

CHAPTER 2: The Therapeutic Relationship and Motivational Enhancement

CHAPTER OUTLINE

OVERVIEW

EFFICACY OF PSYCHOSOCIAL THERAPIES

COMMON DETERMINANTS OF TREATMENT OUTCOME

Provider Personal Characteristics

Empathy as the primary characteristic
Empathy as a skill
Empathy and prosocial behavior
Empathy training

The Counselor-Client Relationship

Therapeutic stance
Therapeutic alliance
Reflective acceptance
Enhancing motivation and interest in change
Therapeutic relationship with judicial clients
Therapeutic alliance with the group

The Client as a Person

PROVIDER SKILLS IN INTEGRATING EDUCATION AND THERAPY

The Adult Learning Model

The Psychoeducational Methods and Approaches
Integrating Psychoeducation and Therapy

THE CORRECTIONAL-THERAPEUTIC PARTNERSHIP

Elements of Effective Correctional Counseling Relationship

Anticriminal Versus Procriminal Expressions
Reinforcing Positive Thoughts and Behaviors
Sanctioning Within the Therapeutic Context

Provider and Client Partnership

Interactive Partners With the Correctional System

PROFILE OF THE EFFECTIVE JUDICIAL PROVIDER

The Personal Dimension

The Professional Dimension

Philosophical Perspectives

PROVIDER CULTURAL COMPETENCE: CAPITALIZING ON THE STRENGTHS OF DIVERSITY

CHAPTER REVIEW

CHAPTER OBJECTIVES

- ▶ Provide an understanding of the importance of the therapeutic relationship.
- ▶ Learn the principles of effective judicial counseling and facilitating the correctional-treatment partnership.
- ▶ Learn the dimensions, skills and characteristics of the effective SA judicial client counselor.

OVERVIEW

The focus of this chapter is one of the foundational strategies of *SSC*: Building a therapeutic relationship of trust and rapport with clients through developing a working alliance and the use of motivational enhancement skills. We first look at the efficacy of psychosocial therapies and the common factors that account for much of the variance contributing to positive treatment outcome. We then look at one of the most important of these factors, the therapeutic relationship. Two important components of this relationship are the provider (counselor) and the client. Thus, we identify the characteristics of the effective counselor and the client's contribution to the therapeutic alliance. We then look at one of the critical roles of the counselor and *SSC* provider: integrating the psychoeducation and therapeutic processes. Pertinent to the treatment of substance abusing (SA) judicial clients, we summarize the elements of effective correctional counseling. Finally, we provide a profile that defines three broad dimensions of the primary characteristics of the counselor or provider working with substance abusing judicial clients. The overall purpose of this chapter is to help providers enhance their effectiveness in working with SA judicial clients.

EFFICACY OF PSYCHOSOCIAL THERAPIES

Evidence provided in the literature indicates there is a general positive effect of psychosocial therapies. Meta-analyses of outcome studies conclude "Psychotherapy is effective at helping people achieve their goals and overcome their psychopathologies at a rate that is faster and more substantial than change that results from the client's natural healing process and supportive elements in the environment" (Lambert & Bergin, 1992, p. 363). Roth and Fonagy (2005), in their critical review of psychotherapy research, provide consistent evidence that a variety of psychotherapies across a variety of conditions and applied to a variety of disorders can be effective in producing positive outcomes.

More specific to the focus of this work, the authors (Milkman & Wanberg, 2007; Wanberg & Milkman, 2008) provide a summary of the efficacy of treatment across a wide variety of conditions and spe-

cific groups within the judicial system. We looked at the efficacy of the therapeutic community, CB approaches, aftercare, outcomes related to specific types of offenders, and outcomes related to specific correctional programs. The general conclusion, both in terms of meta-analyses and individual studies, is that there is strong evidence to support the efficacy of correctional treatment in terms of the reduction of relapse and recidivism. Another conclusion in these reports is that the efficacy of correctional treatments is enhanced by the use of cognitive-behavioral therapy approaches (e.g., Andrews & Bonta, 2003; Lipsey & Landenberger, 2006).

In their summary of *What Works*, Roth and Fonagy (2005) report that certain types of therapies are more effective for different types of disorders and psychological problems. For example, there appears to be evidence of the efficacy of cognitive-behavioral approaches for major depression, general anxiety, panic disorders, posttraumatic stress disorders, and dialectical behavior therapy for personality disorders (Roth & Fonagy, 2005). And, as noted, CBT has been found to be more effective than other approaches in reducing recidivism among judicial clients.

Somewhat contrary to conclusions that specific therapies may be more effective with different types of disorders, Lambert and Bergin (1992) argued that across the general application of various theoretical approaches, no one clinical approach seems to be superior over another; and that different therapeutic approaches, e.g., behavioral, psychodynamic, client-centered, "appear to secure comparable outcomes" (Garfield, 1992, p. 349). Differences in outcome between various forms of treatment are simply not as pronounced as might be expected (Lambert & Bergin, 1992) and "other purportedly unique features of a system may be relatively inconsequential" (Strupp & Howard, 1992, p. 313).

This argument is supported by the findings of Project Match (Project Match Research Group, 1997) which compared three treatment approaches administered on a one-to-one basis to those whose history involved only alcohol abuse using large samples of clients conducted within a random clinical trial design: CBT Coping Skills Therapy; Motivational Enhancement Therapy (Brief Therapy); and 12-Step

Facilitation; all delivered over a period of 12 weeks. Although significant and sustained improvements were achieved across all three treatment groups with respect to drinking outcomes, the outcomes did not differ across the three approaches.

First, what is important from the above discussion and our review of the literature summarized in other documents (Milkman & Wanberg, 2007; Wanberg & Milkman, 2008) is that psychosocial therapies are efficacious in bringing about change and positive outcomes in individuals across a variety of psychosocial problems and that CBT appears to offer greater benefits with selected disorders, e.g., criminal conduct and substance abuse. And, Roth and Fonagy (2005) conclude: "Our interpretation of the evidence is that a variety of techniques in the hands of well-trained and supervised practitioners, operating within a structured and controlled framework, are likely to be both safe and effective" (p. 487).

Second, even though there are somewhat diverse findings regarding the contribution of different theoretical orientations and therapeutic approaches, it is concluded that different therapies embody common factors that are curative but not emphasized by the theory of change central to a particular school (Gurman & Messer, 2003; Wampold, 2001). Besides treatment approach and orientation, what are those common factors that contribute to positive outcomes of psychosocial therapies?

COMMON DETERMINANTS OF TREATMENT OUTCOME

The common determinants of treatment outcome that cut across therapeutic approaches and types are: personal characteristics of the provider; the counselor-client relationship; and the characteristics of the client. Each of these three variables and their interaction contribute significant variance to change in the client and to treatment outcome. *Figure 2.1*, page 35, provides a summary of these three broad variables. Each will be discussed.

Provider Personal Characteristics

One common factor that contributes to the effectiveness of psychosocial therapies is a set of core personal

characteristics and features of the treatment provider. Carl Rogers provided the foundation for understanding these core dimensions (1957). He concluded that the communication of **genuine warmth** and **empathy** by the therapist alone is sufficient in producing constructive changes in clients. He was the first to clearly identify in the literature the traits of **warmth, genuineness, respect** and **empathy** as essential in not only establishing a therapeutic relationship with clients, but also in producing the desired therapeutic outcomes.

Early pioneering studies by Truax and Carkuff (Carkuff, 1969, 1971; Carkuff & Truax, 1965; Truax, 1963; Truax & Carkuff, 1967) and others (e.g., Berenson & Carkuff, 1967; Carkuff & Berenson, 1977; Rogers, Gendlan, Kiesler & Truax, 1967; Truax & Mitchell, 1971) supported this conclusion. Lazarus (1971) found that the most desirable characteristics that clients found in counselors were sensitivity, honesty and gentleness. And, in more recent work, Ackerman and Hilsenroth (2001, 2003) confirmed the personal characteristics of empathy, warmth and understanding, and perceived trustworthiness as essential contributions to the therapeutic process.

These core characteristics are invariably seen as part of effective substance abuse counseling. George (1990) identifies the personal characteristics of the effective substance abuse counselor as genuineness, ability to form warm and caring relationships, sensitivity and understanding, sense of humor, having realistic levels of aspirations for client change and self-awareness. The characteristics of empathy, warmth, and genuineness are also seen as necessary characteristics of the correctional counselor (e.g., Andrews & Bonta, 1994, 2003; Masters, 2004).

Thus, although interpreted in different ways, these core characteristics of empathic understanding, genuineness or congruence, positive regard and respect, warmth, and concreteness (specificity of expression) are considered basic to the effective helping relationship. It is safe to say that these characteristics are emphasized in virtually every text on therapy and counseling, including texts addressing counseling of substance abuse and criminal justice clients. They are foundational to the therapeutic change process.

Empathy as the primary characteristic

Rogers (1959) defined empathy as an ability to “perceive the internal frame of reference of another with accuracy and with the emotional components and meaning which pertain thereto as an ability if one were the person, but without ever losing the ‘as if’ condition” (p. 210). It is the ability to enter into another person’s subjective world, to put oneself into the place of the other person.

Rogers’s definition clearly implies that empathy has a cognitive component, e.g., “to perceive.” Feshbach (1997) notes that although empathy refers to an emotional response that stems from the emotional state of another person, “it is contingent on cognitive as well as emotional factors” (p. 36). She concludes that the general consensus is that empathy involves both affective and cognitive elements. Thus, the counselor has both an emotional as well as a cognitive response to the client’s situation or condition.

Rogers et al. (1967) made the bold statement that through the therapist’s warmth and empathy, even the most severely disturbed clients can be helped. What they were saying is that empathy is the **core of the core characteristics** of the effective therapist.

The bulk of the studies of the impact of empathy on treatment outcome were done in the 1960s, 1970s and 1980s. Certainly, the early studies by Rogers, Truax, Carkhuff and associates gave robust support for the efficacy of empathy on the positive outcome of therapy. Bohart and Greenberg (1997) note that since that time, “research on empathy has been sporadic” (p. 15; see pp.17-19 for a summary of studies).

Studies of substance abuse clients not only identify empathy as a significant determinant of their response to treatment, but contributing to the major variance of outcome (Miller & Rollnick, 2002). A series of studies reported that empathy shown by counselors during treatment accounted for two-thirds, one-half, and one-fourth of the variance of drinking outcomes at six months, 12 months and 24 months, respectively (Miller & Rollnick, 2002).

Bohart and Greenberg (1997) note that empathy is

often taken too lightly and is often seen as a kindly and supportive posture in treatment. It is more than this. It is “.....central to therapeutic change and far more than just acknowledging the client’s perspective and being warm and supportive. It is a major component of the healing process.” It “....includes the making of deep and sustained psychological contact with another person” and includes “...deep sustained empathic inquiry or immersing of oneself in the experience of the other” (pp. 4-5). Acknowledging that different writers see different meanings of empathy, they schematize therapeutic empathy as:

- rapport that is kindly, global understanding, being tolerant and accepting of the client’s feelings and frame of reference;
- experience near understanding of the client’s world, and grasping the “whole of the client’s perceived situation”; and
- communicative attunement involving frequent understanding expressions and putting oneself into the client’s shoes and communicating in the moment what the client is experiencing.

Empathy as a skill

Describing empathy as a counselor characteristic does not mean that it is a trait that one has or does not have. Although some individuals seem to have greater ability to show empathy than others, we see it as a learned characteristic.

The fact that empathy has important cognitive elements suggests that it is based on operationally defined skill that can be learned. Some of these learned skills are inherent in its definition. Feshbach, through her broad meaning of empathy, implies that the skills of communication is at the core of learned empathy, as she states: “Empathy is a basic form of social communication that can occur in many different social contexts” (1997, p. 33).

For example, communicative attunement is seen as one of these skills (Bohart & Greenberg, 1997). Other skills that operationally define empathy are: listening, verbal and nonverbal attending, and responding.

Empathy and prosocial behavior

There are two important values regarding empathy and SSC. First, as established in the above discussion, the utilization of empathic communication is essential in establishing a working relationship with SA judicial clients. Second, empathy is the core of prosocial responding and responsibility towards others. Empathy training in the treatment of judicial clients is a given (recognized early on by Ross et al., 1986). Feshbach's (1997) model describes the prosocial aspects of empathy:

- ▶ it allows one to discriminate emotional cues in others; and
- ▶ it involves the more mature cognitive skills that allows others to take the role or perspective of someone (and society).

Others have established the relationship between empathy and prosocial behavior (Eisenberg & Miller, 1987). Bohart and Greenberg (1997) note that "empathy also has motivational properties in that it motivates altruistic and moral behavior" (p. 23).

Feshbach (1997), defining prosocial or moral behavior (she equates the two) as "behavior that reflects caring and concern for others" (p. 45), cites research findings that support the relationship between empathy and prosocial behavior (pp. 45-46).

Other correlates of empathy that have prosocial implications are (studies referenced by Feshbach, p. 48): helping behavior; cooperation; generosity; academic achievement; better adjustment after a social and interpersonal stress experience; and fewer adjustment problems in school. Generally, this suggests that "empathy may function as a coping skill or serve as a protective factor in reactions to stress" (p. 48). This has a bearing on antisocial behavior in that one of the risk factors for relapse and recidivism that we work on in SSC is stress - both emotional and interpersonal.

Empathy training

If one important goal in working with judicial clients is to increase prosocial behavior, then empathy

training should be part of the treatment process. Feshbach's (1997) discussion of empathy development in children concludes these are interactive. Empathy training can increase prosocial behavior. However, "for prosocial behavior to occur when the child is empathic, the prosocial response must be in the child's repertoire and occur in the situation" (p. 47). Thus, this implies that "empathy training must be accompanied by prosocial behavioral-transaction training" (p. 47).

Some of the skills that can be learned and are part of enhancing empathy and prosocial behavior include (Feshbach, 1997, pp. 49-50):

- ▶ role-taking and perspective-taking skills enhanced through the therapy techniques of role-reversal and doubling;
- ▶ perceptual training that focuses on perceptual accuracy and sensitivity;
- ▶ cognitive analysis training, such as analyzing non-verbal behavior, e.g., meaning of facial expressions; and
- ▶ mediation and compromising.

Specific techniques to facilitate the learning of empathy include role-playing, modeling, doubling, role-reversal, affective recognition of emotions using pictures and audio-suppressed video, vicarious problem solving (solving someone else's problems), and communication skills training, e.g., practicing active listening (see *Session 37* in the *Workbook* and in *Section III* of this *Guide* for a summary of these techniques).

The Counselor-Client Relationship

One of the robust predictors of treatment retention and outcome is the relationship between the client and the provider, regardless of the therapeutic orientation or treatment approach (Bachelor, 1991, 1995; Barber et al., 2001; Beutler et al., 1994; Connors et al., 1997; Gaston, 1990; Hartley & Strupp, 1983; Horvath, 2006; Horvath & Symonds, 1991; Krupnick et al., 1996; Martin, Garske & Davis, 2000; Raue & Goldfried, 1994; Raue et al., 1997; Roth & Fonagy, 2005; Zuroff et al., 2000). In fact,

there is “evidence that the therapeutic relationship is the best predictor of success in psychotherapy” (Bohart & Greenberg, 1997, p. 3). And, as Washton and Zweben (2006) note, “The therapeutic relationship is by far the most important ingredient of the integrated approach and, as in all other forms of effective psychotherapy, it is the primary vehicle for facilitating positive change” (p. 74).

Strupp and Howard (1992) state poignantly: “...the research literature has strongly suggested, generic (or common) relationship factors in all forms of psychotherapy (e.g., empathic understanding, respect, caring, genuineness, warmth) carry most of the weight...” (p. 313). “Reviewers are virtually unanimous in their opinion that the therapist-patient relationship is central to therapeutic change” (Lambert & Bergin, 1992, p. 372; also documented in other references cited above).

The elements of the therapist-client relationship are central to verbal therapies that are premised on acceptance, tolerance, therapeutic alliance, working alliance and support (Lambert, 1983). They are also seen as important elements in cognitive and behavioral therapies “as an essential means for establishing the rapport necessary to motivate clients to complete treatment” (Lambert & Bergin, 1992, p. 371). These are also basic elements of developing motivation in the treatment of the substance abuser (Miller & Rollnick, 1991, 2002).

George and Christiani (1981) contend that the essential elements that promote an effective treatment relationship are trust and acceptance of the client. They outline the following specific characteristics of the effective therapeutic and helping relationship.

- The relationship is affective: it explores emotions and feelings.
- It is intense: the relationship promotes an open sharing of perceptions and reactions between client and worker.
- It involves growth and change: it is dynamic, continually changing.
- It is private and confidential.
- It is supportive: the treatment relationship offers

a system of support.

- It is honest: it is based on honest and open and direct communication between the worker and client.

The more specific components or elements of the therapeutic change relationship are best illustrated by the following, as summarized early on by Marmor (1975).

- The relationship promotes a release of tension.
- It involves cognitive learning.
- It involves operant conditioning and reinforcement.
- The client identifies with the counselor.
- It involves reality testing.

Sloane et al. (1975) indicate that successful clients in treatment identify a number of factors important to their change and improvement, several of which are specific relationship factors. These involve the therapist helping them to understand their problems; receiving encouragement to practice facing the issues that bother them; being able to talk to an understanding person; and developing greater understanding from the therapeutic relationship.

There are a number of specific issues that are relevant to understanding and developing the therapeutic relationship. They include: therapeutic stance; the therapeutic alliance; appropriate use of therapeutic confrontation; use of motivational enhancement skills; developing an alliance with judicial clients; and alliance with the group.

Therapeutic stance

The therapeutic stance or position that builds and sustains the therapeutic relationship is based on the core counselor characteristics of: warmth, empathy, genuineness and positive regard (Lambert & Bergin, 1992; Rogers, 1942, 1951, 1957). Judy Beck (2005) sees this stance as involving understanding, caring and competence. Style of relating becomes apparent early in treatment and impacts retention, even in one introductory session. With respect to AOD

clients, Miller and Rollnick (1991, 2002) show that successful therapy is predicated upon counselors presenting the therapeutic posture of accurate empathy, non-possessive warmth, and genuineness.

The therapeutic stance also involves the provider's attitude towards clients. This is of particular importance regarding clients whose problem behaviors are repudiated and looked upon in a negative way by the community and society. Providers will have had strong exposure to these negative attitudes long before entering the helping professions. The two problem behaviors most repudiated by society are criminal conduct and substance abuse. The media reports daily the negative aspects of these problem behaviors, particularly when those behaviors cause harm to others and the community.

Given these exposures to sociocultural negativity, judicial counselors must be aware of their own attitudes and biases towards these problem behaviors. It is easy to inculcate society's negative attitudes around these behaviors and society's expectations that SA judicial clients will inevitably relapse or recidivate.

Providers need to be cognizant of their personal attitudes and beliefs around these problem behaviors, and their counter-transference responses to clients who relapse and recidivate (Imhoff, 1995; Kaufman, 1994; Washton & Zweben, 2006). When considering those judicial populations that are strongly castigated by the public, such as the sex and violent offenders, judicial counselors need to have a clear understanding of their own personal attitudes and posture towards these groups.

Washton and Zweben (2006) stress that negative, strong and judgmental attitudes by counselors can "fracture the therapeutic alliance," causing treatment dropout and failure (p. 207). Judicial providers must always keep in mind the seriousness of relapse and recidivism for judicial clients and for the community. Yet, maintaining the therapeutic posture of showing empathy, genuineness and respect is essential even with the most difficult of judicial clients, and under the most difficult of circumstances when the client relapses or recidivates after a period of positive adjustment.

Therapeutic Alliance

Therapeutic alliance builds on but goes beyond the therapeutic stance. Therapeutic alliance involves a collaborative relationship, affective bonding, rapport building, and a mutual understanding and sharing of the intervention goals between the client and the provider (Bordin, 1979; Connors et al, 1997; Raue, Goldfried & Barkham, 1997). It "acts as a moderating variable - a catalytic mode of action that makes treatment more effective" (Roth & Fonagy, 2005, p. 464). It is seen as the therapist's "most powerful tool" (Washton & Zweben, 2006, p. 167).

The importance - viz. necessity - of rapport in the therapeutic relationship and therapeutic alliance has been a construct established very early in psychosocial therapies (Horvath, 2006). Freud made it clear that treatment should proceed when the therapist has effectively established rapport with the client (1913). Such rapport is established when the therapist shows interest in the psychological condition of the patient but also shows personal concern for the patient (Freud, 1893-1895, p. 265). He notes that the initial phase of treatment will go well when the therapist demonstrates concern and interest and "sympathetic understanding" (Freud, 1913, pp. 139-140) and that a "pact" is established where patient and therapist "band" together to work on the problems presented by the outside world (1964). Roth and Fonagy (2005, p. 461) note that Zetzel (1956) coined the term "therapeutic alliance" which involves deliberate collaboration and a rational agreement between therapist and client.

Connors et al.'s (1997) examination of the therapeutic alliance data gathered in Project MATCH (Project MATCH Research Group, 1993, 1997) revealed a consistent positive relationship between therapeutic alliance and treatment participation and positive drinking-related outcomes, regardless of whether the rating was based on client self-report or on therapist report. This finding was consistent across treatment approaches, modalities and different nosological groupings and clearly indicates the crucial importance of this component in the treatment process.

Although, as noted above, most research confirms that the therapeutic alliance is a common underlying

factor in treatment outcome, there is some evidence that the therapeutic alliance varies across therapeutic orientations. Roth and Fonagy (2005) cite a number of studies to indicate that client-therapist partnership ratings (by clients), overall alliance ratings, and the association between alliance and outcome tended to be higher for CB approaches when compared to other approaches (pp. 469-470). They conclude that this may result from the fact that part and parcel of the CB approach is clear and explicit collaboration between client and therapist (p. 470).

A variety of studies and literature reviews indicate several important conclusions around therapeutic alliance (Bachelor, 1991, 1995; Barber et al., 1999, 2001; Beutler et al., 1994; Castonguay, Constantino & Heltforth, 2006; Connors et al., 1997; Gaston, 1990; Hartley & Strupp, 1983; Horvath, 2006; Krupnick et al., 1996; Martin, Garske & Davis, 2000; Raue & Goldfried, 1994; Raue et al., 1997; Roth & Fonagy, 2005; Zuroff et al., 2000):

- Client ratings of therapeutic alliance are more predictive of outcome than therapist ratings (Barber et al., 2001);
- Therapeutic alliance scores tend to be higher for cognitive-behavioral sessions than for sessions conducted under a psychodynamic-interpersonal orientation;
- The efficacy of therapeutic alliance is found across various therapeutic approaches, modalities and intervention methods;
- Positive therapeutic alliance developed early in treatment predicts positive outcomes.

Judy Beck (2005) notes that the modification of core beliefs is more likely to be successful when clients have trust in the therapist and for the treatment process, particularly when they discover the process helps and that belief change brings better outcomes (p. 269). She also stresses that the therapeutic alliance is a major vehicle through which the goals of treatment can be met and notes three main strategies to accomplish this (pp. 77-85):

- providing positive relationship experiences between therapist and clients;

- working through problems that develop between therapist and clients, and in the case of groups, between an individual client and the group;
- when positive outcomes of the therapeutic relationship model how the client can establish positive relationships with others and how it generalizes to other relationships.

Beck provides five strategies to build the therapeutic alliance (p. 64):

- collaborate with the patient;
- demonstrate empathy, caring, understanding;
- adapt one's therapeutic style;
- alleviate distress; and
- elicit feedback at the end of sessions.

Finally, therapeutic alliance is not a simple variable that operates consistently over time in treatment. After reviewing a number of studies of how alliance is affected by symptom change over time, Roth and Fonagy (2005) conclude "at the very least, it seems appropriate to question the assumption that the alliance represents a homogeneous variable" (p. 468). It is multidimensional and represents complex processes, varies across stages of therapy and that at different points in treatment, it acts in different ways (p. 468). Thus, the provider is wise to monitor the therapeutic alliance over time and in relationship to the stage of change that the individual or group might be in at particular points in treatment.

Reflective acceptance in managing resistance and preserving therapeutic alliance

Developing a positive intervention relationship, building rapport and trust, and developing a therapeutic alliance with the client all depend on how client resistance, defensiveness and ambivalence are managed. This management is of particular importance in the early stages of treatment.

We distinguish reflective therapeutic confrontation from the traditional methods of confrontational therapy and coercive intervention in managing resistance and "denial." The traditional methods

were previously touted as the treatment choice for substance abuse and often resulted in increasing client resistance and defensiveness. Bill Wilson, one of the co-founders of Alcoholics Anonymous, held that intervention works best on the basis of attraction and support. Wilson advocated that alcoholics be treated with an approach that “would contain no basis for contention or argument. Most of us sense that real tolerance of other people’s shortcomings and viewpoints, and a respect for their opinions are attitudes which make us more helpful to others” (Alcoholics Anonymous, 1976, pp. 19-20). These words are of particular relevance to the treatment of judicial clients with substance abuse problems.

According to Miller and Rollnick (1991) research does not support the common belief that people with AOD problems display pathological lying or an abnormal level of self-deception. Nor does self-labeling promote more effective recovery. In fact Sovereign and Miller (1987) found that problem drinkers randomly assigned to confrontational counseling showed a far greater incidence of arguing, denying or changing the topic than those given a more client-oriented motivational intervening approach.

The most effective way to manage client resistance, defensiveness and ambivalence is to **first** encourage the client to share thoughts and feelings of resistance and defensiveness, and **second**, to use reflective-acceptance skills to help clients hear their resistance. These are the two basic steps of the therapeutic change process as described above, and represent the elements of reflective or therapeutic confrontation (Wanberg, 1974, 1983, 1990; Wanberg & Milkman, 1998; Wanberg, Milkman & Timken, 2005).

These are the key components in Miller and Rollnick’s motivational interviewing model (Miller & Rollnick, 1991, 2002). This involves fostering an environment of acceptance for clients to share their thoughts and feelings and then reflecting the client’s specific statements of anger, resistance and ambivalence. Miller’s (Miller & Rollnick, 2002) clinical principles of avoid argumentation, develop discrepancy and roll with resistance underlie the reflective-acceptance approach in dealing with client resistance and defensiveness.

Enhancing Motivation and Interest in Change

Miller states: “Addiction is fundamentally a problem of motivation” (2006a, p. 134). We can say the same for criminal conduct. But motivation cuts both ways. It contributes significantly to the development and maintenance of CC and addiction patterns; it is critical in the change of those patterns.

In the summary of their edited book: *Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It*, Miller and Carroll (2006) include as one of the 10 broad principles of drug use and problems: “Motivation is central to prevention and intention” (p. 296); and the companion recommendation for intervention is that “enhancing motivation for and commitment to change should be an early goal and key component of intervention” (p. 307).

Motivation for change and the therapeutic relationship are interactive. First, there is a great deal of research evidence supporting the efficacy of motivational enhancement as an important component in building the therapist-client relationship and implementing treatment readiness and change in AOD abuse clients (e.g., Miller & Rollnick, 1991, 2002; Project Match Research Group, 1997). On the other hand, a person’s strength of motivation for change is strongly influenced by the client-therapist relationship. Thus, therapeutic alliance increases motivation; and motivation strengthens the therapeutic alliance.

Miller points out that the most critical component of motivational enhancement is focusing on the client’s own verbalizations and expressions of an intrinsic desire, perceived ability, and need and rationality for committing to change (Miller, 2006a). The critical barrier that this component targets is the ambivalence to change. As Miller and Carroll note, “ambivalence is the resting state, the status quo from which instigation to change begins” (p. 147). The critical step in that change is instigation, which happens when individuals see that their current situation is discrepant from their most important goals and values. And, what influences instigation is the confluence of intrapersonal, interpersonal and contextual factors.

As with the erosion process involving the many links in the chain of relapse (Daley & Marlatt, 1992) and recidivism (Wanberg & Milkman, 1998; Wanberg, Milkman & Timken, 2005), there is a process involving many variables that leads to change. Yet, as Miller (2006a) notes, it seems that there is a time “of reaching a decision, making a commitment as a final common pathway to change” (p. 149). And this “instigation” could be: “something clicks.” Or, it could be an insignificant factor that from a linear measurement standpoint has little weight, but the results are geometric as in catastrophe theory (Thom, 1975; see pp. 23-24 in Marlatt & Witkiewitz, 2005; and *Chapter 5* in this *Guide*). Or, there is no identifiable event, not even an “I will change” verbal expression (Miller, 2006a). But what is important, for many substance abuse and judicial clients - it does happen, change does occur.

Research has identified some methods and approaches that are not effective in enhancing motivation to change. These include: punishment; confrontation with the intent to elicit fear, shame, guilt or humiliation; pure education programs that are designed **only** to enlighten clients around the dangers of drugs; and large doses of attention in the form of generic treatment (Miller, 2006a).

Two approaches that work in enhancing motivation to change are: short-term, brief interventions that utilize the FRAMES model described below; and a strong positive reinforcement approach for non-use or the use of alternatives to AOD use (Miller, 2006a).

The necessity for the use of motivational enhancement methods is found in managing client resistance and ambivalence. Most individuals with AOD and CC histories display an ambivalence about changing their lives, or at least, changing the behavior patterns that lead to these problems (e.g., Connors et al., 2001; Miller & Rollnick, 1991, 2002). Resolving ambivalence and resistance to these patterns, and helping clients to develop an internal sense of readiness, openness and responsiveness to treatment are primary objectives of the early phases of treatment.

Motivational strategies are based on the compensatory attribution model of treatment (Brickman et

al., 1982), which sees the client as having the power to influence change and focuses on building client self-efficacy and responsibility in the change process. Motivation is a state of readiness and openness or eagerness to participate in a change process. Miller, Zweben et al. (1994, p. 2) summarized the research on what motivates problem drinkers to change. Their work on Motivational Enhancement Therapy (MET) highlights the effectiveness of relatively brief treatment for problem drinkers. The elements that the authors consider necessary to induce change are summarized by the acronym **FRAMES** (also in Miller, 2006a, p. 146):

- **FEEDBACK** of personal risk impairment;
- Emphasis on personal **RESPONSIBILITY** for change;
- **ADVICE**;
- A **MENU** of alternative change options;
- Therapist **EMPATHY**;
- Facilitation of client **SELF-EFFICACY** or optimism.

Therapeutic interventions containing some or all of these motivational elements have been demonstrated to be effective in “initiating treatment and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking” (Miller et al., 1994, p. 2).

Therapeutic relationship with judicial clients

Establishing a working relationship with judicial clients is complex and difficult. As noted, these clients often have great distrust in the “system” and have a difficult time believing and trusting that judicial providers and counselors will advocate for and support their treatment needs.

One problem of developing a working relationship is compounded by the vast differences among offenders, e.g., many different types of offenders and different offender populations. Different approaches will be required for the sex-offender versus the substance abusing offender. Whereas one judicial client may need more compassion and caring at the initial stage

of treatment, another may need more structure to control acting out in the group.

Another problem is the diversity of judicial settings. Peters and Wexler (2005) also note that the therapeutic alliance will vary according to the judicial setting. Developing a therapeutic relationship with a prison inmate who will be incarcerated for a longer period of time will take more time, deliberation and patience. With a jail inmate where the stay is shorter, the working relationship may be less interpersonal and more task oriented, e.g., completing a short-term treatment program. As Springer et al. (2003) note: "One size does not fit all when it comes to treating the complex needs of substance-abusing offenders. In other words, 'start where the client is' " (p. 43).

The most challenging part of developing a therapeutic relationship with judicial clients is that correctional treatment is both client-centered and society centered. As discussed in some detail in *Chapter 1*, the provider/counselor represents both the judicial system and the client, and works at integrating the therapeutic and correctional system in the delivery of treatment.

An important focus in enhancing motivation and interest for change in judicial clients is that of developing "a more enlightened view of their self-interest and recognize that it is in their own best interest to anticipate the long-term consequences of their actions..." (Freeman et al., 1990, p. 229). This model is designed to help judicial clients to control impulsivity long enough to perceive the consequences of drinking and committing a crime as not as rewarding as the long-term consequences of prosocial behavior. In essence, motivation is enhanced by helping clients take a long-term view of their self-interest. This can only be done when the provider takes a collaborative approach to treatment (a key component of CBT) and a trust-based working relationship has been developed. These two objectives of treatment - building a collaborative relationship and helping the client take a long-term view of self-interest - are primary focuses in the treatment of substance abusing judicial clients.

Therapeutic alliance with the group

Most of our discussion of the therapeutic alliance has been in relationship to the client and provider. Since SSC, and probably most correctional treatment programs, are administered in a group modality, it is important to apply the principles we have discussed to the group as a whole. It is also important to recognize that the group, in and of itself, is a social unit that has its own resistance, set of values, goals and objectives, stages of change, relationship with the provider, and need for change. In this sense, the group becomes "the client" and all of the skills used to develop the therapeutic alliance should be applied to the group as well as the individual. We will discuss this approach and the "treatment of the group" in more detail in *Chapter 7*.

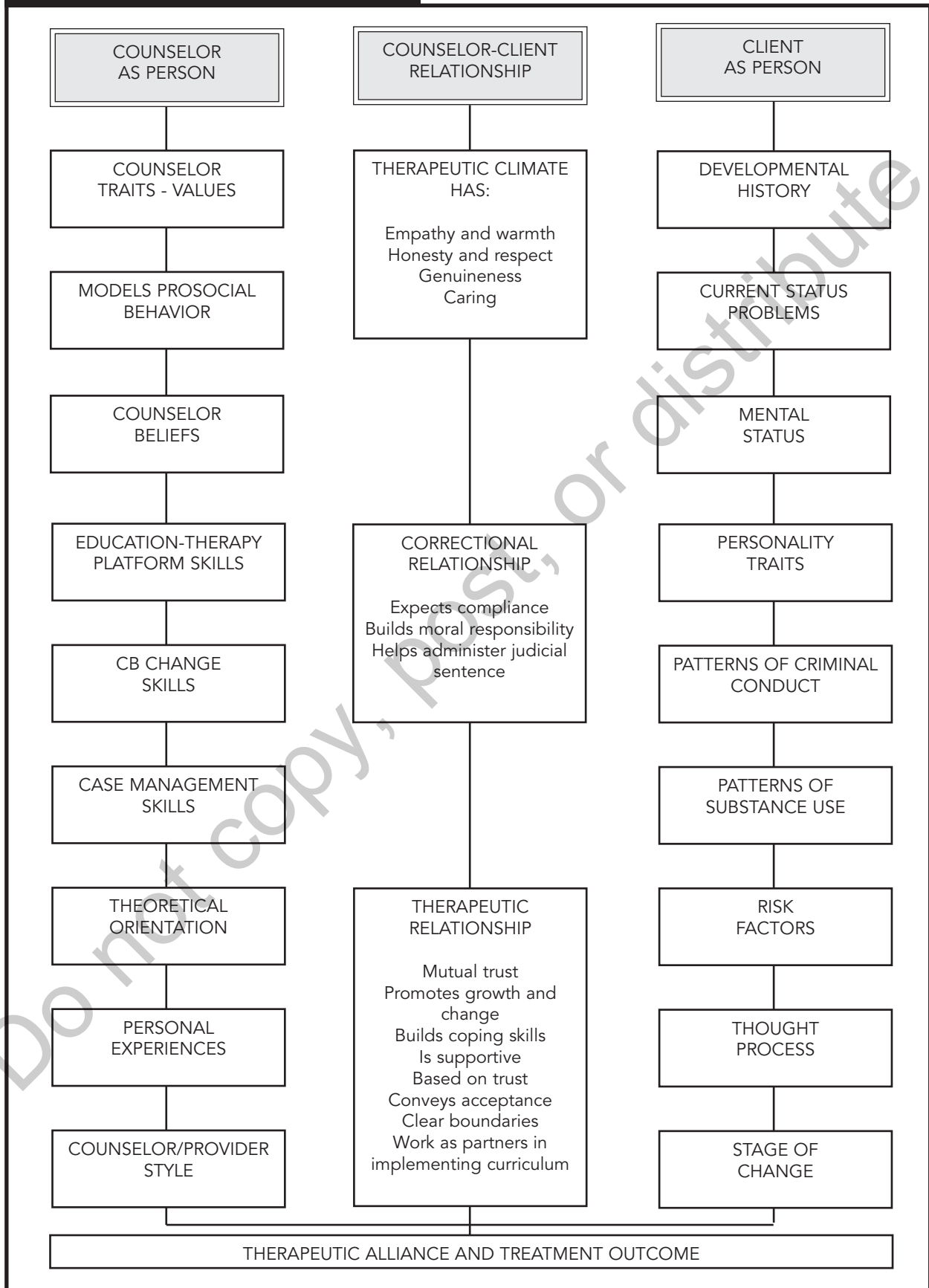
The Client as Person

Therapeutic alliance and motivation to change is in the hands of both the provider and the client. We looked at the characteristics of providers that contribute to the establishment of the therapeutic relationship and therapeutic alliance. However, *Figure 2.1* also shows that the client as a person is a critical variable that coalesces with the therapeutic relationship to effect change.

Given that the therapeutic alliance is a powerful tool to effect change, what contributions do clients make towards this alliance? *Figure 2.1* provides categories of client characteristics and circumstances that influence the therapeutic alliance. At a more specific level, Roth and Fonagy (2005) summarize findings from their review of the research on client characteristics that contribute to a poor therapeutic alliance and treatment outcome (see p. 465 for this review): At the intrapersonal level, a lack of hope, lack of psychological mindfulness, and a poor or negative view of others; history of difficulty in maintaining and sustaining good relationships with others and family; and an inability to establish secure attachments to others. Their summary also indicates that clients with higher expectations of improvement tend to predict the level of alliance and treatment outcome.

FIGURE 2.1

Interactive Components of the Treatment Process.



PROVIDER SKILLS IN INTEGRATING EDUCATION AND THERAPY

The third core strategy of *SSC* introduced in *Chapter 1* is integration of the educational and therapeutic process. We identified psychoeducation as being an important component of CB treatment and treatment of judicial clients. This strategy falls within the domain of the provider's skill necessary for effective treatment delivery.

The Adult Learning Model

The correctional treatment provider is both educator and therapist or - to use DeMuro's concept - assumes the role of a therapeutic educator (DeMuro, 1997). He points out the difference between pedagogy, or the art and science of helping children learn, and andragogy, which is the process of adult learning and education (Knowles, 1980, 1984, 1990). In pedagogy, the learner is viewed as underdeveloped and dependent upon the teacher. In andragogy, it is assumed that learners are diverse and have reached certain levels of physical, intellectual and emotional maturity allowing for greater collaboration between educator and learner in the process of learning. The adult learner "enters a learning situation with his or her own complete set of values, beliefs, attitudes, needs, life experiences, self-concept, and perceptions of life" (DeMuro, 1997, p. 59).

Knowles (1980) sees the adult educator as a teacher, facilitator, mentor and role model who has five main functions:

- ▶ to **help** individuals identify (diagnose) their needs for learning;
- ▶ to **plan** their learning experiences;
- ▶ to **motivate** the learner;
- ▶ to provide a **method** and **resources** for learning; and
- ▶ to **evaluate** the learning process.

The goal is for *SSC* providers to integrate these adult educator functions with those of the therapist, resulting in a role that helps individuals interpret their

life experiences in order to change their behaviors (Demuro, 1997, p. 65).

Psychoeducational Methods and Approaches

Psychoeducation acknowledges that the learner is an adult with vast experiences and background and cognitive sets that have been operating for some time. However, effective integration must include more than the application of the adult educator functions.

Psychoeducation involves using a variety of methods in presenting, teaching, and explaining concepts and skills, and in helping clients to integrate these into the change process. To effect change, it must use methods that are interactive and experiential and clients must have a sense of personal identification with the material being presented and learned. These methods include in-session exercises, interactive journaling, role playing, cognitive and behavioral rehearsal, and interactive discussion of the concepts and ideas being presented.

Methods should be varied and use multi-media approaches such as flip-charts, chalk boards, drawing diagrams and presenting graphic presentations (see J. Beck, 2005, p. 258 for illustration of the use of diagrams in helping clients understand the process of change). Psychoeducational methods also include the use of video feedback, computer-assisted learning, actiongrams, reading assignments and homework.

Integrating Psychoeducation and Therapy

Psychoeducation is an important component of the *SSC* program. Clients are taught basic schemas for change, important concepts related to AOD abuse and CC, problem solving, negotiation skills, interpersonal skills, and how to restructure thinking. Clients are then helped to apply this knowledge and these skills to their own personal-emotional situation with the goal of enhancing prosocial and positive outcomes in the clients' relationship to themselves, others and the community.

The education approach of *SSC* is based on a learner-centered rather than an information-centered

model (Hart, 1991) with the goal of giving personal meaning to learned content. SSC sessions create a learning environment whereby clients interact with the curriculum content so as to disclose personal information for the purpose of self-assessment and to identify personal problems. The curriculum encourages clients to make changes with the goal of preventing relapse and recidivism.

Throughout the SSC program, information and knowledge that are provided are always followed by interactive group activity and exercises designed to help clients apply the concepts and knowledge to their own personal situation. The goal is to help achieve the first step to change - facilitating self-disclosure. In the interactive process, clients identify and share how the concepts fit them. This helps to achieve an important second step towards change - self-awareness.

Clients then learn to use the knowledge and the specific skills to make changes and discover that these changes can lead to positive outcomes and more adaptive living. These changes get reinforced and strengthened by persons in their lives and by the treatment process (the provider and the group). Review of the concepts and skills and continual practice continue to result in positive outcomes, and change is further reinforced.

This model translates into an important mantra of SSC:

- ▶ self-disclosure leads to self-awareness (which includes mindfulness and acceptance);
- ▶ self-awareness leads to change;
- ▶ change results in positive outcomes that further strengthen change.

Thus, integrating education with the principles of therapy, SSC moves the client beyond the level of self-awareness to a level of cognitive, affective and behavioral change. Therapy helps clients deal with the realms of thoughts, feelings, attitudes and behavior at a more intense and deeper level. The client is more involved in the affective elements of change and there is greater focus on helping the client have more intense personal identification with the thera-

peutic themes and content. To use Patterson's (1966) concept, therapy (in contrast to education) is clearly more "conative" in nature - that is, it directs mental processes (thought and feeling) and behavior towards action and change. Therapy moves the client through the challenge (precontemplative-contemplative-preparation) stage of change to a commitment (action) and ownership (maintenance) level of change. These stages of change are discussed in more detail in *Chapter 3*.

THE CORRECTIONAL-THERAPEUTIC PARTNERSHIP

Most judicial clients are different from other AOD abuse clients in that they are usually required to attend treatment. In this sense they are coerced clients. This is the basis of the **eighth core strategy** of SSC: that the therapeutic and correctional roles and functions must be integrated for effective treatment of the SA judicial client. As discussed in *Chapter 1*, this means that the SA judicial counselor is part and parcel of the administration of the client's judicial sentence. SSC and the SSC provider are often part of that sentence.

The provider must be both a therapeutic and a correctional specialist, that is, a correctional practitioner (Milkman & Wanberg, 2007). Thus, it is important to understand the elements of an effective correctional counseling relationship and the correctional partnership. This relationship certainly includes the elements of the counselor-client relationship discussed above. The provider utilizes the skills and traits of warmth, genuineness, respect and empathy in developing and maintaining that relationship.

However, there are some unique elements of the correctional-therapeutic relationship that serve to enhance effectiveness in working with SA judicial clients. We review some of these elements that have been identified in the literature and some emerging out of the clinical experience of the authors and then define the correctional-intervention partnership.

Elements of Effective Correctional Counseling

Andrews and Bonta (2003) identify the following elements as essential for effective correctional counseling (pp. 311-319).

- Establish high-quality relationship with clients.** Productive interactions between correctional counselors and clients are predicated upon staff enthusiasm and openness to the free expression of attitudes, feelings and experiences. Mutual respect and caring facilitate the meaningful disapproval of procriminal expressions. Within the limits of mutually agreed upon boundaries, counseling is offered in an atmosphere of genuineness, empathy and caring.
- Model and demonstrate anticriminal expressions.** Judicial clients look for antisocial characteristics and behaviors and features in others in order to justify their own antisocial and criminal thinking and behavior. The effective correctional counselor must be consistent and unerring in demonstrating prosocial and high moral values.
- Approve (reinforce) the client's anticriminal and prosocial expressions.** This is a vigilant process. Capturing opportunities to reinforce client changes and efforts to change may make significant differences in the overall change process. A continual reinforcement of abstinence from drug use and abuse and sustaining a crime-free life and reinforcing thinking and behaviors that prevent relapse and recidivism are absolutely essential in bringing about change in judicial clients. Acknowledging that it is difficult to stay free of crime and drug use, and that clients face daily temptations to return to these behaviors is part of this reinforcement repertoire.
- Disapprove (punish) the client's procriminal and antisocial expressions.** Often, this must go beyond disapproval to actually engaging in the sanctioning process by reporting violations of probation and court sentencing conditions. This sanctioning should take place within the therapeutic process. Ultimately, the provider is obligated to be sure that the judicial system is informed of client infractions. It is not enough to disapprove of procriminal expressions such as spending time with old criminal associates. Effective correctional work will provide and demonstrate alternatives to antisocial and procriminal behaviors, e.g., help the client find social groups that are committed to change and recovery and prosocial behavior. Client advoca-

cy should be part of the correctional counselor's ongoing agenda.

Anticriminal Versus Procriminal Expressions

Many judicial clients do not see themselves as criminals or offenders per se. And many do not see themselves as antisocial or having serious characterological problems. One obvious goal of the self-disclosure and self-awareness phases of SSC treatment is for judicial clients to get an accurate picture of the degree to which they have engaged in criminal conduct. Many SSC exercises are geared towards achieving this objective. This involves understanding the difference between procriminal and anticriminal thinking and behavior.

However, making these distinctions is only half the picture. It is important for clients to understand the difference between criminal thinking and behavior and prosocial thinking and behavior. Clients may come to clearly see themselves as having committed crimes and may come to understand what criminal conduct is. But having a full understanding of and engaging in prosocial behaviors is another step.

Although providers will not see themselves as antisocial or procriminal, it is not difficult at times to give that impression to their clients. This is often very subtle. For example, providers can easily find themselves as having and expressing negative attitudes towards the "system", towards the law, police and the courts. Acceptance on the part of providers of rule violations or disregarding the law will communicate procriminal beliefs and attitudes. For example, knowing that a client is driving with a suspended license, or has done some minor shoplifting, or who has used an illegal drug on one or two occasions and has not therapeutically confronted those behaviors is modeling procriminal attitudes and behaviors. It is easy for providers to side with clients around "unfair" rules of probation, of the prison setting, or of a sentence issued by the courts.

Providers express anticriminal attitudes when emphasizing the painful consequences of the impact of criminal conduct on the community and victims; rejecting rationalizations for criminal conduct; and

highlighting the hazards of associating with criminal associates. Correcting errors in thinking that judicial clients often have, such as “everyone uses drugs,” “everyone breaks the law,” “everyone speeds” will model anticriminal attitudes.

Reinforcing whenever possible prosocial attitudes and behaviors models prosociality. An example would be: reinforcing clients when they engage in alternative ways of acting in situations that are high risk for recidivism (spending time with criminal associates). Attending sessions and completing homework assignments are seen as prosocial expressions.

Therapeutic effects are significantly enhanced when group members begin to reinforce anticriminal and prosocial thinking and behaviors in each other. This is a strong indication that the group as a whole is developing an environment of prosociality.

Reinforcing Positive Thoughts and Behaviors

Rewarding positive thoughts and behavior requires the availability of a wide variety of reinforcers in the repertoire of SSC counselors. Minimal visual cues such as eye contact or approving smiles may sometimes be effective while other anticriminal expressions may call forth explicit comments reflecting agreement and support. The continuation of a positive and therapeutic counseling relationship serves as the most powerful reinforcer of prosocial attitudes and conduct.

Andrews and Bonta (1994, 1998, 2003) offer specific suggestions regarding high level reinforcement of offenders by their counselors or providers.

- ▶ Strong, emphatic and immediate statements of approval, support and agreement with regard to expressions of prosocial attitudes and conduct of clients, e.g., nonverbal expression, eye contact, smiles, shared experiences.
- ▶ Elaboration of the reason why agreement, approval and reinforcement are being offered, i.e., identifying specific attitudes and behaviors being approved of.
- ▶ Expressions of support should be sufficiently intense and have affective components.

- ▶ The provider’s statement should at least match the client’s statement in emotional intensity (i.e., be empathic) and his or her elaboration of the reason for support may involve some self-disclosure (i.e., openness).

Sanctioning Within the Therapeutic Context

Sanctioning and punishment around administering the judicial client’s sentence should occur within a therapeutic context. Andrews and Bonta (1994, 1998, 2003) indicate that effective sanctioning and punishment occur within the context of a caring, genuine and empathic relationship. Providers should not let the fear of client retribution or termination prevent appropriate confrontation of antisocial and procriminal attitudes or conduct.

Expressed disapproval is more effective in an atmosphere of trust and mutual caring. Yet, supportive statements should outnumber disapproving ones, e.g., a ratio of 4-1 (Andrews & Bonta, 2003). The expression of disapproval should stand in contrast to the levels of interest, concern and warmth previously offered. The levels of disapproval should be immediately reduced and approval introduced when the client expresses morally responsible and prosocial attitudes and behavior.

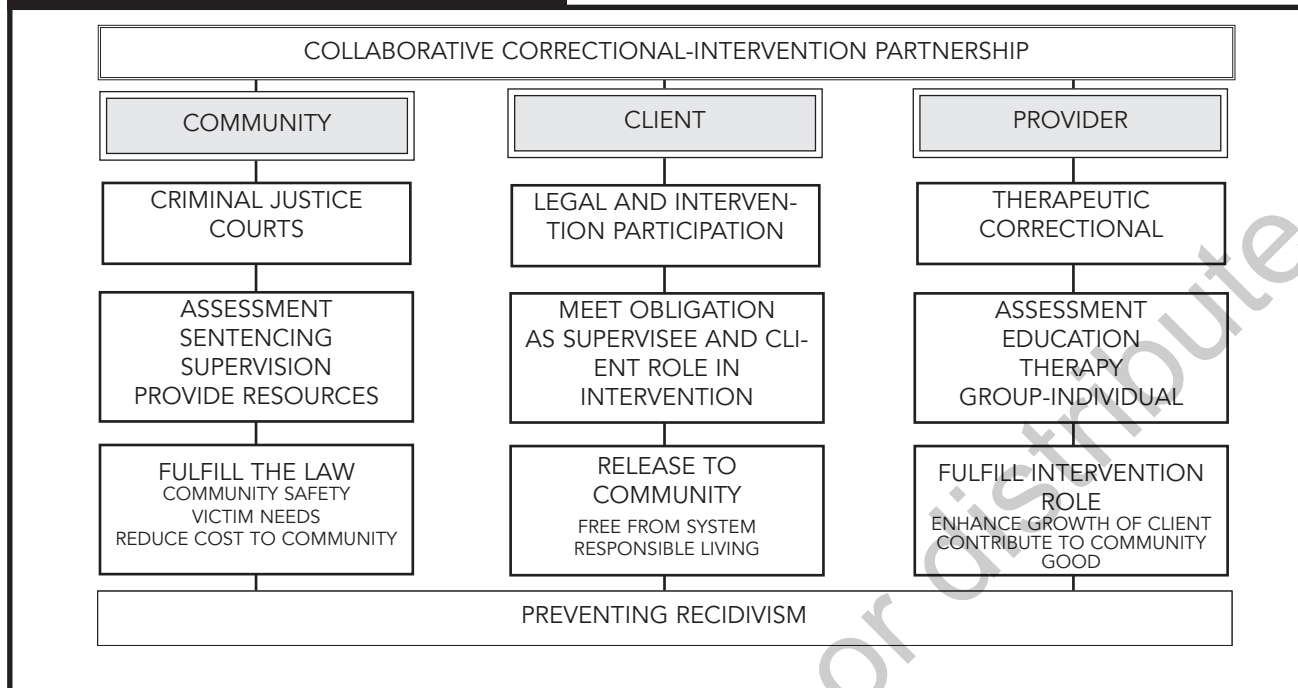
Provider and Client Partnership

A strong alliance does not necessarily guarantee a working partnership, although the alliance is a foundation for an effective partnership. It is helpful to view the provider-client relationship as similar to a business partnership. That relationship is defined by the degree of investment the partners have in achieving the goals of the business. There is a mutual investment of their own sets of skills and talents in helping the business, an external entity, to prosper and thrive. Although profit may be the primary objective, and is the basis for the existence of the business, outcome is also measured by the satisfaction and meaning the partners derive from their involvement in the business entity.

In the case of the judicial treatment partnership, the counselor has a set of skills and knowledge to achieve

FIGURE 2.2

Collaborative Correctional-Intervention Partnership



the goals of the therapeutic business. The client also brings to the partnership, skills and the potential to learn new skills as well as first hand knowledge of his/her problems and traits. The primary goal of the judicial treatment business is to achieve the bottom line profit that benefits the client, provider and community: prosocial outcomes and preventing relapse and recidivism.

The partners plan, problem solve, apply techniques and skills, and review work done so as to advance the external business entity and profit. Achieving prosociality and the prevention of relapse and recidivism are the overriding goals of the partnership. However, mutual satisfaction and meaningful involvement in the business is also important, and are predictors of the bottom line business profit - prosociality.

Interactive Partners with the Correctional System

The correctional-treatment system involves a three-way partnership: the community, the client and the provider. The success of the correction-intervention system in preventing relapse and recidivism depends on the development of a collaborative relationship among these three partners. Initially, clients do not

see themselves as being part of this three-way partnership. If intervention is successful, clients - mainly in the **Commitment** and **Ownership** phases of intervention - will begin to see themselves as part of the partnership.

Figure 2.2 describes this collaborative partnership and the parts that each plays in fulfilling the terms of the partnership. The payoff for the community is fulfillment of the law, safety, victim satisfaction and reduced cost to the community.

For clients, the payoff is: fulfilling their obligation to the community; increasing positive thoughts and feelings about self; having a sense of pride in being morally responsible in the community; freedom from further correctional involvement; and a sense of satisfaction in contributing to the good of the community and responsible living.

The payoff to the provider is: fulfilling the therapeutic and correctional role and obligation; enhancing client growth; contributing to the safety and good of the community; generating models for the prevention of recidivism; and fulfilling an important societal role of promoting community responsibility and safety.

PROFILE OF THE EFFECTIVE JUDICIAL PROVIDER

There are three broad dimensions that define the primary characteristics of the effective judicial counselor: 1) the counselor's personal characteristics and traits; 2) professional or technical development; and 3) philosophical perspectives (see Wanberg, 1990). *Figure 2.3* provides an outline of these three dimensions.

We consistently use the term provider to refer to a counselor or therapist delivering treatment services to judicial clients. At the broad level of correctional service delivery, these individuals represent correctional practitioners (Milkman & Wanberg, 2007) who deliver a variety of correctional treatment services to judicial clients. We will continue using provider (counselor or therapist) throughout this *Guide*, keeping in mind that they fulfill the role of correctional practitioners.

The Personal Dimension

The personal dimension is defined by the core counselor traits of warmth, genuineness, empathy and respect. Although some providers are able to express these more easily than others, as discussed above, each of these characteristics is observable, measurable, and thus trainable. Other personal characteristics that impact on effective criminal conduct intervention counseling are the counselor's values, beliefs, personal experiences, social role orientation and unresolved personal conflicts.

Biases and negative attitudes with respect to orientation towards social and cultural roles, representative groups within the society, and orientation towards job productivity can all influence the SSC provider's response to the client and the correctional system. As discussed above, biased attitudes can have a profound influence on the provider's therapeutic stance.

Each counselor has a set of unique personal experiences, personal values, attitudes and beliefs which can impact on treatment. Counselors with unresolved personal issues may find these issues getting in the way of being client-oriented and objective.

Effective counselors have full awareness of their own values, beliefs, attitudes, personal experiences and biases and will understand how these personal characteristics can contribute to or hinder effective treatment delivery to judicial clients. Self-disclosure is the primary skill through which these personal values, beliefs and experiences can be effectively utilized in treatment (Wanberg, 1990).

Self-disclosure is the sharing of personal, emotional and experiential feelings and experiences that are unique to the counselor. It can enhance the opening up process and increase treatment communication between the counselor and client or among clients. It can help the client feel more at ease knowing that the counselor has had very real and human feelings and experiences. There is evidence that self-disclosure is working when: 1) clients continue to share at a deeper and more personal level; 2) clients begin to utilize some of the personal approaches that the counselor has used in his or her own problem-solving and conflict resolutions; and 3) clients express greater acceptance of their own inner feelings and problems.

Self-disclosure can present major barriers in treatment (Wanberg, 1990). It can slow down or even stop the opening up and sharing process. If the counselor indicates having been through such and such an experience, the client may internally reflect that "there is no reason to go on; the counselor already knows what I've been through." Self-disclosure may cause the client to lose confidence in the counselor. As a consequence of self-disclosure, the client may move away from self-focus and focus more on the counselor's issues. Finally, self-disclosure may cause the counselor to lose concentration and attention on the content and affect flow of the client.

In summary, self-disclosure becomes effective when, following its use, clients think they are better understood and more deeply supported and then continue to share personal material at a deeper level. It should be used with caution. It is a complex factor in the treatment process. It does not necessarily enhance, and may inhibit, the client seeing the counselor as empathic, trustworthy or competent. It could reinforce antisocial behavior. It should never be used by the counselor for personal-emotional gain, but only

when it clearly fits into the plan of enhancing the therapeutic alliance and providing clients with additional tools and information that will prevent relapse and recidivism.

The Professional Dimension

The second dimension that defines the effective judicial counselor and SSC provider is the area of professional training and development. This involves the development of the psychoeducation and therapy skills necessary to deliver a manual-guided and group-based intervention program as well as skills of assessment and of client management. These skills form an important component of the conceptual framework of the treatment platform discussed in *Chapter 1*.

In *Chapter 7* and *Section III*, specific skills are outlined that providers need in order to effectively deliver each SSC treatment phase. Most of these skills are learned by counselors in professional training, and are used continually in their work with clients.

A standard for the application of the professional dimension is found in the practice of surgery in medicine. During a surgical procedure, a physician's knowledge, skills and ethical behaviors are continually used. At any given moment in the surgical process, the surgeon knows what skills are needed for successful surgery. The surgeon knows the process for each surgical procedure. The skills, tools and instruments are precisely labeled and identified, and the surgeon knows under what conditions the application of the skills and the use of the instruments are needed. You would not only expect, but require that of a surgeon operating on you. Imagine being operated on, and you wake up and hear the surgeon say: "Gee, that's an interesting instrument. Don't know what it is, but I'll try it." Needless to say, you would be in shock.

Let us apply the same standard to counseling and psychosocial treatment and in the delivery of SSC. We should have an awareness of the process and goals of SSC and the necessary knowledge and skills for effective delivery. We should be able to label our therapy skills and tools, and then we should know when in the intervention and change process we ap-

ply those skills and tools. We should also have a fairly decent idea of the outcome of the application of the process and skills. We would expect no less of our surgeon; our clients should expect no less of us.

In psychosocial treatment, we may not always have definitive knowledge of the process and the skills, as in medicine. Yet we should be grounded in a process that works and in which we have confidence, and which allows us to label and effectively use skills to implement therapeutic and correctional change. A model for the process, skills and strategies for the treatment of judicial clients and the delivery of SSC was provided in *Chapter 1, Figure 1.1*. This model provides a guideline for the adaptation and use of psychosocial and correctional treatment.

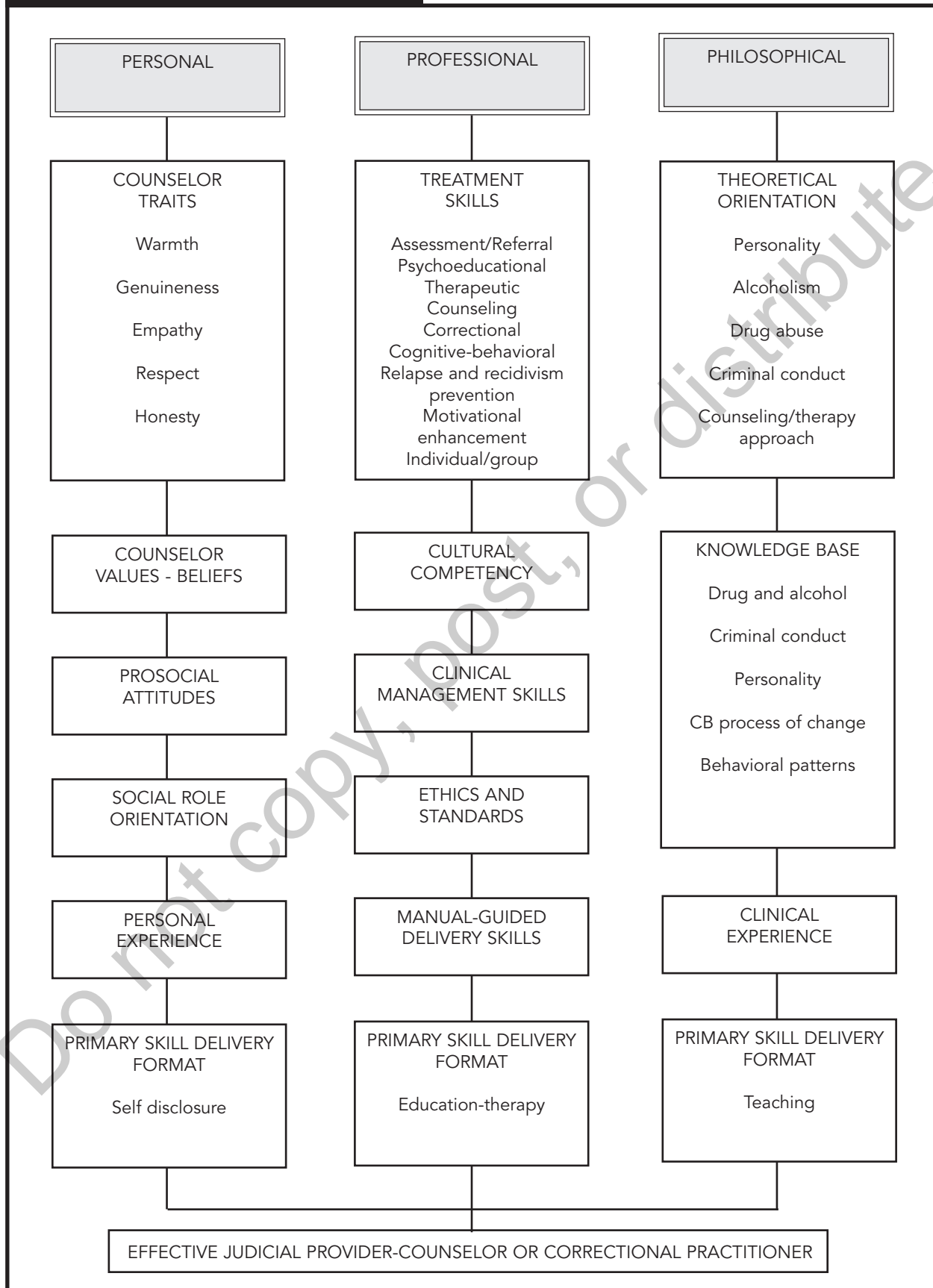
One important component of the professional dimension is being culturally competent in capitalizing on the strengths of diversity. This is discussed in a separate section below. Another important component of the professional dimension is the ethical and professional standards of judicial counselors. This area is covered in more detail in the *Resource Guide* (Wanberg & Milkman, 2008). Some of the key ethical considerations are: confidentiality; complete avoidance of dual relationships (e.g., business, romantic); giving or receiving favors including money, objects, gratuities; bartering; and abusing the power that providers may have in relationship to the client (see Masters, 2004, pp. 19-24). Providers will hold to the ethical and professional standards defined by their respective profession, e.g., addictions counselor, psychologist, probation officer, etc.

Philosophical Perspectives

Finally, the philosophical dimension defines the theoretical orientation and knowledge structure used in the delivery of services to judicial clients. It is important that providers have some theory of human personality, a theoretical view of education and teaching (e.g., learner-centered model), and of counseling and treatment (e.g., cognitive-behavioral, client centered), a theory of drug abuse and alcoholism, and some perspective on the nature, etiology and development of criminal conduct. Teaching and imparting knowledge is the primary skill through which counselors directly bring to bear their knowl-

FIGURE 2.3

Profile of the Judicial Provider



edge and theoretical orientation on the therapeutic process. *Section I* of this *Guide* provides grounding in a theoretical and philosophical perspective in the treatment of SA judicial clients and in the delivery of SSC.

PROVIDER CULTURAL COMPETENCE: CAPITALIZING ON THE STRENGTHS OF DIVERSITY

Counselor cultural competency falls within the professional dimension of the judicial counselor profile. The *Resource Guide* (Wanberg & Milkman, 2008) devotes a chapter to cultural competence, cultural issues and sensitivity, and specific needs and concerns defined by cultural diversity. Here, we point to some of the more important considerations regarding the ability of counselors to be competent in capitalizing on the strengths of diversity among judicial clients.

First, treatment should be culturally responsive and sensitive and address the cultural values, competencies and strengths of judicial clients. It utilizes these strengths and competencies to promote growth and change. The goal is for providers to have the skills and competence to recognize and capitalize on the strengths of diversity in the judicial population.

Judicial clients are very diverse as to ethnic and demographic differences, age, gender, and different populations with specific needs. There is strength in age, in gender, in ethnic heritage, and even in being classified in a judicial group with specific needs. For example, recognizing that a judicial client has a co-occurring disorder will move the judicial system to provide specialized services that can enhance change and prevent recidivism. There is strength in recognizing that a client has an AOD problem since in doing so, such clients will receive treatments that are known to increase the probability of positive outcomes for those clients.

Second, it is important that providers establish a clear awareness of their own orientation towards other cultures, level of cultural competence and specific biases and prejudices. This can range from the position of being:

- exclusionary, negativistic and prejudicial attitudes;

- to the middle ground of being sensitive to the cultural issues that need to be addressed;
- to a higher level of cultural competency that involves openness to cross-cultural interactions, a commitment to valuing diversity, seeing strength in diversity and even celebrating diversity (Cross et al., 1989; Guajardo-Lucero, 2000).

Third, providers should be able to effectively evaluate the system within which they work with respect to its cultural competency. Does the system value diversity, acknowledge the dynamics of interacting cultures, and build in methods and programs that recognize, capitalize on and enhance the positive expression of diversity (Cross et al., 1989)?

Fourth, a set of effective communication skills should be used relative to cultural diversity. This involves recognizing the verbal and language skill level of the group. When using important terms that the group has not integrated into its vocabulary, time should be taken to explain the meaning and purpose of those terms. For example, many, if not most, judicial clients will not understand the term self-efficacy or self-mastery. Since this is an important concept in CB treatment, time needs to be taken to be sure the group understands its meaning. Making a deliberate effort to understand accent and dialect and valuing the individual's primary language are important.

Staying with normative language and not engaging in jargon is important. The goal is to integrate the client into normative language and normative culture with respect to prosocial attitudes and behaviors. Thus, "dig the jive, but don't talk it."

Be sensitive to communication styles that might be offensive. For example, direct eye contact for some people in some cultures is offensive. It is important not to use profanity. It may not bother most, but the few it does is not worth the risk of alienation. After all, an important goal of treatment is to rise above conditions and conditioning (e.g., to extinguish conditioned responses such as profanity, drug taking, and violence) that are part of many offenders' lifestyles.

Finally, providers need to have the skills to work

with the cultural biases and prejudices that surface among judicial clients. Providers will find strong biases and even intense feelings of enmity among judicial groups, and many of these are ethnic and racially focused. The manifestation and even eruption of these intense prejudices can be damaging to group cohesion and provide major barriers to the treatment process.

Here are some guidelines in mitigating and managing these issues when arising in group:

- ▶ Foster positive interactions among group members and when these biases surface, remind the group that the principal guideline for all therapeutic activity is respect for self and others.
- ▶ Facilitate therapeutic processing around prejudice and negative stereotyping using the basic therapy skills of encouragers to share and offer reflective feedback.
- ▶ Give members an opportunity to share their thoughts and feelings within the framework and boundaries of civil discourse.
- ▶ Keep confrontation at the therapeutic reflective-acceptance level when possible while at the same time not reinforcing strong biases, prejudices and enmity.
- ▶ Allow only civil language and set clear limits on and prohibit prejudicial expressions and behaviors, use of racial slurs, demeaning and disparaging language.
- ▶ Set limits on the time spent on such issues. Do not try to resolve the biases and prejudicial attitudes of group members, and acknowledge that these attitudes and differences will exist, and that individuals have the right to hold these views, but not the right to act them out in harmful ways.
- ▶ Keep the group on task - on the goals and objectives of SSC in general and the specific objectives spelled out in each session.
- ▶ It may be necessary to ask group members who want to keep the group focused on these issues and whose attitudes and behaviors are disruptive to the group treatment process to leave the group.

- ▶ The goal is always to work towards and foster a cohesive and prosocial group environment.

CHAPTER REVIEW

This chapter focused on the therapeutic relationship and the specific characteristics of the effective SA judicial counselor, and more specifically, delivery of the SSC curriculum. One of the most robust findings in the treatment literature is the impact of the client-counselor relationship in producing positive treatment outcomes. The therapeutic relationship is a common factor that cuts across different treatment approaches and contributes to treatment efficacy. The provider-client relationship is determined by the specific counselor characteristics of warmth, genuineness, respect, and most important, empathy. It is also determined by the characteristics and motivation of the client.

The therapeutic relationship is forged through the counselor's therapeutic stance, developing a therapeutic alliance with the client, and using skills to enhance client motivation for a positive response to treatment. Empathy, a learned skill, is the key player in the process of developing the therapeutic relationship. It is also a key player in the development and fostering of prosocial attitudes and behaviors.

Motivational enhancement and the therapeutic alliance interact in such a manner that motivational enhancement helps to build the therapeutic alliance and, in turn, the therapeutic alliance provides the basis upon which client motivation is fostered and nourished. Resistance and ambivalence are the resting points from which change emanates, and need to be resolved for change to take place. The therapeutic alliance and the skills of reflective acceptance are the vehicles to move clients past that resting point.

Other provider characteristics and skills that contribute to the effective treatment of judicial clients are forming a therapeutic alliance with the group, knowing how to integrate psychoeducation with the therapeutic process, and practicing the principles that facilitate effective correctional counseling. Modeling anticriminal and prosocial attitudes and behaviors are ongoing responsibilities of the judicial provider.