if you repeatedly do not show up, are repeatedly intoxicated at the treatment sessions or at the time of the interviews, and if you are untruthful about your alcohol use. Your, obligation to the study is to do your best to stop using alcohol, to be honest about yourself and your problem, and to be available at the right times for tests and group therapy.

Other Information. One of your therapists or a therapist on call will be available by calling the Project Coordinator, (name), at (phone #), or the Principal Investigator, (name), at (phone #). You are encouraged to call at any time with questions or problems.

You are free to choose not to participate. If you do become a subject you are free to withdraw from this study at any time. If you decline to participate or if you withdraw, it will not adversely affect your relationship with this clinic or the doctors here; a list of alternative treatment providers is available upon request, and, if you wish, the staff will make recommendations to assist you in making your choice from among them.

Please feel free to ask about anything you don't understand. Please consider this research and the consent form carefully before you agree to participate. You may take as much time as necessary to think it over.

I, the undersigned, have understood the above explanation and give consent to my voluntary participation in this research project. I have received a copy of this consent form.

Date: _____ Location: _____

Social Security #: _____

Signature of Subject: _____

Witnessed by: _____

Investigator/Person Obtaining Consent Signature: _____

ability to cope with high-risk situations that commonly precipitate relapse, including both interpersonal difficulties and intrapersonal discomfort, such as anger or depression. The program consists of 12 sessions with the goal of training the individual to use active behavioral or cognitive coping methods to deal with problems, rather than relying on alcohol as a maladaptive coping strategy. The skills also include a means of obtaining social support critical to the maintenance of sobriety.

Twelve-Step Facilitation

TSF[126] is grounded in the concept of alcoholism as a spiritual and medical disease. The content of this intervention is consistent with the 12 Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. In addition to abstinence from alcohol, a major goal of the treatment is to foster the patient's commitment to participation in AA. During the course of the programs' 12 sessions, patients are actively encouraged to attend AA meetings and to maintain journals of their AA attendance and participation. Therapy sessions are highly structured, following a similar format for each week that includes symptoms inquiry, review and reinforcement for AA participation, introduction and explication of the week's theme, and setting goals for AA participation for the next week.

Motivational Enhancement Therapy

MET[61] is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own resources. MET consists of four carefully planned and individualized treatment sessions. The first two sessions focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions at the midpoint and end of treatment provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change.

Therapist Training, Supervision, and Monitoring

Extensive efforts were made to provide Project MATCH treatments at a high and consistent level of integrity and quality through the use of a comparatively elaborate protocol for selecting and training therapists, as well as monitoring their implementation of study treatments throughout the protocol. For example, the following selection criteria were required of MATCH therapist candidates:

- Completion of a master's degree in counseling, psychology, social work or a closely related field, or certification as an alcoholism counselor
- At least 2 years of clinical experience after completion of degree or certification

- Submission of a taped clinical work sample to the Principal Investigator at each clinical research unit and to the Coordinating Center for review

- Commitment to and experience with the MATCH treatment that the therapist would be conducting

- Experience treating alcoholics or a closely related clinical population.

By setting uniform training and experience standards across conditions, while also seeking credible therapists representative of the usual practitioners of the study treatments, these selection criteria were intended to strike a balance between comparability of therapists across treatment conditions and generalizability of findings to the broader field of alcohol treatment.[105]

Training and supervision of Project MATCH therapists was centralized at the Coordinating Center using methods developed in previous large-scale collaborative studies.[127] All therapists attended a training seminar that included:

- Background and rationale for Project MATCH

- Detailed review of the pertinent treatment manual

- Review of taped examples of treatment sessions

- Practice exercises

- Extensive discussion of unique issues related to treating clients in matching studies, particularly consideration of challenges related to treating a heterogeneous patient population while conforming to manual guidelines.

Each therapist was then assigned a minimum of two training cases, which were conducted following the MATCH protocol and supervised by Coordinating Center supervisors in weekly individual sessions, in addition to weekly group supervision that was provided at each of the research units.

After certification, therapist adherence and competence were monitored through several sources during the main phase of the study.

- First:

  — All sessions were videotaped and sent to the Coordinating Center, where one-third of each subject's sessions were reviewed by the Yale-based supervisors.

  — Telephone supervision was provided monthly by the Coordinating Center supervisors and supplemented with weekly onsite supervision at each Clinical Research Unit.

All monitored treatment sessions were rated for therapist skillfulness, adherence to manual guidelines, and delivery of manual-specified active ingredients unique to each approach. These ratings were sent monthly to the Project Coordinators at each site to alert local supervisors of therapist drift. Therapists whose performance deviated in quality or adherence to the manual were "redlined" by the Coordinating Center supervisors. Redlined therapists were not assigned new subjects and the frequency of their supervision was increased from monthly to weekly until the therapist's performance returned to acceptable levels.

- Second:

  — Session tapes were evaluated for therapist adherence and competence by independent raters who were blind to treatment conditions using the MATCH Tape Rating Scale, which assesses therapist behavior of 5 types: CBT techniques, TSF techniques, MET techniques, therapy structure, and nonspecific techniques.

  — Compliance was also monitored by a study-wide treatment-tracking system, which assessed sessions attended (treatment dose) and other aspects of compliance.

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