FROM COMPLIANCE TO ALLIANCE: STRENGTHENING THE WORKING ALLIANCE IN MANDATED TREATMENT

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ABSTRACT

Over the past three decades, the United States criminal justice system and mental health treatment providers have collaborated in ways to support more than 20.3 million individuals who are struggling with a substance use disorder (SUD), and who may also be facing drug-related offenses due to their ongoing challenges combatting addiction. Through collaborative efforts we have been fortunate to witness the establishment of adult drug treatment courts, as well as other problem-solving court processes. With more than 1,500 active adult drug treatment court programs in this country, there is a critical need to better understand the working alliance between counselors and clients who have been mandated to receive SUD treatment.

Adult drug treatment court programs have been shown to have discrepant success outcomes (8% to 80%) in terms of reducing criminal recidivism; moreover, the existing literature examining the lived experiences of participants in these programs is both minimal and disheartening. This lack of empirical data is problematic for the counseling profession given that they serve as key change agents in this process. What we do know is that the process of creating treatment goal and modalities, which should be in the hands of the clients and their counselors, can be complicated by court-mandated requirements. This bi-level structure has the potential to create ruptures in the working alliance between clients and counselors providing SUD treatment to this population. Accordingly, additional research is needed to explore the client experience within the working alliance, and in so doing reveal the influences at play when working with

clients who are mandated to receive SUD treatment.

This qualitative study was guided by one central research question: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment? Interview data from eight individuals in court-mandated SUD treatment led to the development of a constructivist grounded theory model: *From compliance to alliance: A grounded theory of building rapport in mandated treatment*. This model and it's components describe and define key factors when working with this population. More research is needed to understand counselors' perspectives of the working alliance with court-mandated clients.

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GENERAL AUDIENCE ABSTRACT

With more than 1,500 active drug court programs throughout the United States, there is a pressing need to better understand the working alliance between counselors and clients who have been mandated to receive SUD treatment. While adult drug treatment court programs have been shown to have positive outcomes in terms of reducing criminal recidivism, the existing literature examining the participants' lived experiences receiving SUD treatment is minimal and disheartening. Due to the nature of the mandated treatment relationship, the confidentiality which has historically bound and secured the therapeutic working alliance is less defined than it is in fully voluntary treatment settings. This shift in understanding what creates a healthy working alliance for mandated clients to work through presenting treatment issues is something that has yet to be explored by current research. The current study sought to explore clients' experiences of the working alliance with counselors during drug court-mandated addictions treatment. Interview data from eight individuals in court-mandated SUD treatment led to the development of a constructivist grounded theory model: *From compliance to alliance: A grounded theory of building rapport in mandated treatment*. This model and it's components describe and define key factors when working with this population. More research is needed to understand counselors' perspectives of the working alliance with court-mandated clients.

DEDICATIONS

For Karen and Vincent Zongrone

I would have never known what I could achieve without your constant love, support, and guidance. I dedicate my achievements in this life, both externally and intrinsically, to you.

I also dedicate this work to every individual, family and friend who has been impacted by the grips of addiction. May peace be with those who we have lost to this fight, and strength to those who are still fighting.

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Introduction

While drug court programs have been shown to have positive outcomes in terms of reducing criminal recidivism (Marlow et al., 2016), the existing literature examining the participants' actual experiences receiving SUD treatment is both minimal and disheartening (Gallagher et al., 2015; Gallagher et al., 2017). Due to the nature of the mandated treatment relationship, the confidentiality which usually binds and secures the therapeutic working alliance is not as defined as it is in fully voluntary treatment settings. This shift in understanding what creates a healthy working alliance for mandated clients to work through presenting treatment issues is something that has yet to be explored by current research. With more than 1,500 active drug court programs throughout the United States (National Drug Court Resource Center, 2020), there is a pressing need to better understand the working alliance between counselors and clients who have been mandated to receive SUD treatment.

Context for Study

Defining Addiction

According to the most recent National Survey on Drug Use and Health, approximately 20.3 million people, aged 12 or older, were identified as having a substance use disorder (SUD) in the United States (SAMHSA, 2019). The American Psychiatric Association (APA) defines an SUD as “a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (2013, p. 483). While substance-related problems can present differently depending on the specific roles

and obligations in a given person's life, the *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* (DSM-5) outlines four main grouping areas where psychologists, psychiatrists, and counselors can assess to determine if there is clinically significant impairment: self-control, social functioning, risky use, and pharmacological criteria (APA, 2013). Contingent upon how many symptoms, or diagnostic criteria, an individual meets, they may be classified as having either a mild (2-3 symptoms), moderate (4-5 symptoms), or severe (6 or more symptoms) SUD (APA, 2013).

Related to the first grouping of diagnostic criteria for an SUD, an individual displays impaired self-control over the use of a substance in several key ways. First, the individual may begin to consume the substance in larger amounts and for longer periods of time than they initially intended. Next, the individual may wish to cease their use of the substance, but have several unsuccessful attempts in order to do so (APA, 2013). Individuals who struggle with control of the substance may spend significant amounts of time obtaining, using, or recovering from the effects of the substance use. Finally, individuals may experience intense cravings for the substance, especially in environments where they have used it before (APA, 2013).

The second grouping of diagnostic criteria for an SUD is concerned with the individual's social impairments due to the substance use. Individuals who meet criteria in these groupings may fail to meet major obligations at work, school, or home and may continue to use substances despite these negative consequences associated with these unmet obligations (APA, 2013). Within this grouping category, individuals might also indicate that they have given up important activities in their professional or personal lives because of their substance use and begin to withdraw socially from friends and family (APA, 2013).

The third grouping of diagnostic criteria for an SUD is concerned with how risky an individual is with the use of a substance. While the term "risky" may be too subjective for diagnosis purposes, the DSM-5 defines this type of behavior well. An individual displays risky use of a substance when they continue to use the substance even when it is physically hazardous to themselves, and/or they continue to use the substance despite being aware of either physical or psychological symptoms that are either caused or worsened by using the substance (APA, 2013). The last grouping category, pharmacological criteria, is concerned with assessing the individual's physical reactions to the continued and/or discontinued use of a substance. Category four consists of two elements: tolerance and withdrawal. An increase in tolerance is evident when an individual reports that they take more of the substance in order to obtain its desired effects (APA, 2013). Withdrawal from a substance is seen when an individual experiences negative symptoms after they abstain from the use of a substance, typically following periods of prolonged use. Withdrawal symptoms vary greatly depending on what class of substance the individual has been using (APA, 2013).

Addiction Treatment

Understanding the symptomology of substance use disorders is important when learning about the various treatment modalities and levels of care. The higher the level of severity an individual experiences from their SUD, the higher the level of care they will need in treatment. The American Society of Addiction Medicine (ASAM) describes four levels of care that are determined following assessment of the ASAM Criteria (ASAM, 2021): (1) general outpatient, (2) intensive outpatient or partial hospitalization, (3) medically monitored inpatient residential care, and (4) medically managed inpatient care (American Society of Addiction Medicine [ASAM], 2015).

Treatment professionals are equipped with assessment tools in order to place individuals in the level of care that is most appropriate for their presenting needs and to help elicit better treatment outcomes (Gastfriend & Mee-Lee, 2004). The ASAM Criteria is a comprehensive, multidimensional assessment tool used to determine the appropriate level of care for clients struggling with a substance use disorder (ASAM, 2021). The ASAM Criteria assesses six dimensions of an individual's psychosocial functioning: (1) acute intoxication and/or withdrawal potential; (2) biomedical conditions and complications; (3) emotional, behavioral, or cognitive conditions and complications; (4) readiness to change; (5) relapse, continued use, or continued problem potential; and (6) recovery/living environment (ASAM, 2021). Based on the assessment results and presenting needs, individuals will be placed in these aforementioned levels of care.

While a variety of treatment providers utilize the ASAM Criteria while working with individuals in their respective fields, the focus of this study is to examine the work of mental health counselors. Counselors utilize assessment tools such as these regularly in their work with clients to identify the starting point for treatment. After the starting point, or level of care, has been identified, counselors will use a variety of evidenced-based practices (EBP) to provide ongoing treatment. Some EBP commonly utilized in addiction work include motivational interviewing, cognitive behavioral therapy, contingency management, and the community reinforcement approach (SAMHSA, 2020).

Addiction, Criminal Behavior, and the Brain

While addiction-related issues can be extraordinarily difficult to overcome due to the physical and psychological dependence on the substance, there are often additional social and legal pressures caused by the disease of addiction. Addiction-related issues are inextricably connected with criminal behavior by proxy of two main factors. The first factor is that current

legal statutes mandate that using and possessing illicit drugs is against the law. The second factor includes the neuroscience behind addiction itself. It has taken years of social progress and scientific research to assist our society in finally understanding the concept of addiction as the development of disease rather than an individual's personal struggles or moral failure (Leshner, 1997; Volkow et al., 2016).

Understanding the neuroscience of addiction is essential for recognizing and addressing the social behaviors associated with substance use—and more so chemical dependence. The cycle of addiction is rooted in the part of the brain that releases dopamine, which is a neurotransmitter that releases chemical messages from our brains to our bodies (Queensland Brain Institute, 2017; Volkow et al., 2016). When dopamine is released, it activates our reward pathways, which primarily serves humans (and all animals) by telling us which behaviors we practice that feel pleasurable, and therefore support our survival (Taber et al., 2012); such common behaviors include eating, sleeping, and procreating. As the release of dopamine is associated with survival behaviors, our frontal lobe is activated during these times as well. This part of our brain lights up when we are engaging in behaviors that require problem solving, decision making, learning, and motivation (Berke, 2018; Volkow et al., 2016).

So what do dopamine and the brain have to do with the disease of addition? In seeking to understand why criminal behavior is so closely linked to individuals who struggle with an SUD, the answer is virtually everything. As explained, the release of dopamine in our brain informs us of behaviors necessary for survival. Many survival behaviors are logical and essential, such as eating, sleeping, and procreating. But what happens when dopamine is released in response to using a synthetic substance that is designed to release such a high spikes of dopamine in an individual's brain the first time it is used, but will then subsequently decrease the release of

dopamine over longer, continued periods of use? This is where human brain chemistry is extraordinarily unique, in the worst way (Volkow et al., 2016). Rather than continuing to receive the same release level of dopamine when using a substance, our brains actually begin to release less, and transfer high spikes of dopamine through to the conditioned stimuli, or *cues*, which are the behaviors associated with the substance use rather than the substance itself (Volkow et al., 2016). In SUD treatment, clients and counselors take time to learn these cues as *triggers*—namely, the people, places, and things an individual associates with the use of the substance itself. So as brain chemistry in an individual shifts from the use of the substance to the behaviors associated with use of the substance, this is where we see the increase in engagement in criminal behaviors in order to obtain the substance (e.g., lying, stealing, impulsivity, compulsivity, etc.). As Volkow and colleagues explained, "Their behaviors are now governed by the uncontrollable overvaluing of the drug and by growing insensitivity to the deterrent value of potential punishments" (Volkow et al., 2011, p. 2). By nature of this fact, it is highly likely that addiction counselors will not just be faced with assisting clients in overcoming symptoms of an SUD, but potentially interacting with the criminal justice system as well.

Drug Court

Throughout the past three decades in the United States, the criminal justice system and mental health treatment providers have collaborated in ways to support individuals who may be struggling with an SUD and continue to be charged with drug-related offenses due to their ongoing issues with addiction. Through these collaborative efforts, we see the development of drug courts and other problem-solving court processes (e.g., mental health courts, family treatment courts, juvenile courts, veteran's courts). Adult drug courts were first established in 1989 in Miami, Florida, in response to the crack cocaine epidemic (Marlowe et al., 2016;

Weisheit, 1990). It was during this time and the years preceding (1980-1987) that the United States saw a 52% influx of drug arrests across the nation (Weisheit, 1990), making it evident that incarceration alone would not remedy the chemical and psychological dependence on addictive substances.

Currently, more than 3,000 problem-solving court programs exist across all 50 states in America, with half of those serving specifically the adult drug treatment court population (U.S. Department of Justice, 2020). On a national level, adult drug treatment court participants represent the following races and ethnicities: White or Caucasian (67%), Black or African American (17%), Hispanic, Latino, or Spanish (10%), American Indian or Alaskan Native (5%), and Pacific Islander (1%) (Marlowe et al., 2016). Adult drug treatment courts provide a structured, community supervision process for individuals who are assessed as being eligible for the program with the goal of reducing the criminal recidivism rates of individuals who are charged for drug-related offenses (Marlowe et al., 2016).

The structure and associated processes of drug court programs are intentionally designed to keep its participants accountable to their legal proceedings, as well as therapeutically combatting the root of the overall issue: the addiction itself. Participation in drug court, if eligible, includes frequent interactions with and supervision by drug court officials (e.g., judges, probation officers, prosecuting attorney, defense attorney, and law enforcement representatives), coupled with frequent, random, and continuous urinalysis screenings and addiction treatments (National Association of Drug Court Professionals [NADCP], 2004). While this alternative legal process has high expectations of accountability for its participants, it has also been demonstrated to have positive effects in its overall outcome goals in reducing recidivism rates, treating the disease of addiction, and decreasing criminal behaviors (Marlowe et al., 2016).

The counseling community holds a significant stake in the drug court process as one of its key elements is requiring the participants to engage in a long-term substance use disorder treatment program (NADCP, 2004). According to the Adult Drug Court Best Practices, participants should receive "approximately 200 hours of counseling over nine to twelve months" (NADCP, 2013, p. 39) in order to complete their SUD treatment requirement. Counselors work with each participant to identify the correct level of care at the onset of treatment (e.g., detoxification, residential, sober living, day treatment, intensive outpatient and outpatient services), after which participants and counselors work collaboratively towards the participant's treatment goals. Due to the nature of the participants being mandated to SUD treatment as a requirement of the drug court program, the treatment goal is predefined by the courts: to achieve abstinence from all alcohol and illicit substances (NADCP, 2013).

Working Alliance

The counselors who work with drug court participants are part of an intricate interdisciplinary team that works to create the most successful future for the individuals they serve. While drug court is intended to support rather than incarcerate individuals who struggle with an SUD, in reality it presents many challenges in terms of the counselor-client working alliance. The counselor-client working alliance has proven to be more effective in predicting positive treatment outcomes than any variation of treatment models or theoretical orientations used (Hauser & Hays, 2010; Wampold et al., 1997).

Initially established by Bordin (1979), the client-counselor working alliance consists of three main features: the creation of goals, identification of tasks, and bond development. The working alliance inventory (WAI) is a clinical assessment tool developed and validated by Horvath and Greenberg (1989) to "measure some of the generic (non-specific to a theory or

technique) variables affecting the degree of success in counseling" (p. 223). The WAI is a 36-item survey that examines the three features of the working alliance (goals, tasks, and bonds) originally proposed by Bordin, who later acknowledged that the presence of external stressors do have an impact on a presenting client's issues. Moreover, the working alliance does not specifically address the challenges a counselor may face when working with a client who has been mandated by a court of law to receive substance use disorder treatment.

The counselor-client working alliance within the context of the mandated treatment relationship is obstructed by several key factors. The collaborative creation of goals is not a process that this particular type of therapeutic relationship is afforded. In the mandated counselor-client working alliance, the goals have been set by the conditions of the court: to abstain from the use of alcohol and illicit substances (NADCP, 2013). While this goal may align with that of the drug court participant, it does not negate that the *experience* of creating treatment goals with their counselor has been predetermined. No research has been done to show how this omission of the typical co-creation of goals process impacts the working alliance. Second, the identification of tasks will depend on the type of treatment modality used. As noted in the Best Practices of Adult Drug Court (NADCP, 2013), cognitive-behavioral therapy (CBT) is the prescribed and expected treatment modality for its treatment providers to use. This creates another tension in a potential rupture to the working alliance, since the freedom of the development of goals and tasks between the counselor and client are what inevitably leads to the creation of the therapeutic bond (Sackett & Lawson, 2015). Due to the court's control of both of these key features of the working alliance, the counselor's ability to develop a strong working alliance with a participant of drug court could be hampered.

Researchers have employed meta-analytic studies to determine the key personal characteristics of the counselor that can either positively or negatively impact the counselor-client working alliance—regardless of treatment setting or theoretical orientation used (Ackerman & Hilsenroth, 2001; 2003). Ackerman and Hilsenroth (2001) discovered through their work that counselors who were "rigid, aloof, tense, uncertain, self-focused and critical" (p. 183) had a poor working alliance with their clients. Conversely, counselors with personal characteristics aligned with "dependability, benevolence, responsiveness, and experiences" (Ackerman & Hilsenroth, 2003, p. 7) were identified as being more helpful to the client in fostering a positive working alliance.

While there is no existing literature in the field of counseling about the impact a court mandate can have on the working alliance between client and counselor, there are several studies in the field of social work that have examined the overall program-based experiences of drug court participants (e.g., Gallagher et al., 2015; Gallagher et al., 2017). As related specifically to the counseling profession, drug court participants have identified the treatment portion of the program as being unhelpful and unsupportive in reaching their overall treatment goals (Gallagher et al., 2015; Gallagher et al., 2017). In fact, most participants in one qualitative study described their counselors as being punitive and judgmental in their counseling style (Gallagher et al., 2017). Moreover, an earlier study of drug court participants reported that their individual treatment needs were not being met, and that respondents indicated a general lack of trust with their treatment providers due to their counselor's requirement to report specific treatment progress back to the court (Gallagher et al., 2015). While their study was not specific to working with clients who were actively enrolled in drug court, Miller and Moyers (2015) suggested that certain characteristics of the counselor can play an important role while working with SUD

clients. As such, research such as this suggests that counselors who treat clients enrolled in drug court may need to re-evaluate the way they are providing SUD treatment to ensure they are working *with* their clients towards treatment goals and not *against* them.

Statement of the Problem

Currently, there are more than 20.3 million people (aged 12 and older) in the United States struggling with a substance use disorder (SAMHSA, 2019). Considering how widespread addiction-related issues are, it is important that systems that are put in place to help support these individuals in gaining access to treatment services, and that those treatment services are perceived as helpful. Unfortunately, not all individuals who are enrolled in SUD treatment services do so voluntarily. Oftentimes, individuals will seek care under some type of external factor, or through a referral from drug court.

With more than 1,500 active adult drug treatment courts, mental health agencies are seeing an influx of clients in need of SUD treatment services (National Drug Court Resource Center, 2020). Given what we know about the neurobiology of addiction, we will continue to see a need for alternative legal processes, such as drug courts, to help treat rather than incarcerate individuals struggling with a substance use disorder (Leshner, 1997). Addiction is a chronic disorder that wreaks havoc on the parts in the brain that control our ability to problem solve, make decisions, learn, and behave appropriately (Berke, 2018; Volkow et al., 2011). The establishment of drug courts are a first step in a positive direction to finally address the surge of individuals who struggle with a substance use disorder in the United States as a public health concern rather than a legal one.

Although drug courts represent an innovative criminal justice reform, further work needs to be done to examine how the experience of substance use disorder treatment may be different

for individuals who present to treatment as a mandated referral from these programs. The first discrepancy that exists between drug court and clinical practice is the initial rupture in the working alliance between client and counselor. This rupture is likely to manifest early in the treatment process based on the fact that the development of treatment protocols and goals between client and counselor will to some degree be mandated by the courts. Specifically, the goals of the courts are for clients to achieve abstinence from alcohol and illicit substances, and the tasks, or the way to achieve these goals, is by utilizing cognitive-behavioral therapy (NADCP, 2013).

Importantly, this researcher is not suggesting that abstinence from illicit drugs and alcohol is an unrealistic goal for individuals to achieve during clinical treatment—or that counselors providing treatment utilizing cognitive-behavioral therapy is ineffective. What this study was designed to determine more effectively is how the constraints placed on an individual's SUD treatment process could negatively impact the drug court participant's experience in building a working alliance with their SUD counselor(s), and overall treatment outcomes. For drug courts, positive treatment outcomes correspond to participants graduating from the program and reducing the likelihood of criminal recidivism.

Given that a strong working alliance between counselor and client has the most positive impact on treatment outcomes (Bordin, 1979, Hauser & Hays, 2010; Wampold et al., 1997), it is essential that we more fully understand the clients' experiences of the working alliance with counselors during drug court-mandated addiction treatment. The WAI and related research describe critical elements for developing a strong working alliance based on perceptions of the client's relationship with their counselor (Horvath & Greenberg, 1989) and key personal characteristics of the counselor (Ackerman & Hilsenroth, 2001; 2003). Nonetheless, additional

research is needed to explore the client experience within the working alliance, and in so doing reveal the positive influences at play when working with clients who are mandated to receive SUD treatment. Therefore, this qualitative study was guided by one central research question: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment?

Definition of Terms

Drug court: A structured alternative sentencing process for individuals who are assessed as being eligible for the program, which is intended to reduce the criminal recidivism rates of individuals who are charged for drug-related offenses (Marlowe et al., 2016).

Drug court officials: Individuals who primarily serve or supervise a participant and help them navigate their court-mandated responsibilities (e.g., judge, case managers, probation officers) (NADCP, 2013).

Drug court participants: Adults who have a substance use disorder diagnosis, are convicted of a drug-related crime, and are sentenced to an alternative sentencing process (NADCP, 2013).

Client: In the context of this study, a client will refer to an individual who is actively receiving substance use disorder treatment services as required by their local drug court program.

Participants: Individuals who have been recruited and agreed to take part in this research study.

Overview of Methodology

This qualitative research study explored clients' experiences of the working alliance with counselors during drug court-mandated addictions treatment. This investigation was guided by a constructivist grounded theory framework (Charmaz, 2014) to help answer the overarching

research question: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment? The participants who took part in this study were actively enrolled in their local drug court program, were at the time of this investigation receiving SUD treatment, and were at least 18 years old. This research methodology was expected to capture the lived experiences of the research participants and thus augment the literature in this important area.

Chapter 2: Literature Review

Drug court programs have proven to have moderately positive outcomes in terms of reducing criminal recidivism (Marlow et al., 2016); nonetheless, the existing literature examining the lived experiences of participants who receive SUD treatment as required by the courts is minimal and disheartening (Gallagher et al., 2015; Gallagher et al., 2017; Witkin & Hays, 2019). Due to the nature of the mandated treatment relationship, the confidentiality the typically binds and secures the therapeutic working alliance is not as defined as it is in fully voluntary treatment settings. Current research has yet to explore how the development of goals and tasks are impacted by the mandated treatment relationship. With more than 1,500 active drug court programs throughout the United States referring clients to community mental health agencies for SUD treatment (National Drug Court Resource Center, 2020), there is a pressing need to better understand the working alliance between counselors and clients who have been mandated to receive SUD treatment.

Context for This Study

Working Alliance

The client-counselor working alliance has proven to be more effective in predicting positive treatment outcomes than any variation of treatment modalities, interventions, or theoretical orientations used (Hauser & Hays, 2010; Wampold, et al., 1997). Initially established by Bordin (1979), and later validated as a clinical assessment tool by Horvath and Greenberg (1989), the working alliance consists of three main features: the creation of goals, identification of tasks, and bond development. In Bordin's explanation of the working alliance, he emphasizes the autonomy of the client as being essential to the treatment process and to the subsequent development of the working alliance. As Bordin stated, "The aim of treatment is to examine,

modify, or ameliorate his or her own contributions to, or exacerbation of, these pains" (p. 253). In the first stage, development of goals, there is an agreement, or *bargain*, between the client and counselor outlining what the client would like to work on. As it relates specifically to external pressures, and in the context of drug court, this component has the potential to obstruct the client from being able to develop goals for themselves, and thus can add to the difficulty of a client being able to develop an intrinsic motivation for change.

Bordin (1979) indicated that the process of task creation between client and counselor is inherently undefined at first as these tasks are constructed after a goal has been identified. Bordin does critique the lack of client autonomy in behavioral and other psychodynamic therapies as such structure can diminish the client's perception of how they are achieving their identified treatment goals. This issue is important and pertain to this study in that the Adult Drug Court Best Practice Standards outlines that the substance use disorder treatment being provided through the contracted agencies will employ cognitive-behavioral therapy with drug court participants (NADCP, 2013). Bordin also pointed out that the most vital role of the counselor is collaboratively developing tasks with the client and the "vividness with which the therapist can link the assigned tasks to the patient's sense of his difficulties and his wish to change" (p. 254). Bordin (1979) noted that to achieve a collaborative working alliance, the counselor's role is to employ "activity-passivity, empathic understanding, communicating, interpreting, self-disclosing, etc." (p. 254) in order to help the client experience autonomy throughout their treatment experience.

As expected, there is a significant level of nuance in explaining the bond development aspect of the working alliance. Bordin (1979) described how the length of treatment (e.g., three years versus three months) can initially serve as a platform or barrier in developing a more

bonded relationship with the client. Bordin (1979) noted that the nuance in bond-development is primarily situated between the counselor serving as "a care-taker and a consultant" (p. 255). In utilizing a behavioral therapy framework, the counselor has a much higher risk of being seen as the consultant, or expert, within that therapeutic space, which has the potential to decrease the client's sense of autonomy. Again, this issue can negatively impact the development of a positive working alliance with drug court participants when cognitive-behavioral therapy is the prescribed treatment modality for this population (NADCP, 2013). However, on the other end of this continuum is the therapist being seen as more of a caretaker, attending to the client's feelings rather than achieving the agreed-upon goals. While this relationship can feel comforting to some extent, it again diminishes the collaborative nature of a true client-counselor working alliance.

When comparing the three elements of the working alliance (Bordin, 1979) against the operational best standards of adult drug courts (NADCP, 2013), it becomes evident why drug court participants may have a harder time developing a more bonded therapeutic relationship with their counselor(s). Two primary reasons account for this difficulty. First, there is the lack of autonomy in the development of goals, and therefore tasks. Second, one must account for the perceived power differential between counselor and client during behavioral therapy treatment. For drug court participants, their goal is pre-determined upon entry into the program, which is to achieve abstinence from all alcohol and illicit substances (NADCP, 2013). Counselors who work with this population are required to employ cognitive behavioral therapy, which can influence the client's perception of their autonomy in agreed-upon tasks and ability to makes changes in their own lives. Moreover, this approach has been criticized for not fully addressing wider problems in family systems that can impact behavioral and life choices (Ray et al., 2020). Despite these major discrepancies as it relates to the SUD treatment of drug court participants,

we do have tools to help counselors determine the strength of their working alliance with their clients.

The Working Alliance Inventory (WAI) is a 36-item questionnaire designed to examine various elements in the therapeutic relationship; when its results are analyzed collectively it may determine the strength of the working alliance. The WAI is available in two forms, WAI-C and WAI-T. The WAI-C, which was deployed for this investigation, is intended to capture the perceptions of the client regarding the components of the working alliance. The 36-item survey measures the three components of the therapeutic relationship: tasks, goals, and bonds. The survey items are represented as a list of statements with a space where clients are instructed to insert the name of their therapist. Clients are asked to rate each of these factors on a 7-point scale. A score of 1 would indicate that the client "never" feels this way about the survey item; a score of 4 would indicate that the client "sometimes" feels this way; and a score of 7 would indicate that the client "always" feels this way. For example, the first item on the survey states the following: "I feel uncomfortable with _____." (Horvath & Greenberg, 1989, p. 2).

It is important to examine the available literature on the client's perception of the working alliance to determine if these constructs of the alliance adequately capture their experiences and treatment outcomes. While assessing the health of the working alliance between client and counselor is important—and assessment measures are available to facilitate this goal—the real question as it relates to the present study is whether this is being done for drug court clients. Based on Bordin (1979), we know that intrinsic motivation, session content, and various interpersonal characteristics of the counselor are important in forming a healthier working alliance. As there is little literature examining the experiences of the working alliance with drug court clients, it can be helpful to review the related literature on constructs of the working

alliance, and specifically with clients who have been mandated to receive treatment.

Assessing for Relational Rupture. Doran (2016) conducted an extensive review of the available literature pertaining to the constructs of the client-counselor working alliance. Using a meta-analysis review, Doran dove into decades of theoretical and empirical literature to explore the strengths and limitations of the working alliance. While there is extensive literature on the working alliance as being one of the most promising predictors for positive treatment outcomes, this review of the available research points to several assumptions about the client-counselor working relationship that merit further examination given the evolution of the field of psychotherapy. For this study, the research that most directly impacts the working alliance in the context of mandated substance use disorder treatment will be explored more closely.

Doran (2016) highlighted the plethora of empirical studies addressing the working alliance, noting that more than 30 assessments have been developed on this concept. What appears to have been under-emphasized over the past few decades, however, is an emphasis on *agreement* in the working alliance (Doran). Indeed, a therapeutic relationship that may not have been established jointly and voluntarily can have severe repercussions on the efficacy of the working alliance. This notion requires counselors, counselor educators, and researchers to think critically about external factors for client compliance in treatment, and whether those external influences truly support to a healthy working alliance. Doran further critiqued the concept of inherent agreement in the working alliance in light of the fact that instances of *rupture* and *repair* were discussed as being normal and healthy in the therapeutic process. Many relational theorists have positioned these experiences as overall strengthening the therapeutic alliance, but still are not captured in assessments constructed to assess the working alliance. This notion is also

particularly relevant to using a relational cultural theory (RCT) framework with mandated clients as more meaningful connections are made through instances of repairing disconnection (Jordan, 2000).

The next critique that Doran (2016) discussed involves the ways that psychotherapy research data are being analyzed. Due to the overabundance of univariate statistical testing techniques (e.g., ANOVA) on working alliance assessments, it is suggested that the results of these tests may be producing type I errors. Doran explained this issue as related to the fact that because features of the working alliance are dependent on one another (e.g., client, therapist, and client-therapist relationship), basic statistical testing is not sufficiently sophisticated to control for confounding factors. Instead, the author suggested that more advanced statistical analysis be conducted on working alliance assessments, which would do a better job at explaining any variances and control for such confounding factors. Doran specifically suggested techniques embedded within hierarchical linear modeling and multilevel models of statistical analysis.

The review of this literature is important to this study for two main reasons. First, it highlights the ever-evolving characteristics of the working alliance in current practices, now involving more relational features than when this concept was first developed in the late 1970s. However, the maturation of this field presents some problems as these features are not always represented by the current assessment measures counselors use (Doran, 2016). The specific type of relational factors that can impact the working alliance should be studied and validated through qualitative approaches, and existing assessments should be revised to include this information. Second, the review of current literature shows a major flaw in the type of statistical analyses used. Future researchers who intend to study the working alliance must remain aware of all confounding factors that can influence the interpretation of results (Doran, 2016). Reviewing the

available literature that addresses specific supportive behaviors on behalf of the therapist can provide more insight into what can be helpful in creating a more bonded and effective relationship between client and counselor.

Perception, Technique, and Relational Eclecticism. Due to some of these noted confounding factors examining the working alliance through a quantitative inquiry, it is important to highlight a recent study that explored the working alliance through a qualitative inquiry. MacFarlane, Anderson, and McClintock (2015) examined some earlier studies highlighting the discrepancies between how clients view the working alliance against the constructs of the working alliance as developed by Bordin (1979). Some studies they reviewed noted that clients will tend to minimize the importance of their contribution to the working alliance (Bedi, 2006), and/or overemphasize the counselor's supportive behaviors (Bedi, 2006; Bedi & Duff, 2009; 2010). Given that these elements are not necessarily captured by the Working Alliance Inventory (Horvath & Greenberg, 1989), such emphasis can be problematic in fully understanding what strengthens a working alliance.

Specifically, MacFarlane and colleagues (2015) focused on the impact of these discrepancies, seeking to better understand four key areas regarding the client-counselor working alliance:

> (a) the level of client contribution to the therapeutic relationship and the establishment of the alliance; (b) the complex interactions of the components of the alliance… ; (c) elaboration of the alliance components; and (d) psychotherapists' activities that either enhance or reduce the strength of alliance. (p. 364)

The researchers used secondary data collected by Holmberg (2003) for their investigation. Data from a total of 54 participants (undergraduate and graduate students recruited from a college

counseling center) who completed all phases of the study where included in the final analysis and results section of this study. The majority of participants in this study identified as white (92.3%), female (86.5%), with an average age of 21.5 years old (MacFarlane et al., 2015). The authors used three separate measures to examine key areas in the client-counselor working alliance: the Outcome Questionnaire-45 (OQ-45) (Lambert et al., 1996), the Working Alliance Inventory (Horvath & Greenberg, 1989), and the Alliance Workbook (Holmberg, 2003).

The results of this study yielded 884 recording units that were later clustered into four categories: (1) client's initial misgivings about psychotherapy, (2) organization and meaning-making, (3) psychotherapist supportive activities, and (4) client appreciation of techniques (MacFarlane et al., 2015). Findings from the first category (client's initial misgivings about psychotherapy) indicated that participants expressed that "not knowing what to expect and not knowing what might be expected of them" (p. 366) as being an initial barrier in the formation of a positive working alliance between counselor and client. MacFarlane and colleagues did note that due to the rapport-building in these initial stages, that bond was developed in tandem with goals and tasks development in early therapy. This finding is important to the current study as the development of goals corresponds to the first stage of building the working alliance, as well as being one of the areas obstructed by the requirements of the courts. Importantly, this finding supports the possibility that a strong rapport/working alliance can be developed between counselors and clients who are mandated to receive substance use disorder treatment, despite the fact that goals are set by the courts and not entirely developed by the individual seeking treatment.

The second category that emerged from this study (organization and meaning-making) describes the barriers that can exist for clients in forming a positive working alliance due to

specific psychotherapy-related activities implemented early on in counseling sessions (MacFarlane et al., 2015). For instance, the authors indicated that clients felt “overwhelmed” by the line of questioning used by the therapists to understand their presenting issues, rather than focusing on understanding the client as a whole. This factor is relevant to the current study as counselors working with drug court participants in their SUD treatment should be mindful of not over-pathologizing the presentation of their clients substance use in the first session—but rather ensure that they are working to understand the whole person in that counseling space.

The third and fourth category clusters (psychotherapist supportive activities, and client appreciation of techniques) emphasize how strength is built within the working alliance between counselor and client (MacFarlane et al., 2015). Some of the ways that clients identified supportive activities included instances when their therapist reassured and empowered them, when they normalized their experience and kept a calm demeanor, and when they instilled hope for healing (MacFarlane et al.). In particular, the clients in this study noted the importance of reassurance techniques and feedback, the development of concrete tools for moving forward, and how they offered suggestions and provided constructive feedback. Both categories highlight positive ways whereby a therapist's supportive activities can be well received and help build a positive working alliance.

As MacFarlane et al. (2015) detailed, there are various ways that the first two sessions in psychotherapy treatment can be viewed as being essential for either contributing to, or hindering, a positive working alliance between the client and counselor. Their findings correspond to Bordin’s (1979) earlier work about the working alliance, in that there is still a great deal of nuance as to how therapeutic relationships are built, as well as the specific factors related to the therapist's ability to employ various relational techniques during a session. While a general

inquiry into the client-counselor working alliance is useful in understanding how these concepts have evolved over time, it is important to review work that specifically examines the elements that can impact the working alliance for individuals who have been mandated to receive mental health treatment.

Perceived Coercion and the Impact on Alliance. In a cross-sectional cohort study, Sheehan and Burns (2011) explored the perception of treatment coercion among voluntary and involuntary psychiatric hospital admission patients. Their sample of participants consisted of five adult psychiatric care units at two different hospitals in Oxford, England. Overall, responses were gained from 164 participants who were primarily white (88%), middle-aged (38.8±12), and men (57%). One-third of research participants in this study presented with a co-occurring substance use disorder (34%) and had been previously hospitalized (70%).

Sheehan and Burns (2011) used three primary instruments for data collection to explore any perceptions of coercion among the inpatient psychiatric clients who took part in this study. The first was the MacArthur Admission Experience Survey (AES), which consisted of three subscales totaling 14 items: the AES-PC (perceived coercion), the AES-NP (negative pressure), and the AES-PJ (procedural justice). The researchers also used the Helping Alliance Scale (HAS) to measure the therapeutic relationships between the clients and their assigned clinician, and the Global Assessment of Functioning (GAF) to measure each client's psychological, social, and occupational functioning. Descriptive statistics were run on sociodemographic and clinical characteristics to separate the sample into two groups: participants with low AES-PC scores and high AES-PC scores (Sheehan & Burns, 2011). From there, the researchers tested these two groups with t and Mann-Whitney tests to determine continuous variables, after which they conducted a chi square test to determine the categorical variables. They then used a multiple-

variable logistic regression analysis to determine which variables were most closely related to perceived coercion. A hierarchical logistic regression analysis was performed to determine if the baseline sociodemographic information and clinical characteristics would be useful in predicting the perceived coercion levels (Sheehan & Burns, 2011).

Results from this study did not reveal any significant associations between the sociodemographic characteristics and perceived coercion (Sheehan & Burns, 2011). Not surprisingly, significant associations were found between clients who had been admitted involuntarily and higher perceived coercion scores. Moreover, the researchers also reported that the HAS scores were "significantly associated with perceived coercion" (p. 474); specifically, the higher the clients rated their perception of coercion entering into treatment, the higher the likelihood that their therapeutic relationship with their assigned therapist would be negatively impacted. These findings are important to the current study as they reinforce the idea that focusing on strengthening the working alliance can have positive effects on client's experiences in treatment despite the court-mandate.

Seeing Eye to Eye: Patient and Therapist. Seaward and colleagues (2021) conducted a large-scale qualitative research study examining the mental health of older adults living in correctional facilities in Switzerland. The researchers conducted single interviews with 41 individuals mandated for treatment, as well as 63 mental health professionals (MHPs)—the goal of which was to determine the perspectives of service providers and users regarding therapist-related characteristics. (Note that specific demographic information for the incarcerated individuals and the MHPs were not included in this article.) Data analysis was completed alongside data collection to determine when saturation had been met. Some of the topics included in the semi-structured interview guide included personal background information, aging

in the prison context, access to and quality of mental health care, and risk assessment information (Seaward et al., 2021). For this particular aspect of the study, only instances that described "therapist characteristics and activities were extracted" (p. 6).

Results from this qualitative inquiry produced five themes that correlated therapist characteristics and activities with subsequent positive effects on the patient's receptivity to treatment and expert-participants delivery of treatment: (1) treating patients with respect, (2) displaying genuine interest in helping the patient, (3) recognizing and responding to patients' needs, (4) tackling topics in detail, and (5) the skill of the therapist (Seaward et al., 2021). The first three themes were noted by both the patients and MHPs, while the last two themes were only noted by patient who contributed to this study.

The first theme was strongly linked to mental health providers "avoiding stigmatization" and taking a "humanistic approach" towards their clients (Seaward et al., 2021, p. 7). The mental health care professionals explained this humanistic approach, noting the importance of not further condemning their patients as that is something "the judge has already done" (p. 7). The patients experienced a more positive relationship with the MHPs who took this approach, noting that they felt "treated as a regular human being" (p. 7). The second theme of displaying genuine interest in helping the patient was also noted by both patients and clinicians; indeed, the latter noted how seeing patients heal and have a better quality of life under their care was "very rewarding" (p. 8). Patient-participants also reported that it was evident when the mental health professionals were intrinsically motivated to provide services, rather than it feeling like just a job they were doing in order to receive a paycheck. The third theme to emerge from this inquiry highlighted the importance of recognizing and responding to patient needs (Seaward et al., 2021). The MHPs who took part in this study emphasized that "content has to be something that

they find useful" (p. 9) if cognitive and behavioral change is to occur and be sustained. Similarly, the patients described how mental health professionals who attended to their needs rather than coming in with their own agenda helped the therapy feel "less constrained...and less coercive" (p. 9).

The fourth and fifth themes that emerged from this study (tackling topics in detail and the skill of the therapist) were principally discussed by the patients (Seaward et al., 2021). With respect to the former, the patient-respondents complained when therapy topics were discussed too generally, noting that "the more detailed and specific the MHP's focused on their problematic behavior, the more they perceived treatment as being a learning experience" (p. 10). Regarding the perceived skillfulness of therapists, respondents described instances such as therapists not able to respond to therapeutic questions, having a lack of manners, or expressing feelings of helplessness when not knowing how to help the patient—all of which heightened their negative experiences (Seaward et al., 2021).

Results from this study are helpful in understanding what characteristics can be helpful in facilitating the change process in a mandated treatment setting. Researchers continue to confirm that the client's perception of their therapist's behaviors plays a key role in mandated clients having a positive treatment experience (Doran, 2016; MacFarlane, 2011; Seaward et al., 2021; Sheehan & Burns, 2011). Concepts such as the therapist seeming genuine, attending to the client's individual needs, and honoring a client's perspectives during treatment are reported to be key elements in forming a positive working alliance. This review of the literature now addresses what barriers exist in developing a healthy working alliance in other mandated treatment settings, and in drug courts specifically.

Drug Court

The development of drug court programs represents one of the largest reforms to the criminal justice system since the late 1980s (Marlowe et al., 2016). Currently, there are more than 1,500 adult drug court programs in the United States serving individuals who struggle to refrain from criminal behavior (National Drug Court Resource Center, 2020). These behaviors are either directly linked to substance use, behaviors engaged to obtain the substance, or behaviors engaged in due to intoxication from the substance (U.S. Department of Justice, 2020).

In terms of the current study, a corollary question driving this investigation is the following: *Do drug courts work*? Over the past two decades there have been numerous meta-analysis studies examining the effectiveness of drug courts—the principal goal of which was to determine if drug court programs do decrease criminal recidivism as intended (Aos et al., 2006; Carey et al., 2012; Latimer et al., 2006; Lowenkamp et al., 2005; Mitchell et al., 2012; Rossman et al., 2011; Shaffer, 2010; U.S. Government Accountability Office, 2011; Wilson et al., 2006). In the aggregate, the findings from these studies suggest that drug courts do decrease criminal recidivism on average from 8% to 14%, and at best from 35% to 80% (Marlowe et al., 2016). Determining what *on average* and *at best* looks like has been understudied, necessitating additional research to examine more specific elements pertaining to the efficacy of drug courts (Rossman et al., 2011; Shaffer, 2010; Wilson et al., 2006).

The drug court system in the United States has been described as bordering on labyrinthine (Shaffer, 2010). Various studies have shown that while systematic evaluations have largely focused on retention and graduation rates among participants, they have neglected to understand the individual facets of the programmatic experience that could help increase the only moderately impressive results (Aos et al., 2006; Latimer et al., 2006; Lowenkamp et al., 2005; Mitchell et al.,

2012; U.S. Government Accountability Office, 2011). Several studies have specifically noted that examining relational factors among drug court participants and treatment providers could highlight essential components for increasing retention and graduation rates (Rossman et al., 2011; Shaffer, 2010; Wilson et al., 2006), which served as the impetus for the design of the current study. For the present time, however, individuals interested in the success of drug court programs will need to continue to look at how closely drug courts operate their ten key components (NADCP, 2004), as shown in Table 1.

Table 1. *Ten Key Components of Adult Drug Treatment Courts*

	Key Component Description
1	Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2	Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3	Eligible participants are identified early and promptly placed in the drug court program.
4	Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5	Abstinence is monitored by frequent alcohol and other drug testing.
6	A coordinated strategy governs drug court responses to participants' compliance.
7	Ongoing judicial interaction with each drug court participant is essential.
8	Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9	Continuing interdisciplinary education promoted effective drug court planning, implementation, and operations.
10	Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

The National Association of Drug Court Professionals (NADCP, 2004) developed the Ten Key Components to define the goals and functions of drug court programs as they seek to elicit successful outcomes for the participants they serve. While the Ten Key Components were developed for drug court participants specifically, the counseling community also has a significant stake in the drug court process; indeed, six out of ten key components require

participants to engage in an SUD treatment program (#1, #4, #5, #6, #8, #10). This mandate is concerning given that there are currently no standards in formalized counselor training programs requiring counselors-in-training to develop skills to work with clients who fall within this specific clinical population. This lack of formalized training could negatively impact the disparities in graduation rates nationwide. While counselors are trained on how to create a positive working alliance with the clients they serve, it is important to explore the available literature on the client's experiences in mandated treatment settings more broadly.

Is Evidence-Based Treatment That Much Better? Miller and Moyers (2015) compared the importance of evidence-based treatment (EBT) methods in addiction treatment versus what many call *common factors* in terms of which is better at predicting positive treatment outcomes. The authors completed a comprehensive meta-analysis on decades of research that reviewed both general and more specific factors related to positive outcomes in addiction treatment, the goal of which was to increase our clinical understanding of how much influence scientifically proven treatment modalities really have in predicting better outcomes. Miller and Moyers argued that the threshold for what constitutes EBTs in addictions work is far too small and too easy to obtain as "more than 330 different interventions for SUDs are listed as evidence-based" (p. 404). What is known through the existing literature is that there are common factors that have been shown to play a substantial role in treatment, but yet remain vastly understudied.

Miller and Moyers (2015) reviewed one clinical study designed to assess the differences between three treatment modalities (cognitive-behavioral therapy, motivational enhancement therapy, and 12-step facilitation therapy) at nine different SUD treatment locations. (Note that each of these treatment modalities are recommended by national drug court standards to be utilized in clinical settings with clients (NADCP, 2004).) This study's findings confirmed that

across all sites there were no significant differences between the treatments, despite two being evidence-based treatment modalities (Miller & Moyers, 2015). Even though this study incorporated uniformed training and monitoring of trained therapists who facilitated this investigation, the results detailed therein were inconclusive as to why EBTs did not show any statistically significant treatment outcomes. Thus, the authors indicated that here must be other factors influencing the treatment outcomes that cannot be easily defined by EBTs.

In their review of the literature, Miller and Moyers (2015) also indicated that one of the best indicators of treatment outcomes may be determined by the specific counselor to whom the client is assigned. Thus, irrespective of theoretical orientation and the specific treatment modality, it may be counselor's characteristics that have the greatest impact on treatment outcomes in addictions work. The researchers then outlined four themes of counselor characteristics that are related to positive outcomes: expectancy, allegiance, interpersonal skills, and fidelity (Miller & Moyers, 2015).

The characteristic of *expectancy* is important when thinking about counselors who may be working with clients who have been mandated for treatment. This characteristic refers to the counselor verbalizing their expectations for the potential of clients to achieve their treatment goals (Miller & Moyers, 2015). For counselors of drug court clients, this factor would include verbalizing their belief in their clients potential to graduate from the program and/or achieve abstinence from drugs and alcohol. The characteristic of *allegiance* refers to a counselor's dedication to the treatment approach they implement (Miller & Moyers, 2015). This factor, however, could be problematic given that drug court best practices state that only EBTs—and specifically CBT—should be the primary treatment modality delivered through their providers. While competent counselors *should* be able to facilitate a CBT approach with the clients they

serve, it does not account for counselors who may use a more integrative approach with several theoretical orientations. What this research shows is that therapists who practice a treatment modality with which they are theoretically misaligned can have negative repercussions on client treatment outcomes (Miller & Moyers, 2015).

Interpersonal skills have also been identified as being a key characteristic of counselors who achieve positive treatment outcomes. Within the context of addiction treatment, the ability of a counselor to display both verbal and nonverbal cues of empathy towards their client is linked to improved clinical outcomes (Miller & Moyers, 2015). Conversely, when considering the qualitative literature on drug court participants' experiences in SUD treatment, it is evident that a lack of empathy from counselors who treat these individuals could negatively impact graduation success (Gallagher et al., 2016; 2017). Lastly, Miller and Moyers (2015) addressed the characteristic of *fidelity*, which refers to the counselor's ability to continuously assess for and deliver "complex behavioral interventions." This concept is supported by research on motivational interviewing and the counselor's ability to make appropriate linkages between client's speech and interventions. These findings also reinforce the earlier work of Bordin (1979), who emphasized the counselor's ability to respond fluidly to their client's needs in session in order to form a healthier working alliance.

We see through the literature that there are distinct discrepancies between what is required at the programmatic and/or agency level in the provision of court-SUD treatment, versus the client's favorable perspective of how their treatment is progressing. As such, it is important to better understand the experiences of drug court clients entering into mandated SUD treatment compared to clients whose treatment is fully voluntary. The following literature reports shed light on this discrepancy.

Therapist Control: For Better or Worse. Manchak, Skeem, and Rook (2016) facilitated a cross-sectional quantitative study to explore key differences in the mandated mental health treatment relationships against those of fully voluntary treatment relationships. As the researchers described, mental health court is a similar alternative sentencing program to drug court, but focuses on individuals struggling with criminal behavior based primarily on the presentation of severe mental health disorders. Manchak et al. explored two main facets of the therapeutic alliance for individuals who were mandated to receive mental health treatment. First, researchers sought to understand how therapist control functions in the mandated treatment relationship compared to voluntary treatment relationships. Second, they sought to determine if there was an increase in therapist control in the mandated treatment relationship—and if so, did the increase lead to client disaffiliation towards their therapist.

This study used a comparative research approach to answer their overarching research questions, which involved the identification of three existing studies (completed in 1992, 1994, and 2011) that they could use to compare against their sample of mandated treatment participants. In total, 125 mental health court participants (average age of 37) took part in this study. In total, 46% of respondents identified as male, and 54% identified as female. Most respondents (~67%) identified as being White, followed by Hispanic (~16%), African American (~10%), Native American (~4%), and Asian (~3%) (Manchak et al., 2016).

For the Manchak et al. (2016) study, research assistants conducted two-hour interviews with eligible research participants using the INTREX questionnaire (Benjamin, 2000), which is a self-reported assessment based on the Structural Analysis of Social Behavior (SASB) interpersonal model originally developed by Benjamin (1993). The 64-item medium form of this

assessment asked participants to rate their perceptions of their relationship with their therapist between zero (does not describe the relationship) and 100 (perfectly describes the relationship). The assessment sought to understand how the therapist transitively acted towards the client, and how the client intransitively reacted towards the therapist (Manchak et.al, 2016). Researchers demonstrated that the INTREX assessment had good reliability (split half, α= .82; test-retest, α=.84); the internal consistency of this assessment was also shown to be acceptable (α=.85). It should be noted, however, that the authors did not provide adequate evidence for the validity of the INTREX assessment, which is a limitation to their selected methodology.

The results of this study showed significant findings as it relates to understanding facets of the treatment relationship for clients who have been mandated to receive mental health treatment against those who voluntarily present. In response to the first research question, findings confirmed that mandated treatment relationships "involve substantially more therapist control and client submission" (Manchak et al., 2016, p. 53) compared to voluntary participant research findings. Despite this increase in therapist control, it was surprising that this increased control did not impact client affiliation with their treatment provider; in fact, in some cases, mandated treatment participants displayed greater affiliation with their therapist than that of voluntary participants. Manchak and coworkers attributed this outcome to the fact that mandated treatment individuals may have a small network of positive social supports in their lives; thus, despite the increased level of control in this relationship, it was still viewed more positively.

From a methodological standpoint, it is important to note that participants were given guidance in completing the INTREX assessment. Specifically, 56% of research participants were enrolled in day treatment programs, which typically involve working with several mental health providers at one time. For this study, researchers assisted participants in identifying the mental

health provider to assess, with instructions to single out “the mental health provider you are most likely to turn to when you need advice or assurance, who helps you the most, and/or with whom you have the most significant discussions” (Manchak et.al, 2016). Thus, this directive should be viewed as limiting the internal validity of this study. For example, asking a respondent to select the provider who “helps” the individual the most may elicit a participant to reflect on interactions with their case manager. Additionally, asking the respondent to identify the provider with “whom you have the most significant discussions” may have led participants to focus on their attending psychiatrist who is able dispense medications (a critical component of mental health treatment), but with whom they may not have engaged in more substantive discussions. To counter these potential limitations, that researchers could have required participants to complete the assessment based on their interactions with their assigned mental health therapist, especially since the study was designed to investigate the relationship between therapist control and client affiliation.

Another major limitation of the Manchak et al. (2016) study pertains to the diagnostic makeup of the research participants who took part in those earlier baseline studies versus those who contributed to the Manchak et al. investigation. For example, for the earlier voluntary samples the diagnostic makeup of these participants included personality disorders, anxiety disorders and depressive disorders. In comparison, the diagnostic features of the later participants included bipolar and psychotic disorders (Manchak et al, 2016). While the demographic features of all participants were similar in terms of gender, age, and educational levels, this does not compensate for the stark differences in the participants’ presenting mental health disorders, which begs the question of whether comparing these groups was appropriate.

To conclude, one could argue that the findings that emerged from Manchak et al.'s (2016) study cannot be fully ascribed to the differences in participants either being mandated or voluntarily presenting for treatment, and that one should be conservative with the generalizations drawn from the results. For this reason, it is important to continue this critique of the current literature by reviewing a recent study examining how the concept of self-determination can play a vital role in understanding what contributes to positive treatment outcomes for clients who present to addiction treatment under a legal mandate versus those who present voluntarily.

Understanding Client Motivation. Wild, Rush, and Urbanoski (2016) investigated the effectiveness of legal referrals in understanding clients' motivation for seeking treatment. The researchers hypothesized that (1) on admission, participants who were legally mandated to receive treatment versus those who presented on a voluntary basis would have different perceptions of how coerced they felt into entering treatment, and (2) that the "associations between legal referrals and subsequent measures of client engagement...would be moderated by reasons that clients sought treatment, as conceptualized by social determination theory [SDT]" (p. 37). Wild and colleagues facilitated a prospective observational design to test these two primary hypotheses.

The study was conducted at a 42-day western Canadian residential addiction treatment program with 325 respondents, equally split male and female; similarly, half the cohort was legally referred, while the other half presented voluntarily (Wild et al., 2016). Researchers used three main baseline measures for this study and one measure upon a six-week follow up. First, the MacArthur Perceived Coercion Scale was used to assess to what degree clients perceived control in their decision to enter treatment. Second, the Treatment Entry Questionnaire (TEQ) was used to assess external, introjected, and identified treatment motivation. Briefly, external

motivation explains external social pressures (i.e., legal referral) as to why the participants entered treatment; introjected motivation explains internal pressure (i.e., letting oneself down); and identified motivation indicates a more intrinsic rooted motivation for entering treatment (i.e., personally wanting the changes). Notably, the TEQ was particularly important for the overall results of this study as understanding the motivation for why research participants entered treatment should be considered key to the results. Third, researchers also used the Substance Problem Scale to determine the client's perception of the severity they may have with their drug of choice (Wild et al., 2016). Six weeks after the study, participants were required to complete the Client Evaluation of Self and Treatment to assess their cognitive involvement while in treatment (Wild et al., 2016).

Cognitive involvement should be viewed as a crucial measure to assess in this study as it asked participants to self-report their perceived level of involvement in their treatment. To expand on this concept, merely physically *showing up* is not enough to elicit positive changes during behavioral health treatment; there must be a cognitive commitment to the treatment process to yield positive results. This factor is particularly salient to the legally mandated treatment population.

Wild and colleagues (2016) began this study by running bivariate t-tests and chi-square tests to compare clients who presented to treatment voluntarily against those who were legally referred. A chi-square test was used to test the first hypothesis aimed at exploring the level of perceived coercion among legally mandated and self-referred clients. The findings that emerged from this investigation did confirm the first hypothesis: clients who were legally mandated for treatment did perceive coercion (63.8%) at admission with greater frequency compared to those who presented voluntarily (37.9%). While these findings should not be considered to be

surprising, they do pertain to the current investigation. Counselors need to be aware that there will likely be feelings of coercion while working with drug court clients who are mandated to receive SUD treatment.

Wild and colleagues (2016) then used advanced statistical analyses to explore the more intricate second hypothesis they posed regarding the level of client engagement, why they sought treatment, and how this information might be applicable to social determination theory. The researchers employed a Cox proportional hazards model to account for time-to-dropout among research participants. They then conducted a regression analysis to account for the level of cognitive involvement among research participants who either remained in treatment or dropped out. Following the analysis of these results, Wild et al. reported that client engagement was heterogeneous in determining what specific factors impacted client motivation regarding the SDT. Results of this study showed that "legally-mandated clients who . . . reported that they had low levels of identified or external motives for seeking treatment exhibited faster drop-out" in comparison to clients who were legally mandated but rated higher in these areas of motivation (Wild et al., 2016, p. 40). What is unique about this study is the exploration of the temporal features that led to higher dropout rates among legally referred clients.

Wild et al. also indicated that legally referred clients who experienced higher levels of guilt and shame when leaving treatment evidenced significantly higher levels of cognitive engagement compared to their legally referred counterparts who did not feel guilt or shame when leaving treatment. Overall, this study did confirm that using social determination theory could be an adequate measure of determining treatment motivation among legally referred participants. If the components of SDT could be implemented soon after admission, said approach could

decrease treatment dropout rates among legally referred clients who present with lower levels of identified motivation.

Now that factors unique to clients who have been mandated to receive behavioral health treatment have been explored, it is important to examine the available literature on the experiences of drug court participants. The following studies do shed light on this topic and support the design of the current study.

Barriers in Building Trust. Gallagher, Nordberg, and Kennard (2015) examined six of the Ten Key Components of drug court (NADCP, 2004) that they felt most directly impacted participants. In total, 41 participants contributed interview-based data for this study (29 male-identified and 12 female-identified; 22 identified as White, 16 as African American, and 3 as Hispanic). A single research question guided this investigation: *How do drug court participants view the program, regarding the quality of substance abuse counseling they receive, the supportiveness of the drug court team, the effectiveness of sanctions and incentives, the effectiveness of frequent contact with the judge, and the effectiveness of frequent and random drug tests*? Gallagher et al. asked each participant five questions; for the current study, however, only the findings related to the first interview question (i.e., regarding participants' perceptions of the strengths and limitations of their substance abuse counseling services while in drug court) will be assessed.

Due to the nature of the overarching research question, Gallagher et al. (2015) conducted a qualitative analysis guided by phenomenology. The researchers used open coding to identify similarities between participant responses, coupled with a memoing process to assist in understanding the meaning behind the collected participant responses. Through the technique of concept mapping, codes were grouped into theme.

Two primary themes emerged from this study as it related to participants' experience with mandated SUD treatment. The first theme was that participant wanted to receive a combination of individual treatment with, or in lieu of, the traditional group psychotherapy format (Gallagher et al., 2015). Most participants who indicated the need for individual therapy were able to provide specific reasons why, such as needing to work through past trauma and not feeling comfortable to do so in a group setting. Participants also expressed how the attitudes of fellow group members were discouraging and/or inhibiting in being able to process certain topics in the group format (Gallagher et al.).

The second theme to emerge was that participants generally felt a lack of trust with their treatment providers (Gallagher et al., 2015). The authors attributed this finding to the fact that since treatment providers become an extension of the participant's probation officer—as they are required to report updates on progress as well as any lapses in their treatment—the participants were less likely to wholly trust their provider (Gallagher et al.). Several of the participants' quotes reported by Gallagher and colleagues framed treatment providers as "snitches" or giving "mixed messages" about the openness and corresponding confidentiality of the mandated therapeutic relationship (p. 71). Due to these experiences, drug court participants in this study began to refrain from reporting relapses or struggles in their substance abuse counseling services for fear that it would be reported back to the courts (Gallagher et al., 2015).

Gallagher et al. (2015) acknowledged a key limitation to this study that is important to note—namely, that the data collected throughout the interview process had a higher risk of social desirability bias due to the participants being recruited through the criminal justice system. In other words, the respondents might have felt pressure to provide more favorable

answers towards their experiences due to legal repercussions if their identity in the study was compromised. This limitation is important to note since, overall, participants did express positive experiences in the drug court program, apart from their experiences in SUD treatment, which tended to be rated poorly.

The findings reported by Gallagher et al. (2015) have grave implications for addiction counselors as it positions the therapeutic relationship within the context of drug court as being ineffective. If clients who are mandated to receive SUD treatment cannot be open with their treatment providers due to fear of violating the terms of their probation (and thus risk incarceration), treatment providers will be unable to (a) deliver the appropriate clinical interventions needed to assist their clients achieve their treatment goals, and (b) create an effective working alliance with these clients, which has been shown to be the best predictor of positive treatment outcomes (Hauser & Hays, 2010; Wampold et al., 1997). To conclude, the findings from this study highlight key elements of the experiences of drug court participants, which if not properly managed could hinder the establishment of a more trusting and bonded relationship with their treatment providers.

Ineffectiveness of Tough Love. In a similar investigation, Gallagher, Nordberg, and Lefebvre (2017) conducted a qualitative study designed to examine participants' experiences of drug court. A single research question guided this study: *How do drug court participants view the program, in regards to the most helpful aspects that support them in graduating the program and how the program could be more helpful in supporting them in graduating the program*? (Gallagher et al., 2017). In total, 42 participants with an average age of 31 contributed to this study. Among the 42 respondents, 29 identified as male and 13 identified

as female. Their ethnicities were reported as follows: White (29), African American (9), Hispanic (3), and multiracial (1) (Gallagher et al., 2017).

This study used a narrative analysis guided by a phenomenological framework, an appropriate methodology considering the overarching question and the population being studied. Participants were asked to complete the Drug Court Satisfaction Survey, which Gallagher et al. (2017) themselves developed, using a pen and in the presence of the researchers in a private location outside the court setting. The researchers followed a three-step data analysis process (data immersion, data grouping, and review of data consistently) and took several steps to help improve the validity of the qualitative research findings (observer and interdisciplinary triangulation, peer debriefing and support, and personal bias exploration).

Two key themes emerged from this study. First, in terms of supportive factors, participants felt that "random and frequent drug testing and having frequent contact with the judge" (Gallagher et al., 2017, p. 474) were most helpful in graduating from the program. The second theme to emerge addressed specific factors that participants expressed as hindering them from graduating the program—the most common was "treatment being offered through a punitive and judgmental lens" (p. 476). The present study will focus on the results from the second theme.

Out of the 42 research participants, 28 reported experiences consistent with the findings from the second theme (Gallagher et al., 2017). With more than half (67%) of participants feeling like their relationship with treatment providers in some way hindered them from graduating the drug court program, this factor is extremely concerning to counselors who may work in agencies that service the drug court population. Some of the

language used by research participants to describe their experiences included statements like they were being “degraded” or “demeaned” by their counselor, as well as feeling like they did not have a voice in their treatment (Gallagher et al., 2017). Many participants admitted that they held back information from their counselor due to the fear of a punitive and judgmental response. Some participants even described their counselor’s tactics as being coercive if they did not follow certain treatment recommendations. These findings are consistent with the results from a prior study (Gallagher et al., 2015) wherein participants described their relationship with their counselor as an extension of their probation officer. In contrast, however, participants who contributed to Gallagher et al.’s (2017) study described their interactions with their judge and probation officer to be more rehabilitative than their relationship with their assigned counselor.

While these research findings are not broadly generalizable given the population under scrutiny, it is concerning that the existing literature on drug court participants' experiences with mandated SUD treatment is sparse and largely negative. As such, the counseling profession needs to think critically about what role they play in preparing counselors to work with clients who may be mandated to receive SUD treatment through drug court programs. Furthermore, counselors must strive to identify what changes need to be made regarding court-mandated reporting requirements, especially given the urgency to protect and enhance the client-counselor working alliance.

The Importance of Choice in Treatment. As discussed by Witkin and Hayes (2019), "Drug court success depends heavily on implementing the drug court model with fidelity and adhering to widely recognized best practices, in particular, following the 'Ten Key Components' of drug court success" (p. 971). To investigate this assertion, the authors used a qualitative analysis to study the operations of drug courts based on the point of view of participants. This research study, which was conducted throughout five rural counties that had recently established drug courts in the two years prior to this investigation, was a part of a larger inquiry to understand the functionality of this newer drug court system (Witkin & Hays, 2019).

In total, 15 respondents took part in this study: 13 identified as White and 2 identified as African American. In terms of gender, 6 identified as female and 9 identified as male (Witkin & Hays, 2019). Data collection was achieved via 45-minute, face-to-face interviews conducted over a two-month period. The interviews followed a structured questionnaire protocol, first gathering general information about participants' experiences in the program and then proceeding to determine the respondents' perspectives regarding incentives, sanctions, and their experiences receiving SUD treatment. Members of the research employed a line-by-line coding method to determine major themes based on the participants' lived experiences (Witkin & Hays, 2019).

Subsequent qualitative analysis revealed several key themes. First, while many participants stated that the drug court requirements to which they would be held were clearly explained at the outset, the actual length of time they would be involved in drug court was ambiguous (Witkin & Hays, 2019). Although this uncertainty is principally due to a participant's time in drug court being contingent upon meeting certain performance benchmarks—which cannot be determined unequivocally at the onset of drug court—it is still important to note that

participants wanted some sense of how long they would be involved in the program (Witkin & Hays, 2019). This study also addressed participants' experiences with attending their status hearings, which many described as “long” and “anxiety provoking;” nonetheless, the majority of respondents felt heard and understood by the judge who heard their case. In terms of incentives (e.g., encouragement, tokens marking the achievement of key milestones) and sanctions, participants indicated that these were fairly implemented (Witkin & Hays, 2019).

The findings from this investigation were not uniformly consistent, however, with respect to other aspects of drug court-mandated SUD treatment. For instance, Witkin and Hays (2019) described that while some participants reported that they enjoyed attending treatment and acquiring tools and strategies to help them maintain their sobriety, others were negatively impacted by the limited treatment options due to program’s rural location, which impacted their ability to fully engage. Moreover, some respondents noted that the SUD treatment they received was not impactful in helping them make lasting changes in their life.

Another interesting finding was that several participants discussed how knowing most fellow group members from their time using substances represented a potential trigger to backslide (Witkin & Hays, 2019). In extrapolating this finding, it seems clear that the opportunity to have more options in groups to join and therapists to work with could improve the experiences and programmatic efficacy of those engaged in SUD treatment. While a limited number of group selection and therapists to work with is a common barrier in rural settings, it nonetheless does help in clarifying and understanding perceptions of these drug court respondents.

In terms of this study’s limitations, the rural location for this study and the small number of respondents do limit the broader generalization of findings to larger cohorts and different

locations. Additionally, a follow-on study could deploy a semi-structured interview protocol to allow participants to expand on specific concerns as they arose throughout the interview process. This approach could have allowed for greater detail to come to light regarding elements of the working alliance between participants and their treatment providers.

Summary

Based on a comprehensive review of the available literature, it is evident that there are still many gaps in understanding drug court participants' experiences in mandated SUD treatment and the potential impact of this complex factor on the working alliance. This research deficit is concerning given the high number of individuals living with a substance use disorder in the United States, as well as the likelihood that those individuals will be involved in the court system and mandated to receive treatment (SAMHSA, 2019). What the available literature does indicate is that the counseling profession should focus on specific areas to move forward in assisting this at-risk clientele. Several main themes emerged from this review of the literature.

Doran (2016) and MacFarlane et al. (2015) explored how a healthy working alliance is developed, and what specific interpersonal characteristics can contribute to positive client experiences. Both studies also reviewed how relational rupture is experienced in the working alliance, and what characteristics of the therapist were most helpful in repairing the therapeutic relationship. Sheehan and Burns (2011) examined how coercion can influence the working alliance and what characteristics counselors should evidence to help increase the perception of choice in treatment—even in involuntary settings. Similarly, Seaward and colleagues (2021) discussed the positive characteristics of counselors from the perspective of clients who were incarcerated.

With respect to the evidence-based literature focusing on mandated treatment strategies involving drug court participants, several studies were reviewed. Miller and Moyers (2015) highlighted how the relational elements between client and counselor were just as important (if not more important) than common treatment modalities used in substance use disorder treatment. Manchak et al. (2016) reviewed the perception of therapist control in involuntary mental health treatment settings, indicating that while the perception of therapist control was high, it did not impact client affiliation with their therapist. Wild and colleagues (2016) examined levels of motivation among legally referred clients versus self-referred clients using an SDT framework. Their quantitative results confirmed that clients with low levels of treatment motivation who were mandated for SUD treatment were more likely to exit treatment programs compared to legally mandated clients with high levels of personal motivation.

Three qualitative studies examining the experiences of participants in drug court-mandated programs were assessed for this review of the literature (Gallagher et al., 2015; 2017; Witkin & Hays, 2019). The results of these reports emphasize why building trust between treatment providers and their clientele can be challenging based on court-mandated reporting requirements, as well as how greater leeway in identifying choice of treatment is desirable. Thus, there is a need to expand our understanding of the alliance dynamics between the participants and SUD treatment providers.

According to the U.S. Department of Justice, there are more than 3,500 drug courts across the United States, which are intended to serve a diverse population struggling with addiction and criminal recidivism (2022). Based on literature findings and existing gaps in this body of scholarship, this study was designed to explore the working alliance between individuals engaged in drug court-mandated addition treatment and their counselors. It is expected that the

results described in this dissertation will expand our understanding of the working alliance within the context of drug court-mandated treatment settings. Since this type of exploration has yet to be fully explored within the field of counseling, the findings from this study may (a) assist addiction counselors in ensuring that their drug court clients complete treatment, (b) contribute to assisting drug courts to institute programmatic interventions that are effective in reducing drug-use relapse and criminal recidivism.

Chapter 3: Methodology

Research Design

The purpose of this study was to explore clients' experience of the working alliance with their counselor(s) during drug court-mandated addictions treatment. As there is a current dearth of literature available on this population's lived experiences, it was important that this investigation implemented a qualitative approach. Qualitative research is particularly useful when attempting to understand how individuals or groups of people with a shared experience construct meaning of that experience (Patton, 2014). In the case of drug court clients, more research needs to be done to understand how these individuals experience the working alliance between themselves and their counselor(s), while at the same time being mandated to engage in SUD treatment as a drug court participant.

Although numerous counseling theories have been developed to assist counselors in their work of behavioral change, none specifically pertain to individuals who are mandated to receive treatment. The absence of a germane theoretical foundation for this study and its population of interest further supports the implementation of a qualitative approach, which may assist in the development of a theory based on this cohort's experiences, while also acknowledging the subjectivity of the researcher. That said, two theoretical approaches are relevant to this study. First, grounded theory is a systematic approach to qualitative research that produces theory derived from social data (Glaser & Strauss, 2017). Second, constructivist grounded theory, an extension of traditional grounded theory, allows for the researcher to acknowledge their own, "past and present involvements and interactions with people, perspectives and research practices" (Charmaz, 2014, p. 17).

Researcher Reflexivity

A crucial step in constructivist grounded theory is the researcher's own reflexivity process. In short, the reflexivity process can best be understood as “an ongoing examination of what I know and how I know it” (Patton, 2014, p.70). A qualitative researcher must be willing to examine the dimensions of their own insights surrounding what perspectives they bring to any study within a cultural, social, and political context (Patton). As the investigator of this qualitative inquiry, it was important to explore my own relationship within the contexts of this research study.

Given that my personal demographic characteristics (a White, educated, upper-middle class, cisgender female living in southwest Virginia) will influence the way in which I navigate my world, it was essential for the authenticity of this study that I practiced reflexivity exploring my professional relationship with the research population of interest. After receiving my master’s degree in 2017, I began my first professional working experience within clinical mental health services. As a counselor providing inpatient and outpatient treatment, I began to develop a passion for working with the clients within the addictions population. While I was drawn to the relationship-building dynamics between myself and the clients I served, I continued to notice themes in their presenting needs that I felt ill-equipped to support in various ways.

One of the most recurrent challenges I encountered involved clients who were not there voluntarily—or at least not entirely. For the most part, my counseling training prepared me to work with clients who would present voluntarily, and would be motivated and ready to address the maladaptive coping strategies that no longer served them in a positive way. In contrast, as a licensed counselor I began working with clients who were mandated to attend services as a referral from drug court programs, or court-mandated sanctions in general. As an extension of

these mandates, I was also required to disclose information back to the courts about my client's progress (e.g., attendance and relapses with drugs or alcohol), despite that information being considered confidential in voluntary counseling services. This added level of external oversight was both eye-opening and challenging, but nonetheless created a deep empathic response to assist them in achieving their treatment goals while still protecting our therapeutic working alliance.

I should also note that the entirety of my clinical work has been done in central and southwest Virginia—which is also where I grew up. Thus, I didn't consider these individuals as merely clients, but also as my neighbors and members of my community. There is a pervasive universality about the disease of addiction in that it does not discriminate against its victims and the family members and friends who are also impacted concurrently. I doubt I will ever dispel images of friends and family members that I have lost to the disease of addiction. While I personally have not struggled with an addiction-related issue, I do feel highly motivated and empowered to use my privilege as an educated person and trained clinician towards the collection and analysis of data on the lived experiences of individuals who are mandated to address their addiction issues. My hope is that the findings from this study will produce positive changes within the context of mandated addiction treatment.

Participants

The sample for this study included eight research participants who were actively engaged in outpatient substance use disorder treatment as a requirement of their drug court program (see Table 2). There are currently 44 approved Adult Drug Treatment Court Dockets in the state of Virginia—39 of which are currently operational (Supreme Court of Virginia, 2020) (Appendix A). The majority of SUD treatment is contracted through local community service boards within

each respective municipality. As detailed in the next section, participants for this study were recruited through these agencies and given a web-link to complete the recruitment survey and provided with an information form if they were interested in participating. Participants for this study had to meet the following inclusion criteria: (1) be 18 years of age or older, (2) be actively engaged in SUD treatment as mandated through the requirements of their respective drug court program, and (3) completed at least one month of SUD treatment. Participants were only asked to indicate "yes" or "no" for if they had been enrolled in the drug court program for at least one month to be eligible for this study. Employment status was collected through the recruitment survey to gain a better understanding of the participants lived experiences and progress in the drug court program. Drug court requires participants to actively seek employment while enrolled in the program (NADCP, 2013). Eight individuals (four females and four males) agreed to take part in this investigation. The names shown are pseudonyms to protect their anonymity.

Table 2. *Participant Characteristics*

Participant	Age	Gender Identity	Race/Ethnicity	Employment Status
Brian	57	Male	Black or African American	Employed full time
Jade	41	Female	White	Unemployed, looking
Jed	47	Male	Native Hawaiian/Pacific Islander	Employed part time
Alvin	32	Male	White	Employed part time
Brooke	29	Female	White	Employed part time
Russell	29	Male	Asian	Employed part time
Gale	45	Female	Black or African American	Unemployed, looking
Bonnie	26	Female	White	Unemployed, looking

As defined by federal regulations for human-subjects research, the potential risks for research participants encompass five categories: psychological, social, legal, privacy, and

economic (Policy for Protection of Human Subjects, 2018). Pertaining to the research population of interest for this study, the possible risks include all but the economic component. To address psychological risk, research participants were asked questions about their experiences in SUD treatment specifically, and within the drug court program in general. Responding to these questions could have elicited potential stress, since reflecting on their experiences might have been negative and uncomfortable to disclose. In terms of social risk, research participants might have been concerned that their participation in the study could identify them as a drug court probationer—and thus be negatively impacted socially because of this disclosure. While the researcher's goal was to help create a safe and comfortable environment for participants to disclose information about their experiences, it is reasonable to assume that participants might have felt aspects of stigmatization being asked to discuss this aspect of their lives.

In terms of any legal risk, the participants for this study were actively on probation for drug-related offenses. Thus, it is possible that respondents would inadvertently disclose activity that would violate the terms of their probation (i.e., recent drug or alcohol use, breaking probation curfew, tampering with urine and drug screens, etc.). Lastly, in terms of privacy risk as determined by the researcher, it was necessary to gain identifying information from the research participants (phone number and email address) to conduct the data collection portion of the research study. If participants' phone numbers or email addresses were inadvertently released to individuals not involved in the research study, a respondent's confidentiality as a participant in this study or as a participant in the drug court program could be violated. Considering these potential risks to the research participants, the researcher instituted every foreseeable precaution to decrease these risks and protect participant confidentiality. Additionally, the researcher

detailed these risks in the recruitment materials so individuals could choose to participate accordingly.

During the interviews, the promise of anonymity was extended to each interview subject, which was expected would elicit more meaningful and direct responses. Interview subjects were informed that their responses in this study would be linked to pseudonyms, and any identifying information (e.g., location, counselor(s) names, unique circumstances) would be redacted from their transcripts. Participants were invited to contact the researcher to request to redact any other information shared. Participants were informed that they would not be sent copies of their transcripts, and a member check would not be initiated by the researcher.

Recruitment

To enhance this study's data validity and generalizability, it was essential to gather and analyze the perspectives of as many participants as possible. Participant recruitment for this study was facilitated through the 39 operational drug courts in Virginia. The investigator sent recruitment emails to contact persons for each operational drug court in Virginia with a flyer attached to that email to be distributed to all active drug court members within that locality. The researcher also shipped or delivered flyers to be physically distributed to drug court members. In one case, the researcher was given permission to distribute recruitment flyers directly to the drug court participants at the drug court meeting. The researcher also contacted community service boards within the state of Virginia who provide contracted services to drug court participants for flyers to be distributed in these areas as well. While drug court participants are not considered to be a *vulnerable population* as defined by the Institutional Review Board (IRB), they are protected legally. In summary, the researcher attempted to disperse recruitment material to as many agencies and drug court officials within the state of Virginia as possible.

The recruitment flyers included a summary of the study, inclusion criteria for participation in the study, compensation for participation in the study, a QR code and TinyURL™ that linked directly to the recruitment survey, and the contact information of the investigator (Appendix B). Contact information included the researcher's direct email address and Google Voice™ phone number. It was important that participants had multiple modalities to contact the researcher and express interest for participating in the study. Participants were also able to leave voicemails and send text messages to the Google Voice™ phone number to increase ease of communication. Any eligible respondent who contributed to this investigation would receive a $10 virtual gift card as compensation.

Collecting this identifying information (a) allowed the researcher and participants to have more flexibility in scheduling a preferred time for the interviews, (b) facilitated the conveyance of the virtual compensation, and (c) enabled the researcher and participants to conduct the virtual interviews in an environment that was mutually convenient and comfortable. Note that since drug court participants have very demanding schedules and the potential pool of respondents might reside in other parts of the Commonwealth, the researcher determined that being able to host virtual interviews was more convenient for individual participants. Also, as related to health/security concerns, conducting interviews over the telephone or through Zoom audio software helped to increase the safety and welfare of both the researcher and this study respondents.

Data Collection Procedures

In total, eight participants agreed to take part in this study (Table 2). Each respondent was given the information sheet (Appendix C), and then asked to complete the recruitment survey (Appendix D), which requested demographic information, provided inclusion criteria for taking

part in this study, and asked for participant contact information. Using a constructivist grounded framework, this study's data collection was facilitated by a 60-minute, semi-structured, intensive interviewing model, which has been described as the most effective and appropriate way to collect data from research participants. The interviews were designed to explore the experiences of the participants who had first-hand experience with the research topic (Charmaz, 2014). Intensive interviewing has several key characteristics that align with the purpose of this study. Intensive interviewing allows for a deeper exploration of individuals with firsthand experience of the research topic.

Interview Protocol

Open-ended questions were used to collect rich and detailed responses that would enhance the researcher's understanding of the participants' perspectives and meaning-making processes with the research topic; this approach also allowed for follow up of unanticipated areas of interest brought forth by the participants (Charmaz, 2014). The interview protocol (Appendix E) was designed to answer the overarching research question that guided this investigation: *What are clients' experiences of the working alliance with their counselor(s) during drug court-mandated addictions treatment*? The interview protocol consisted of ten questions aimed to answer this question as thoroughly as possible. In line with an intensive interviewing model, all questions were open-ended, emphasized the participants' perspectives of these firsthand experiences with the research topic, and allowed for follow-up questioning if unanticipated areas of interest were brought forward (Charmaz, 2014).

Each interview question served a particular purpose in helping answer the overarching research question within three primary categories. Table 3 provides the full list of interview questions. The first category pertained to a participant's initial experience in drug court program

and any previous experiences with SUD treatment. This category was included so that the researcher would be able to explore any patterns in responses in these initial experiences and determine whether and how it influenced their present experiences. The second category of interview questions, present experiences in SUD treatment and relationship with counselor(s) (3-7), served to answer the overall research question directly. Question 3 was used to capture each respondent's overall perceptions regarding having to complete SUD treatment. Questions 4 through 7 were developed in line with the Working Alliance Inventory (Horvath & Greenberg, 1989), and asked questions specifically related to these features (goals, tasks, bonds). The last category (questions 8 through 10) was designed to enable participants to reflect more broadly on their overall experiences in the drug court program and SUD treatment. While it was integral to the research questions to focus on the working alliance specifically, it was important to the researcher to provide the space for participants to reflect on other aspects of their experiences which they found to be important.

Table 3. *The Interview Instrument Used in This Study*

Category 1: Initial Experiences in Drug Court Program and SUD Treatment
1. I'd first like to start by asking you about your experiences leading up to your enrollment with drug court. Would you mind sharing with me about how you referred to the program and what that process was like for you?
2. Have you had any previous treatment for substance use or mental health counseling in the past?
Category 2: Experiences in SUD Treatment and Relationship with Counselor(s)
3. A requirement of the drug court program is to complete substance use disorder treatment, how do you feel about that?
4. Do you feel as though you have a say in what your goals are for your substance use disorder treatment?
5. Do you feel as though you have a say in what you do while in treatment in order to accomplish your goals while in substance use disorder treatment?
6. Do you feel respected and cared for by your counselor(s) who provides you substance use disorder treatment?
7. Do you feel like you can be honest with your counselor(s)?

Category 3: Reflections on Overall Experiences
8. Are there any aspects of the drug court program that you find most challenging?
9. If you were to use one or two words to describe your experiences in drug court, what word would you use?
10. What improvements, if any, would you suggest to enhance your experiences while receiving mandated substance use disorder treatment as a participant in drug court?

Data Analysis

> Similar to a camera with many lenses, first you view a broad sweep of the landscape. Subsequently, you change your lens several times and shorten your focal point to bring key scenes closer and closer into view. (Charmaz, 2014, p. 26)

As illustrated by this quote, the data-analysis process as mandated by a grounded theory framework features multiple processes that require flexibility, adaptability, and the researcher's keen sense of direction. Data analysis using this methodological approach has two main phases, initial coding and focused coding (Charmaz, 2014). Based on this protocol, data analysis began with an incident-by-incident coding process, which is particularly effective when studying a phenomenon that involves processes or experiences that can be broken down toward the development of more holistic understanding of the problem (Charmaz). Charmaz explained that "coding is the pivotal link between collecting data and developing an emergent theory to explain the data" (p. 113). The comparative coding process enables the researcher to compare incident-by-incident and determine that theoretical saturation had been met, which is the point at which no new emergent themes emerged from the data-collection process.

It is important to note that grounded theory incident-by-incident coding is a flexible and adaptable approach to discovering emergent themes in the data (Charmaz, 2014; Glaser & Strauss, 2017). For instance, themes in certain initial codes could be anticipated based on the development of the interview protocol, based on what responses those questions could elicit from

the participants. However, determining whether these experiences are negative or positive from the individual's perspective could not be determined until all the data had been collected. More generalized responses pertaining to the experiences of respondents in mandated substance use disorder treatment were also anticipated and were found to be useful during the data analysis process. After completing the initial coding phase, the focused coding strategy was employed to answer the overarching research question.

Initial Coding

Initial coding strategies began after the first transcript was available and continued throughout the data collection process. Initial coding results from this study yielded a total of 78 codes. Forty-two of these codes described participant experiences that were specific to drug court, while 35 codes were specific to their experiences in SUD treatment. In line with a grounded theory framework, the researcher used theoretical sampling throughout this process to identify that were found to relate to the original working alliance theoretical framework.

Focused Coding

Once the initial coding efforts had been concluded and theoretical saturation had been achieved, the researcher turned to focused coding efforts. This phase of data-analysis phase was essential for (a) identifying the specific incidents that influenced working alliance between the research participant and counselor, and (b) for determining the emergent themes. As shown in Table 4, the focused coding strategy yielded 18 codes that were then categorized into the three categories recognized in the client-counselor working alliance model (Bordin, 1979): goals, tasks, and bond. The codes were also separated into two sub-categories: strengthening and weakening. When a code was noted as strengthening, it refers to an action taken by the counselor that strengthened the working alliance within that sub-category. Alternatively, if a code was

determined to be weakening, it corresponds to an action taken by the counselor that weakened the working alliance within that sub-category. Chapter 4 provides a full discussion of the results of these findings.

Table 4. *Total Codes and Categories*

Category	Total Codes	Strengthening	Weakening
Goals	2	1	1
Tasks	5	5	0
Bond	11	6	5
Total	18	12	6

Rigor and Credibility

For decades, researchers have debated the merits of a qualitative inquiry in terms of its credibility and reliability—especially in comparison to quantitative research. With the emergence of the grounded theory methodology, Glasser and Strauss (2017) argued that the theory's approach for collecting, coding, and analyzing qualitative data lends credence to the findings of a qualitative research study. As the researchers outlined, there are four essential steps to this process: (1) conveying the theoretical framework that underpins the intended research study, (2) providing clear and vivid descriptions of the data collected, (3) using "a codified procedure for analyzing data" (p. 229), and (4) keeping well maintained notes of the researcher's comparative coding process that demonstrates the development of the emerged theory.

For this study, the data analysis and coding process was completed by the author of this study. However, to ensure this study's credibility, this process was overseen by the primary investigator and a committee of senior scholars who have extensive experience with qualitative research. Indeed, one of the members of that committee was known to be an expert methodologist with extensive experience facilitating their own grounded theory research studies.

During the developing of this study, this expert methodologist reviewed the methodology and consulted as procedural questions emerged throughout the data-collection process. To increase this study's validity, the author instituted a peer review process during the planning, initial coding, and data analysis stages of the research process. Additionally, two fellow doctoral candidate colleagues with experience with qualitative research methodology and professional counseling experience reviewed the participant interview transcripts (not identified by name or pseudonym) and initial coding efforts to ensure all relevant codes were captured accurately. The researcher also asked the peer reviewers to process relevant field notes as related to researcher reflexivity, as well as to ensure there were no leading questions present in the interview protocol or semi-structured interview process.

Summary

This study was designed to explore clients' experience of the working alliance with their counselor(s) during drug court-mandated addictions treatment, which is a topic that is currently under-explored in the counseling literature. This investigation was facilitated using a qualitative approach utilizing a constructivist grounded theory framework. This framework allowed the researcher to acknowledge their own subjective experiences with this study population. Ongoing reflection, memo-writing, and oversight by esteemed faculty members helped increase the rigor and credibility of this study.

The opportunity for eligible candidates to take part in this study was disseminated to all 39 operational adult drug courts in the Commonwealth of Virginia. Potential participants were able to contact the researcher directly if they were interested in contributing to this study. Ultimately, a total of eight individuals took part in this study. Data was collected from the deployment of semi-structured interviews from which transcripts were coded and analyzed to

develop overarching themes related to drug court participants' experiences within mandated substance use disorder treatment. An interview protocol (Appendix E) was developed to guide these interviews and prompt participants to share their overall experiences in drug court and, more specifically, the working alliance with their counselor(s).

Chapter 4: Results

Development of the Modified CGT Model

The purpose of this qualitative inquiry was to explore clients' experiences of the working alliance with their counselor(s) during drug court-mandated addictions treatment. This inquiry was framed by the following research question: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment? The results from this investigation yielded a novel constructivist grounded theory (CGT) model: *From compliance to alliance: A grounded theory of building rapport in mandated treatment*. This model, whose components are detailed in Table 5, was developed from the findings of this study and serves to expand and operationalize Bordin's (1979) working alliance model. Notably, this model defines the treatment context-specific components of the modified working alliance model that best serves clients in mandated SUD treatment.

Table 5. *Constructed Grounded Theory Development Components*

Theory Component	Definition	Components with Expanded Working Alliance Model
Context	The research context in which the phenomenon takes place.	Mandated substance use disorder treatment
Core phenomenon	The central concept or phenomenon on which the process under study is based (Hachtmann, 2012)	Building rapport between client and counselor.
Causal conditions	Factors that cause the core phenomenon (Charmaz, 2014)	Honoring individualization in client treatment process.
Strategies	Actions taken in response to the core phenomenon (Charmaz, 2014)	Counselor's actions taken in goal development, assignment of tasks, and bond development.
Intervening conditions	Broad and specific situational factors that influence strategies (Charmaz, 2014)	Client's reactions to their sense of agency and support in a mandated treatment setting.
Outcomes	Consequences that result from the strategies (Charmaz, 2014)	The strengthening or weakening of the working alliance.

Explanation of the Model

This section explains the key components of the constructivist grounded theory model developed from this study: *From compliance to alliance: A grounded theory of building rapport in mandated treatment*. First, the term *context* refers to the research context in which the phenomenon takes place. For the present study, the context can best be described as mandated substance use disorder treatment. Next, the central concept or, *core phenomenon,* details the underlying processes on which a given study is based (Hachtmann, 2012). For the present study, that core phenomenon was determined to be the process of building rapport between client and counselor. *Causal conditions* are defined by Charmaz (2014) as factors that influence the core phenomenon. The results of this study showed that causal conditions for building rapport are linked to when clients feel that their individual needs, experiences, and perspectives (i.e., individuation) have been honored throughout the treatment process. The term *strategies* in this study is used to describe a counselor's action during goal development, assignment of tasks, and bond development with their client during treatment. *Intervening conditions* are defined as broad and specific situational factors that influence strategies; for the present study, the intervening conditions were identified as the client's reactions to their sense of agency and support while receiving SUD treatment in a mandated setting. Finally, *outcomes* are the consequences that results from the strategies employed during treatment (Charmaz, 2014); for this study, outcomes were identified as incidents that contributed to either strengthening or weakening the working alliance.

While the findings from this research study are novel, Bordin's (1979) original working alliance provides the framework of how they can be interpreted. The results from this study are best explained in light of the three features of Bordin's working alliance model: the agreement of

goals, the assignment of tasks, and the development of bond. The grounded theory model developed from this study expands each component of Bordin's model to better capture the dynamics of how these features exist within the working alliance when providing SUD services to a mandated treatment population. These components will be referred to as *features* throughout the remainder of this dissertation, or as a summary of the individual feature itself (*goals*, *tasks*, and *bonds*). Within each of these features, the specific strategies that were used to strengthen or weaken the working alliance will be explored. Figure 1 provides a visualization of working alliance features, which are color coded to indicate whether the feature strengthens or weakens the working alliance.

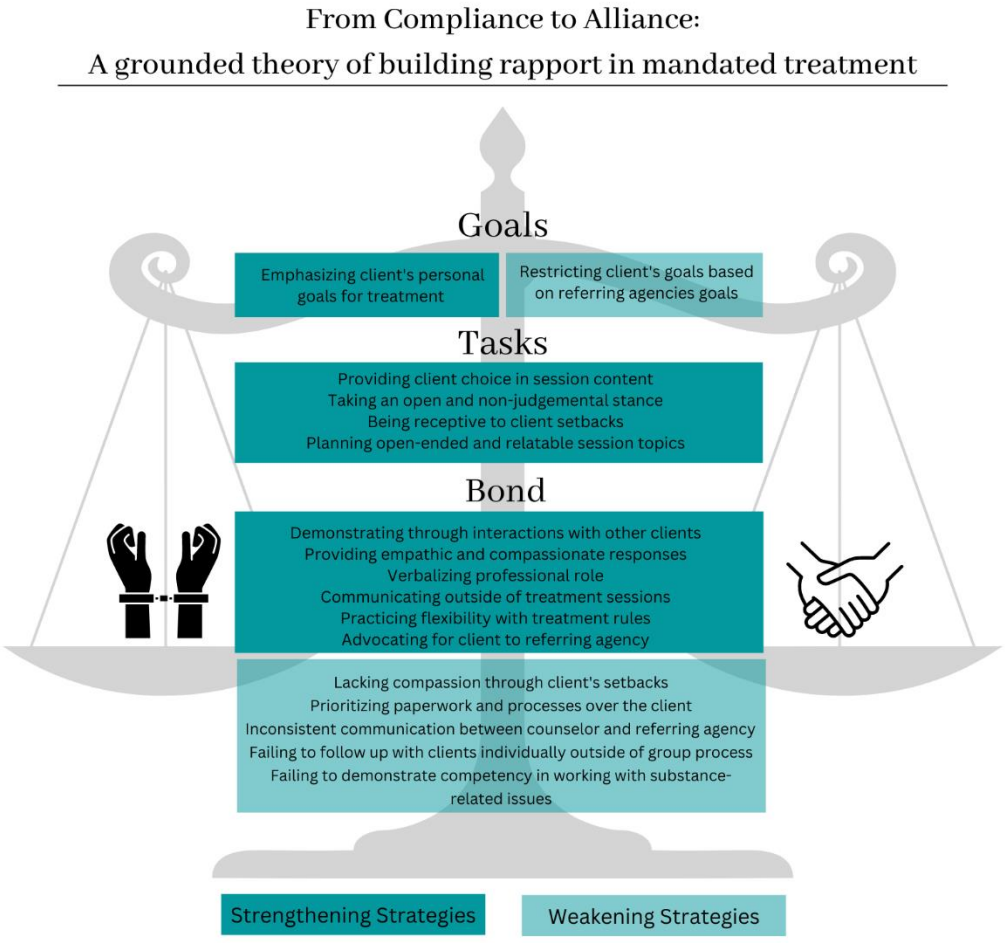

Figure 1. Visualization of Working Alliance Features: Strengthening and Weakening Strategies

Goals

The category of *goals*, which consists of two strategies (one strengthening and one weakening), refers to the actions that counselors implemented during this stage of building the working alliance with their client. The strengthening strategy was linked to when participants noted their counselor was emphasizing their personal goals and motivation for change when developing their treatment goals. This finding is consistent with the causal conditions of the developed model from this study, as we learned that honoring the individualization of a client aids in building overall rapport and thus strengthening the working alliance. The direct quotes from research participants are included herein to support the findings from this study.

Pertaining to the development of goals, Russell noted:

> Well, yeah. As in goals for yourself, they are completely based on what you want to do.… and what you want to do in treatment, and what you want to do after treatment, that is definitely all up to you.

Another research participant, Bonnie, also indicated that she had autonomy in the creation of her treatment goals, as she stated during the interview: “I feel like you get to choose your own path and your own goals, so they really just kind of like listen and try to hold you to them things.” While two research participants noted feeling supported in goals development, most research participants (75%, n = 6) stated that their counselor-client working alliance was weakened by their counselor’s need to restrict or modify their treatment goals based on the goals outlined by their drug court program. Jade captured this sense of disconnect:

> They present the goals that they want me to achieve. And basically, they're moving me towards the goals that they want me to achieve. And they're basically telling me that, ‘This is what we want you to do. We're right. We know what's best. And this is what you

> have to do. And you sign the contract. And you're going to be Drug Court. And you're going to do what we tell you to do.' And basically…I've learned to just let it go because regardless if I'm right about something, they're going to tell me I'm wrong…I just have to shut up and do what I'm told.

Another research participant, Alvin, explained having felt restricted in developing his goals during court-mandated SUD treatment, therefore hindering his feeling of individualization in the agreement of goals with his counselor:

> I feel like that's comparable to asking someone performing in a sports competition if they have the authority to-- if they have autonomy within the confines of the game itself. Sure. I can choose when to dribble or when to shoot or when to pass. But ultimately, my selection is within the confinement of the prescribed parameters of drug court. My goal from day one was to be with my family. My family is in [state]. That has been the most important thing to me since the court started. And the last time I went to go see them, I ended up in jail. So no, I do not feel like I have any real say in what my goals are. I can pick between the bullets on the list that they provide.

Tasks

Within the category of *tasks*, four strategies were identified as strengthening the working alliance: 1) providing client choice in session content; 2) taking an open, non-judgmental stance; 3) being receptive to client setbacks; and 4) planning open-ended and relatable session topics. No research participants noted any strategies their counselor(s) took that weakened the working alliance. In contrast, all research participants described several key actions the counselor would take to aid in strengthening the *tasks* portion of their treatment relationship. The first strategy that was noted in strengthening the working alliance regarding *tasks* was providing the client input on

what would be discussed during treatment. Research participant Gale noted how being honest in what she needed to discuss while in treatment was helpful to her overall progress:

> They're open to whatever's on my mind, and that's one of the things that they want. They want you to be true for an honest. And I'm very open and honest about everything, more than I ever have in my life. So it definitely made a difference.

The causal condition of a client's feeling like they had a voice in their treatment options proved to be somewhat similar to the next strengthening strategy, which was the counselor(s) taking an open, non-judgmental stance on what was discussed during SUD treatment. Specifically, the respondents indicated feeling supported in treatment by their counselors not judging them, which expanded their openness and candor. Again, the causal condition of the counselor's acceptance of their client's situation and struggle enhanced the likelihood that the client would be receptive to inculcating recommended treatment tasks in that they were more motivated and open to engage in the process. Research participant Jed highlighted this when he noted:

> I don't really know how to expand on that other than it's my treatment. And it's not a cookie-cutter situation. And I don't think anybody thinks right, wrong, or indifferent if I say something because I feel a certain way. They [the counselor] accept it. They don't say, 'Oh, you shouldn't feel that way'.

Additionally, research participants voiced how the working alliance was strengthened in relation to completing *tasks* when counselor(s) would plan open-ended discussion topics that were easy to relate to. Research participant, Bonnie, expanded on the importance of such relatable topics when she noted:

> So they [counselor] really pick the topics for the most part, but I feel like all of them [topics] are relatable. So no matter what the topic is, you can, nine times out of ten relate to what the topic is and they chosen.

Another strategy that counselors used to strengthen the working alliance in tasks was demonstrating receptivity to openly processing setbacks/relapses without judgment. One research participant, Brian, noted the importance of not "dwelling" on setbacks when they occurred when he noted:

> I had one slip up while I was in it. I'm not going to dwell on that. The judge don't dwell on it. The drug court don't dwell on it. And they claim that's part of recovery, it's relapsed, and it made me stronger because my penalty for my sanction was 30 days in jail, and I don't ever want to go back there.

Finally, the strategy of providing specific feedback and suggestions was helpful to some research participants in forming a stronger working alliance with their counselor(s). Research participant Gale noted this when she stated:

> I feel respected. I just face it. And they listen. They [the counselor] give pretty good feedback as to how I need to deal with whatever situation that I talk about or what I go through in my day-to-day.

Bond

In exploring the important features of *bond* development, 11 total strategies were identified. Of these 11, six were identified as strengthening the development of the counselor-client working alliance, while five were identified as weakening the development of the counselor-client working alliance. The six strengthening strategies were identified as follows: 1) demonstrating through interactions with other clients, 2) providing empathic and compassionate

responses, 3) verbalizing professional role, 4) communicating outside of treatment sessions, 5) practicing flexibility with treatment rules, and 6) advocating for client to referring agency. Conversely, five factors were shown to weaken the working alliance: 1) lacking compassion through client setbacks, 2) prioritizing paperwork and processes over the client, 3) inconsistent communication between counselor and referring agency, 4) failing to follow up with clients individually outside of group process, and 5) failing to demonstrate competency in working with substance-related issues.

The first strengthening strategy pertains to the demonstrated ability of the counselor to impart a sense of trust and acceptance—whether individually or in group work. Gale described her experience as it related to watching counselor(s) interact with fellow clients in an open, non-judgmental manner:

> Yes, because I have been in a class where people have been honest and shared, was honest about their setbacks, and they [counselor] help. You know what I'm saying? So I have no reason to be dishonest because I know if I'm honest, they [counselor] will still help me move forward, regardless if I have a setback or not.

The second strategy that research participants described as strengthening the bond in the working alliance pertains to when counselor(s) responded empathically and compassionately to their journey. Participants Brooke and Bonnie both expanded on the ways that their counselors were easy to talk to and displayed a genuine understanding to their journey while in recovery. For instance, Brooke explained it this way:

> They're [counselor] really just down to earth. I mean some things I just don't understand, and they've [counselor] either seen it, been through it, or they know what I'm talking

about without me telling them. They [counselor] actually understand me and I don't even understand myself sometimes.

Alternatively, some participants identified strategies taken by their counselor(s) that in their view resulted in weakening the working alliance *bond*. Notably, several respondents described perceiving a lack of compassion from their counselor(s) while in treatment, which led to the research participant feeling as if they had been reduced to "a number" instead of being viewed as a unique individual with challenging needs. This perspective was captured when Alvin stated:

> Ultimately, feel like a number when it comes to the treatment of drug court. They may speak friendly and smile to me while I'm on the straight and narrow while I'm jumping through every hoop that is requested, but honestly, in the times that I have really needed someone to be there to understand and support me, I feel like backs get turned and I am reduced to a silhouette of a person, a shadow of a self, and merely, just a statistic, just a number.

The third strengthening strategy highlighted the importance of counselors demonstrating respect through verbalizing professional role. Respondents noted that when in drug court they are likely to be working with multiple professionals at one time. This factor made it important for counselors to define their role explicitly, which was viewed as a respectful act that aided participants in being able to differentiate their working relationship with their counselor(s) from that of drug court officials specifically. This particular finding is significant in emphasizing how a mandated treatment client's working relationship with their counselor is different from the working relationship between drug court officials in terms of making an impact in their experience and ability to engage in treatment. Jade explained how this articulation of her

counselor's role helped her respect her counselor more when she stated: "He's very respectful. He's very respectful but he said, 'I'm not your friend but I'm not your enemy either.' So, yeah, he's very professional."

The fourth strengthening strategy emerged when research participants described the benefits of their counselor communicating with them outside of structured session times. Research participants noted how having this flexibility in the way they communicated with their counselor(s) was meaningful to them. Brian noted having support in the moments of "slip-ups" when he stated, "If you have a slip-up, call me. Let's talk. Let's talk about it. Do that." That means a lot". Brooke expanded on this theme when she noted her counselor making time for her after work hours:

> Honestly, I know they [counselor] have their own lives. But there's been times I've called them outside of work hours, and they answer immediately…They are on call, literally…Yeah. And it's past time. That's not even about Drug Court. It's something I needed a question answered, and they're there.

Also relating to counselor follow-up outside of structured treatment, several research participants noted that the lack of individual follow-up as a weakening strategy in being able to form a strong working alliance with their counselor(s). Again, we see the causal condition of highlighting individualization throughout client treatment experiences as being key in strengthening the working alliance and overall rapport with their counselor; in contrast, the absence of follow-up check-ins inhibited rapport-building efforts. Jed spoke to this issue:

> I don't have follow-up. I do get concerns when I'm speaking or talking in the meeting, but I don't have any individual follow-up…I'm not hearing anything directly from my

counselors…I'm used to the group dynamic. It's just that individual feedback would be beneficial probably to anybody. It's just that for me, it would be.

The fifth strengthening strategy that was found to contribute to a more bonded working alliance between clients and their counselor pertains to the issue of flexibility. This strengthening strategy was identified when counselors were able to demonstrate flexibility with treatment rules based on each client's individual life factors. Most research participants described how drug court requirements could be demanding (e.g., involving drug court hearings, probation officer meetings, urinalysis screenings), and how difficult this was to manage on top of attending SUD treatment. Jed spoke to the importance of a counselor understanding these contextual life factors:

> If I can't make it to something they [counselors] understand. I just need that understanding. I know that honesty and communication has gone a long way so far. I hope it stays that way. But I don't know how to put it other than it-- I guess understanding, I guess."

The sixth and final strengthening strategy that was identified from the results of this study highlighted the important of advocacy in forming a stronger working alliance when working with clients who have been mandated for treatment. We hear the importance it made for Russell when he described feeling like he had an "extra voice" for him in communicating to the courts when he stated:

> They [counselors] are very respectful, very helpful, especially the counselors in the CSB for IOP. They are wonderful. Any problem I had for drug court, they [counselors] would speak up for me and try to be that extra voice, because a lot of times participants felt like their voices or their concerns weren't being acknowledged or being counted for. So on our behalf-- he reached out for me a couple of times through drug court team and

> probation, letting them [drug court team] know what was going on, even though it didn't make much of a difference. But it just felt good to know that they [counselors] were there to listen and to help us in a manner to reach out, because a lot of people wouldn't even do that."

In contrast to clients describing how they felt supported when their counselor evidenced being their SUD treatment advocate, more than one respondent indicated that the formation of a bonded working alliance was weakened when they perceived that information in treatment was being used against them. For instance, several research participants noted inconsistent communication between their counselor(s) and drug court officials, causing them to feel hesitant in sharing personal information while in treatment due to fear it would be "used against them." This experience was particularly salient for Jade, who stated the following:

> I can't talk to my therapist about it because he says this to my probation officer, and then they're [probation officer] coming to me about it. So bad, it's really tough…I know that he's [counselor] got my best interest at heart and everything, and I know he cares and all that, but I feel like sometimes when I'm too honest with stuff, it just twisted around and gets back to different people. And it's not what I said, you know?

Other factors were also identified as weakening the working alliance between client and counselor. Notably, some research participants expressed concern about the professional competence of their counselor and their skill in working with individuals struggling with substance use-related issues. Alvin spoke eloquently about this important issue:

> No one in drug court has experience, personal experience, with substance use disorder, which I believe is one of the major pitfalls of it as an organization. No matter how many books you read about the phenomenon, if you haven't dealt with it yourself. I really feel

like there's a chasm of disconnect between the clinicians and the participants. So that language barrier is a major handicap, as far as I have experienced…It's a language that they don't speak. So they might as well point you in the direction of people who do speak that language.

Summary

The qualitative results from this study support the formation and theoretical components of a context-specific model that builds on Bordin's (1979) earlier working alliance model. Specifically, this researcher found the existing working alliance model largely discounted the unique experiences of individuals receiving mandated SUD treatment; notably, it could not account for the unique therapeutic factors that can create ruptures in the client-counselor working alliance in a mandated treatment setting. Thus emerged the new model (From compliance to alliance: A grounded theory of building rapport in mandated treatment), whose purpose was to explore and support the experiences of individuals who are mandated to SUD treatment. Based on the qualitative data obtained from the eight research participants who contributed to this study, the foundational process of building rapport between client and counselor was identified as the core phenomenon taking place. Further, results indicate that honoring the individualization of the client throughout the treatment process aided in the rapport-building process. For example, more than one respondent noted that counselors who respected and built upon each individual's motivation for change during goal development led to strengthening the working alliance. The results of this study and its developed model (see Table 5) are expected to augment and strengthen the strategies used by counselors working within this distinctive treatment context toward better outcomes for their clients during and after court-mandated SUD counseling.

Chapter 5: Discussion

With over 1,500 active adult drug treatment courts across the United States, the need for counselors who can effectively treat clients battling substance use/abuse cannot be understated (U.S. Department of Justice, 2020). Based on the researcher's own experience working with this population and the growing need to identify more effective treatment strategies, this qualitative research study was designed to explore and understand clients' experiences of the working alliance with counselors during drug court-mandated addictions treatment. It is vital that participant voices are amplified in research regarding drug court as these are the individuals our national counseling community and criminal justice system is intended to serve. This investigation was guided by a constructivist grounded theory framework (Charmaz, 2014) to help answer the overarching research question: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment?

The results of this study yielded important strategies for strengthening the working alliance between counselors and client who have been mandated to receive SUD treatment. In particular, the findings detailed in Chapter 4 led to the development of a novel framework for understanding key therapeutic strategies that should be considered in working with clients who have been mandated to treatment. Representing a context-specific expansion to Bordin's (1979) original working alliance model, the new model (From compliance to alliance: A grounded theory of building rapport in mandated treatment; see Table 4) will be discussed in greater depth, with a focus on the implications for key stakeholders who work with this unique clinical population. Key stakeholders for this discussion have been identified as counselors and counseling agencies, counselor educators, and adult drug treatment courts.

Implications for Key Stakeholders

Counselors and Counseling Agencies

This study focused on understanding how to strengthen the working alliance between counselors and clients who have been referred for mandated SUD treatment. In this portion of the discussion, key considerations are outlined for counseling professionals and the agencies who employ them. Stemming from the rich data gathered from the research participants, key strategies were identified and categorized into the three primary features of the working alliance (goals, tasks, and bonds). Strategies that were identified as strengthening the working alliance, as well as those reported to weaken it, were recorded. Overall, the core phenomenon of the new model developed from this study was identified as a counselor's ability to build rapport with their client. The emphasis on building relationships with mandated treatment clients was found to be supported in the initial review of the literature (Doran, 2016; Miller & Moyers, 2015), and later echoed by the respondents who contributed to this study.

This study's core phenomenon of building rapport is fitting, given that building relational competencies with client's is one of the first skills that counselors learn in their training. However, Doran (2016) discussed how Bordin's (1979) working alliance framework and its inventories for assessing the efficacy of this model were insufficient for determining the unique relational features that are essential in building a strong working alliance. Doran also highlighted the need for more qualitative work to be done to define what specific factors were important to clients when receiving treatment. In reviewing the literature germane to this topic, the author also pointed out that traditional statistical analysis measures yielded many errors as they were not sufficiently refined to account for key confounding factors.

In the present study, several strategies were defined as being helpful in forming a strong working alliance with mandated treatment clients. While assisting clients in developing treatment goals represents an important first step any counselor, the results of this study highlighted the significance of a counselor emphasizing a client's personal treatment goals in conjunction with supporting that individual's overall needs to fulfill the requirements of the court. Initial interactions are quite important as mandated clients are more likely to experience feelings of coercion in the treatment relationship compared to non-mandated clients' (Sheehan & Burns, 2011). This factor was reinforced in Jade's experiences as she mentioned that she felt like she was being moved towards treatment goals "they want" her to achieve. The results of this study confirmed that counselors who took a humanistic, person-centered approach with clients mandated to treatment tended to strengthen the working alliance. This approach was evident when Bonnie stated how she felt as though she was able to "choose" her path in treatment, with her counselor serving as more of a point of accountability for her. This concept was also supported by a recent literature report describing how participants were more receptive to counselors who were able to display a genuine interest in fostering a helping relationship (Seaward et al., 2012). In this researcher's professional experience, during initial interactions with clients—regardless of whether they are self-referred or mandated to treatment—a key factor involves understanding the importance of *goal* development. Indeed, a working alliance is more likely to be strengthened by honoring the client's personal motivations for change. For the population under scrutiny, however, goal development must be accomplished in conjunction with supporting the required need to fulfill the mandates of the court. Although important, the counselor should not be hyper-focused on these externally imposed preconditions, but rather on the unique needs and hopes of the client.

As counselors continue their interactions with court-mandated clients in the *tasks* portion of treatment, several strengthening strategies emerged from the results of this study. These strategies included giving clients choice in session content, maintaining an open and non-judgmental stance towards what is processed while in treatment, being understanding regarding a client's setbacks, and planning open-ended and relatable session topics. Such factors that reflect a humanistic approach that seeks to validate the unique experiences of clients are in line with skills that have been singled out in the literature as being the most meaningful in supporting clients who have been mandated to receive SUD treatment (MacFarlane et al., 2015; Seaward et al., 2021). In particular, Seaward et al.'s emphasis on the importance of flexible session content as useful for mandated treatment was also confirmed by the results of this study. Bonnie highlighted this factor when she mentioned the benefits of having open-ended session topics that were easy to relate to. Gale also expanded on this issue, noting how her counselor's receptivity to whatever she needed to discuss in treatment promoted honesty, augmenting her motivation to complete the tasks of treatment.

It is critical in the discussion of building a strengthened working alliance with mandated treatment clients that the process of goal development and tasks identification are not overlooked. From the previous literature available on the topic, many mandated-treatment clients actually underestimate the value that they bring to the therapeutic process (MacFarlane et al., 2015). Clients may at times not know what to expect in therapy, or feel as though they are being reduced to a single issue: their substance use disorder. The work of building a strengthened bond should occur in tandem with the development of *goals* and *tasks*, not after it. For this reason, Figure 2 represents the working alliance as a cyclical process.

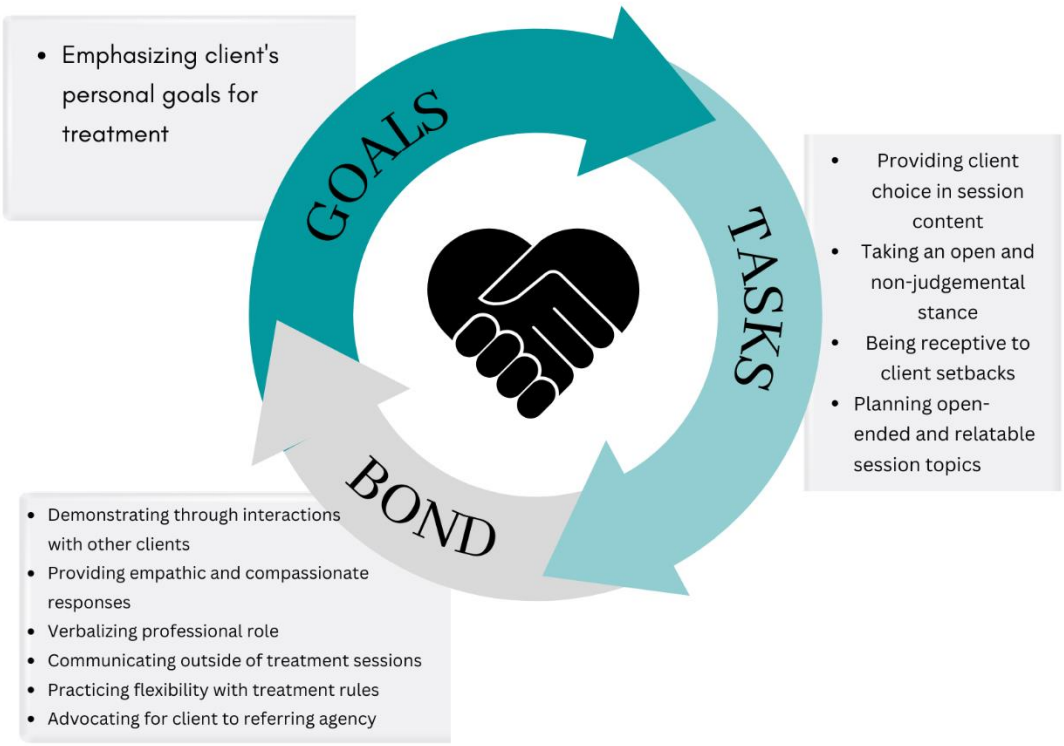

Figure 2. Summary of Strengthening Strategies

As originally stated by Bordin (1979), defining how the counselor-client *bond* is developed in the working alliance is ambiguous in nature. A major contribution of this study was defining what specific strategies help with creating a strong bond between counselor and client. For instance, in considering the behaviors and treatment choices of counselors, prior literature reports indicate that normalizing/validating a client's experiences, coupled with instilling hope in the treatment process, represent strengthening strategies (e.g., MacFarlane et al., 2015; Miller & Moyers, 2015; Seaward et al., 2021). The findings from this study reinforce these earlier reports. Research participants Jed and Brian highlighted this correlation when they reported having more positive experiences with counselors who they perceived as being receptive to setbacks and who took non-judgmental approaches in their work with clients. We know from previous work

(Gallagher, 2017) that clients can feel belittled in their efforts to be honest in treatment if these foundational skills of empathy and compassion are lacking from the counselor(s).

Additionally, Jade's experiences highlighted how inconsistent lines of communication between her counselor and the courts served to weaken the bond formation with her counselor. This finding is supported by the available literature on working with court-mandated clients in that they reported feeling like their counselor was merely an extension of their probation officer (Gallagher, 2015; 2017). For this study, the positive impact of a counselor clearly defining their role and what specific treatment information they need to convey to the courts is reinforced. Similarly, the results of this study and prior literature reports (e.g., Miller & Moyers, 2015) emphasize the importance of clearly verbalizing professional roles in strengthening the bond formation with clients mandated to receive treatment.

In discussing the implications of this study's findings and their impact on counselors, it is also important to acknowledge the role that counseling agencies have in supporting clients who have been referred to them by drug courts. Publicly funded counseling agencies, commonly referred to as community service boards in Virginia, can significantly influence the experiences of drug court clients in that they represent the primary provider of SUD treatment. Indeed, community service boards can be a lifeline for this at-risk population as they provide access to treatment for individuals who might otherwise have to try to manage their illness themselves. However, having to provide such a high volume of services to their local communities, exploring ways that these agencies can continue to provide sufficient oversight of, and assistance to, drug court clients represent a significant discussion point going forward.

In human service professions such as counseling, overseeing and monitoring the provision of services and outcomes are extremely important. Accordingly, community service

boards typically require ongoing evaluations completed by court-referred clients, which can be a valuable source of information. Such routine evaluations (e.g., every 4-6 weeks) help to create more consistent lines of feedback between clients, courts, and providers. From this study, we learned that clients who are referred by the courts are inevitably influenced by a range of unique life factors that will impact their treatment experience. As Jed highlighted, treatment providers who are willing to learn about and understand these personal life factors can strengthen the working alliance. Counseling agencies also have a role to play in clarifying from the outset (i.e., prior to the assignment of a counselor) what information they will be required to share with the courts so there is no ambiguity as to what the client should expect.

A related recommendation involves the implementation of more intentional supervision practices that could help counselors remain focused on their therapeutic work, while also enabling them to keep up with the paperwork associated with working with drug court clients. Also, since many research participants noted the positive impact of having their counselors check in with them outside of their counseling appointment time as strengthening their working alliance, it is suggested that counseling agencies reinforce the importance of such impromptu counseling opportunities. For example, such less formalized interactions could be facilitated via phone calls, emails, or even some type of electronic text messaging system that clients can opt-in for. While such engagements do become the responsibility of the counselors themselves, counseling agencies play a key role in creating expectations and balance for their counselor's workflow processes as it relates to working with this population.

Counselor Educators

Counselor educators represent key stakeholders in discussing the results of this study. To reiterate, the core phenomenon of this study was identified as being a counselor's ability to build

rapport with a client who has been mandated to treatment. The result of this study detailed specific strategies for achieving this goal, such as taking an open, non-judgmental stance towards clients, being receptive to setbacks in the treatment process, responding empathically and compassionately, as well as honoring the individual's personal motivations for treatment. As previously discussed in Chapter 2 and via the findings of this study, clients who have been mandated to receive SUD treatment emphasize the importance of counselors who take a humanistic approach and validate clients in their experiences (MacFarlane et al., 2015; Seaward et al., 2021). Indeed, the majority of research participants in this study indicated that such an approach strengthened the working alliance with their counselor(s). However, if basic counseling skills learned from counselor educators were sufficient in supporting those who work with this population, then why are we seeing such significant ruptures in the client-counselor working alliance?

Moreover, additional specialized training/curricula options for those who may work with treatment-mandated clients, which have yet to be formally instituted in academic institutions that prepare counselors educators, should be routinely implemented in counselor training. Indeed, the Council for Accreditation of Counseling and Related Educational Programs lists "strategies for interfacing with the legal system and working with court referred clients" (2015) as an important element in their standards for counselor education curricula. Given that only anecdotal information is currently available as to whether counseling students feel prepared to work with court-mandated clients, a heightened focus on developing and providing addiction-related courses could be of benefit for the mandated treatment population. In support of this recommendation, several research participants, including Jed, noted how flexibility and an

enhanced understanding of all the unique stressors that court-mandated clients face is an important element strengthening the counselor-client working alliance.

The findings from this study also entailed a range of other factors that could impact the efficacy of court-mandated treatment. Notably, participants discussed the amount of time drug court programs entail, the high levels of external accountability in the form of required support meetings, urinalysis screening, the need for some to find employment, and regular attendance at drug court meetings. While reviewing these unique factors are important for understanding a drug court participant's experience and should be imparted to counselors-in-training, formalized training should emphasize the psychological and other stresses this at-risk population faces and the specific interventions that could be implemented to manage these factors.

Adult Drug Treatment Courts

Adult drug treatment courts are also identified as key stakeholders in discussing the results of this study. Drug courts were the primary context for this study and will continue to serve as a primary referral source for court-mandated SUD treatment. Based on the results of this study, it is suggested that drug courts continue to explore and revise the framework for their stated Best Practices for Adult Drug Court (NADCP, 2013).

A key finding from this study further emphasizes the potential conflict between the stated goals of drug courts and the importance Bordin (1979) placed on goal and bond development between client and counselor. Most participants in this study noted the importance of being able to include their personal goals for treatment, in addition to those stated by the courts. Some participants described feeling support in their goals in stating that they were able to make the experience their own, which included key values in life, such as being reconnected to family. In contrast, when too much emphasis was placed on the drug court-mandated treatment

benchmarks, some participants (e.g., Alvin) discussed how this felt like they were being reduced to a number. In light of these findings, it is suggested that adult drug treatment courts work collaboratively with mental health professionals in the process of revising their Best Practices (NADCP, 2013) to include a more holistic, person-centered approach to this framework.

Another finding from this study that will demand the attention of programmatic leaders in adult drug courts involves fully clarifying the expectations for communication between counselors and drug court officials. Some respondents noted feeling as if their counselor had become an extension of their probation officer, which proved to be a weakening strategy in building the counselor-client working alliance. This theme was also highlighted in prior research conducted with this specific treatment population (Gallagher, 2015; 2017). As such, communication expectations between the referred counseling agency and drug court programs should be better defined and made clear at the start of treatment. In so doing, clients referred to SUD treatment by drug courts are more likely to be able to build a strong working alliance with their counselor(s) while in treatment, thereby creating better treatment outcomes. In the case of drug court clients, this means successfully addressing their substance use disorder, completing their court-mandated treatment program, and avoiding being just another recidivism statistic.

Limitations

Several limitations associated with this study must be discussed. Qualitative research studies tend not to be widely generalizable in nature, but nonetheless have been cited as providing inferential generalizability (Lewis & Ritchie, 2003). In examining the selected methodological framework selected for this research study, the most salient limitation involves the generalizability of findings given the specialized population who served as this study's respondents. Thus, the results from this study are limited to counseling clients who are

mandated to SUD treatment because of addiction to drugs or alcohol. A related limitation is that since the data collected for this study is sensitive in nature, it must be acknowledged that social desirability bias is possible. In other words, participants may have been hesitant to be completely forthright and honest in their recounting their experiences in drug court and substance use disorder treatment. Moreover, while the information sheet for participation in the study clearly outlined how each participant's identity would be protected, it does not negate the possible fear of their confidentiality being breached—and what that could mean during and after treatment. Another limitation of this study is the possibility of recency bias on behalf of the research participant. Since participants were required to be actively enrolled in a drug court program in order to participate, it is possible that a recent experience, either positive or negative, in SUD treatment may influence the way a participant respond when being asked about their experiences. A final limitation of this study is that the study's methodology had to exclude potential respondents who did not have access to an internet connection or a telephone. The researcher determined that collecting identifying information such as phone numbers and email addresses was essential for data collection. Thus, individuals without access to these communication avenues were unable to participate.

It is also important to note some delimitations associated with the employed methodology. First, due to the nature of legal processing being determined and managed at the state level, the researcher decided to only sample active drug court participants from the Commonwealth of Virginia. The interpretation and results from this study should be met with caution for any individual who resides outside of the Commonwealth of Virginia. Second, to prioritize the experiences of drug court participants who elected to participate in this study, the working alliance was only examined from the perspective of the client, which means that only

one-half of the working alliance was captured. This approach could have led to some unforeseen limitations; for example, in the data analysis process, the client's experience alone may not have fully captured the full extent of treatment efficiency.

Future Research

This study represents an important initial inquiry into the treatment experiences of clients who are required to receive mandated substance use disorder treatment. While the results of this study yielded the development of the new model (From compliance to alliance: A grounded theory of building rapport in mandated treatment), the findings detailed herein also serve as a springboard for additional research in this area. Consider, for example, that a principal delimitation of this study was the decision to only gather the perspectives of clients in treatment. A follow-on study should examine the perspectives of the counselors who work with this population, which would essential in helping to guide them in their clinical work toward the development of a strong and effective working alliance. It is suggested that future research be conducted using a more strategic interview protocol to further assess the strategies that emerged from this study. Finally, personal motivation for treatment emerged as a common theme (particularly in goal development). Given this outcome, additional research should be conducted to identify the salient motivating factors for change that exist within this treatment population.

Conclusions

This qualitative study was designed to explore the experiences of clients who have been mandated to receive substance use disorder treatment, with a focus on identifying the specific strategies counselors who work with this population can use to build a strong counselor-client working alliance. As therapeutic courts such as adult drug treatment courts are becoming more prevalent (National Drug Court Resource Center, 2020), the importance of this study and the

subsequent conversation about how counselors can better serve this population is timely. Counselors who serve this population have a unique role in supporting the overall treatment needs of their clients. This mandate includes addressing challenging and high-risk behaviors, as well as attending to the unique stressors that come along with being a participant in a court-ordered program. This study sought to reveal the experiences of individuals in SUD treatment to inform counselors about specific strategies that can support them in their work with this distinct population. This study contributes to the counseling professional by expanding on foundational frameworks used to guide counselors on how to build a strong working alliance with clients, but then expanding this framework to this specific population.

As discussed, a single overarching research question guided this study: How do clients experience the working alliance with counselors during drug court-mandated addictions treatment? The context of Bordin's (1979) original working alliance was used to establish the three core features needed to achieve a successful counseling experience: agreement of goals, assignment of tasks, and development of bond. Following the data analysis process in line with a constructivist grounded theory methodology, key theoretical components were defined (see Table 4), which led to the development of the new and expanded model, *From compliance to alliance: A grounded theory of building rapport in mandated treatment*.

One important strengthening strategy for the working alliance in goal development was identified as the need for counselors to seek out and emphasize the client's personal motivation for treatment. In contrast, one weakening strategy was identified as a counselor influencing a client's goals based on externally imposed mandates from the referring agency. Within the category of *tasks*, four strategies were identified as strengthening the working alliance: 1) providing client choice in session content; 2) taking an open, non-judgmental stance; 3) being

receptive to client setbacks; and 4) planning open-ended and relatable session topics. No weakening strategies were identified in the participants interviews.

Six strengthening strategies supporting the bond development between client and counselor emerged from the results this study: 1) counselors demonstrating their ability to be trusted through interactions with other clients, 2) empathically and compassionately responding to clients, 3) counselors verbalizing their professional role, 4) counselors communicating with client's outside of treatment sessions, 5) practicing flexibility with treatment rules, and 6) advocating for clients to their referring agency. Conversely, five weakening strategies were identified as impeding bond development: 1) counselors lacking compassion through client setbacks, 2) prioritizing paperwork and processes over the individual client, 3) inconsistent lines of communication between counselor and the referring agency, 4) counselors failing to follow up with client's individually outside of group process, and 5) counselors failing to demonstrate competency in working with substance-related issues.

The results of this study update and expand a specific framework for counselors to use in their work with clients who have been mandated to receive substance use disorder treatment, which is likely to be different from approaches used in their work with fully voluntary clients. The findings discussed herein also address important considerations and implications for key stakeholders who have the potential to impact treatment goals and strategies for this at-risk population—namely, counselors, counseling agencies, counselor educations, and adult drug treatment courts. It is hoped that findings from this study will promote thoughtful consideration of the unique factors that drug court participants (and possibly other mandated-treatment clients) are confronting as they seek to overcome additions that hinder them from achieving their full potential.

References

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*(2), 171.

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review*, *23*(1), 1-33.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Society of Addiction Medicine. (2021). About the ASAM Criteria. Retrieved from https://www.asam.org/asam-criteria/about

American Society of Addiction Medicine. (2015). The ASAM principles of addiction medicine. (R. Ries, S. C. Miller, R. Saitz, & D. A. Fiellin, Eds.) ([Fifth edition]). Lippincott Williams & Wilkins/Wolters Kluwer.

Aos, S., Miller, M., & Drake, E. (2006). Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates. Olympia: Washington State Institute for Public Policy. Retrieved from http://www.wsipp.wa.gov/ReportFile/952/Wsipp_Evidence-Based-Public-Policy-Options-to-Reduce-Future-Prison-Construction-Criminal-Justice-Costs-and-Crime-Rates_Full-Report.pdf

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, *53*(1), 26.

Bedi, R. P., & Duff, C. T. (2009). Prevalence of counselling alliance type preferences across two samples. *Canadian Journal of Counselling and Psychotherapy*, *43*(3).

Berke, J. D. (2018). What does dopamine mean?. *Nature Neuroscience, 21*(6), 787-793.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252.

Council for Accreditation of Counseling and Related Educational Programs. (2015). 2016 CACREP standards.

Carey, M.S., Mackin, J.R., Finigan, W.M. (2020). What works? The ten key components of drug court: Research-based best practices. *Best Practices in Drug Courts, 8*(1), 6.

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviours that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly, 23*(1), 91-110.

Doran, J. M. (2016). The working alliance: Where have we been, where are we going?. *Psychotherapy Research, 26*(2), 146-163.

Gallagher, J.R., Nordberg, A., & Kennard, T. (2015) A qualitative study assessing the effectiveness of the key components of a drug court. *Alcoholism Treatment Quarterly, (33)*1, 64-81, doi:10.1080/07347324.2015.982453

Gallagher, J. R., Nordberg, A., & Lefebvre, E. (2017). Improving graduation rates in drug court: A qualitative study of participants' lived experiences. *Criminology & Criminal Justice, 17*(4), 468-484.

Gastfriend, D. R., & Mee-Lee, D. (2004). The ASAM patient placement criteria: Context, concepts and continuing development. *Journal of Addictive Diseases, 22*:sup1, 1-8, https://doi.org/10.1300/J069v22S01_01

Glaser, B. G., & Strauss, A. L. (2017). *Discovery of grounded theory: Strategies for qualitative research*. Routledge.

Hachtmann, F. (2012). The process of general education reform from a faculty perspective. *The Journal of General Education, 61*(1), 16-38.

Hauser, M., & Hays, D. G. (2010). The slaying of a beautiful hypothesis: The efficacy of counseling and the therapeutic process. *The Journal of Humanistic Counseling, Education, and Development, 49*, 32–44. doi:10.1002/j.2161-1939.2010.tb00085.x

Holmberg, J. K. (2003). *Development and evaluation of an alliance workbook*. Ohio University.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223–233. https://doi.org/10.1037/0022-0167.36.2.223

Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., . . . Reisinger, C. W. (1996). Administration and scoring manual for the Outcome Questionnaire (OQ45.2). Wilmington, DE: American Professional Credentialing Services.

Latimer, J., Morton-Bourgon, K., & Chrétien, J.-A. (2006). A meta-analytic examination of drug treatment courts: Do they reduce recidivism? Ottawa, Ontario, Canada: Research and Statistics Division, Canada Department of Justice. Retrieved from http:// www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/rr06_7/rr06_7.pdf

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science, 278*(5335), 45-47.

Lewis, J., Ritchie, J., Ormston, R., & Morrell, G. (2003). Generalising from qualitative research. *Qualitative Research Practice: A Guide for Social Science Students and Researchers, 2*, 347-362.

Lowenkamp, C.T., Holsinger, A.M., & Latessa, E.J. (2005). Are drug courts effective? A meta-analytic review. *Journal of Community Corrections, 15*(1), 5–11.

MacFarlane, P., Anderson, T., & McClintock, A. S. (2015). The early formation of the working alliance from the client's perspective: A qualitative study. *Psychotherapy, 52*(3), 363.

Manchak, S. M., Skeem, J. L., & Rook, K. S. (2014). Care, control, or both? Characterizing major dimensions of the mandated treatment relationship. *Law and Human Behavior, 38*(1), 47.

Marlowe, D. B., Hardin, C. D., & Fox, C. L. (2016). Painting the current picture: A national report on drug courts and other problem-solving courts in the United States. *National Drug Court Institute*.

Miller, W. R., & Moyers, T. B. (2015). The forest and the trees: Relational and specific factors in addiction treatment. *Addiction, 110*(3), 401-413.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*(1), 60–71.

National Association of Drug Court Professionals (NADCP). (2004). *Defining drug courts: The key components*. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/205621.pdf

National Association of Drug Court Professionals (NADCP). (2013). *Adult Drug Court Best Practice Standards: Volume I*. Retrieved from https://www.nadcp.org/wp-content/uploads/2018/12/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018.pdf

National Drug Court Resource Center. (2020). *Treatment Court Map*. https://ndcrc.org/wp-content/NDCRC_Court_Map/

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage publications.

Policy for Protection of Human Subjects. 45 C.F.R. §46, (2018)

Queensland Brain Institute. (2017, November 9). *What are neurotransmitters?* https://qbi.uq.edu.au/brain/brain-physiology/what-are-neurotransmitters

Ray, L.A.; Meredith, L.R.; Kiluk, B.D.; Walthers, J.; Caroll, K.M.; & Magill, M. (2020). Combined pharmacotherapy and cognitive behavioral therapy for adults with alcohol or substance use disorders: A systematic review and meta-analysis. *JAMA Netw Open.* 2020;3(6):e208279. doi:10.1001/jamanetworkopen.2020.8279

Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., … Farole, D. J. (2011). The Multi-Site Adult Drug Court Evaluation: The impact of drug courts, volume 4. Washington, DC: Urban Institute Justice Policy Center. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf

Sackett, C. R., & Lawson, G. (2015). The working alliance and experiences of clients and counselors-in-training. *The Journal of Humanistic Counseling*, *54*(2), 104-121.

Seaward, H., Wangmo, T., Vogel, T., Graf, M., Egli-Alge, M., Liebrenz, M., & Elger, B. S. (2021). What characterizes a good mental health professional in court-mandated treatment settings?: Findings from a qualitative study with older patients and mental health care professionals. *BMC psychology*, *9*(1), 1-16.

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly*, *28*(3), 493–521.

Sheehan, K. A., & Burns, T. (2011). Perceived coercion and the therapeutic relationship: a neglected association?. *Psychiatric Services*, *62*(5), 471-476.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Key substance use and mental health indicators in the United States: Results from the

2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory.

Supreme Court of Virginia. (2020, December). *Virginia Drug Treatment Courts 2020 Annual Report*. Richmond, Virginia.

Taber, K. H., Black, D. N., Porrino, L. J., & Hurley, R. A. (2012). Neuroanatomy of dopamine: reward and addiction. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *24*(1), 1-4.

U.S. Department of Justice. (2022, July). *Drug Courts*. https://www.ojp.gov/pdffiles1/nij/238527.pdf

U.S. Government Accountability Office. (2011). Adult drug courts: Studies show courts reduce recidivism, but DOJ could enhance future performance measure revision efforts (GAO-12-53). Washington, DC: Author. Retrieved from http://www.gao.gov/assets/590/586793.pdf

Volkow, N. D., Baler, R. D., & Goldstein, R. Z. (2011). Addiction: Pulling at the neural threads of social behaviors. *Neuron*, *69*(4), 599-602.

Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, *374*(4), 363-371.

Weisheit, R. A. (1990). *Drugs, crime, and the criminal justice system* (Ser. Acjs/anderson monograph series). Academy of Criminal Justice Sciences.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A metaanalysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin, 122*, 203–215. doi:10.1037/0033-2909.122.3.203

Wild, T. C., Yuan, Y., Rush, B. R., & Urbanoski, K. A. (2016). Client engagement in legally-mandated addiction treatment: A prospective study using self-determination theory. *Journal of Substance Abuse Treatment, 69,* 35-43.

Wilson, D.B., Mitchell, O., & MacKenzie, D.L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology, 2*(3), 459–487.

Witkin, S. H., & Hays, S. P. (2019). Drug court through the eyes of participants. *Criminal Justice Policy Review, 30*(7), 971-989.

Appendix A: Approved Adult Drug Treatment Court Dockets in Virginia (2020)

Figure 6. Approved Adult Drug Treatment Court Dockets in Virginia, FY 2020

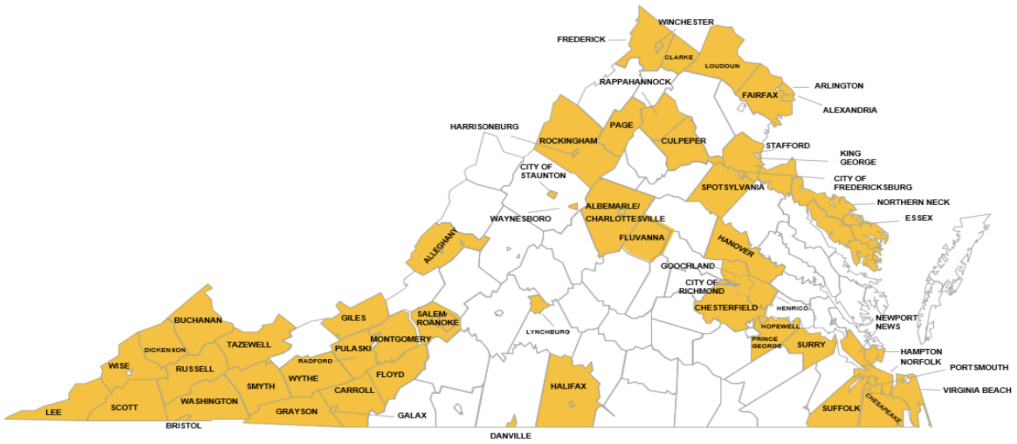

Table 6. Approved Adult Drug Treatment Court Dockets in Virginia, FY 2020

Adult Drug Treatment Court Dockets		
Albemarle/Charlottesville	Loudoun County	***n* = 44**
Alexandria	Lynchburg	
Alleghany County*	Montgomery County	
Arlington County	Newport News	
Bristol	Norfolk	
Buchanan County	Northern Neck/Essex	
Chesapeake	Northwestern Regional (Winchester area)	
Chesterfield/Colonial	Portsmouth	
Culpeper*	Pulaski County	
Danville*	Radford*	
Dickenson County	Rappahannock Regional	
Fairfax	Richmond City	
Fifth Judicial Circuit	Russell County	
Floyd County	Smyth County	
Fluvanna County	Staunton, Augusta County, and Waynesboro	
Giles County	Tazewell County	
Halifax County	Thirtieth Judicial Circuit (Lee, Scott & Wise Counties)	
Hampton	Twenty-Third Judicial Circuit (Roanoke County, Roanoke City, Salem City)	
Hanover County*	Twin Counties and Galax	
Harrisonburg/Rockingham	Virginia Beach Circuit	
Henrico County	Washington County	
Hopewell/Prince George	Wythe County	

** Non-operational Adult Drug Treatment Court Dockets*

Retrieved from: Supreme Court of Virginia. (2020, December). *Virginia Drug Treatment Courts 2020 Annual Report*. Richmond, Virginia.

Appendix B: Recruitment Flyer

Your Experience Matters!

Call for research participants!

1. **What is the purpose of this research study?**
   To improve the experiences of mandated substance use disorder treatment for participants of drug court.
2. **Who can participate?**
   Any individual who is 18 years old or older, an active participant of drug court, and has completed at least one month of treatment.
3. **What does participation look like?**
   Individuals selected to participate will be interviewed by telephone or Zoom for 45-60 minutes about their experiences.
4. **Will I be compensated for my time?**
   Of course! Individuals who complete the interview will receive a virtual $10 gift card.

Interested in learning more?

Text or call: **540- 47-1880**

Email: **czongrone@vt.edu**

Scan the QR code or search

https://tinyurl.com/47u2h7my

to see the participant access page!

This is a Virginia Tech research study that has been reviewed by the Human Research Protection Program (IRB#21-1075)

Appendix C: Information Sheet

Information Sheet for Participation in a Research Study

Principal Investigator: Dr. Laura Welfare, School of Education, Virginia Polytechnic Institute and State University
Investigator: Courtney Zongrone, School of Education, Virginia Polytechnic Institute and State University
IRB# and Title of Study: IRB# 21-1075, From Compliance to Alliance: Strengthening the Working Alliance in Mandated Treatment

You are invited to participate in a research study. This form includes information about the study and contact information if you have any questions. I am a graduate student at Virginia Tech, and I am conducting this research as part of my course work required to fulfill the requirements of my degree.

WHAT SHOULD I KNOW?

If you volunteer for this study and are selected to participate, you will complete a 45-60 minute phone/Zoom interview with Courtney Zongrone. The interviewer will be in a private setting during your interview, and the audio of the interview will be recorded. During the interview, you will be asked questions about your experiences as a participant in drug court. The questions you will be asked during the interview will seek to understand how being mandated by to receive substance use disorder treatment may impact your therapeutic relationship with your counselor(s). If you do not wish to answer a certain question, you can ask to skip that question at any time. The information collected from the interview is confidential and only members of the research team will have access to it. All audio information collected during the interview will be transcribed and de-identified of any personal information. All information will be stored in a secured and private location and will be destroyed five years after the completion of the study. You will receive a $10 gift card as a result of your participation in the study. The gift card will be sent to your preferred email address after the interview has been completed. Participants will need an active email address to receive the gift card. Gift cards will not be sent through postal mail.
While the risks associated with participating in this study are minimal, several risks do exist regarding the personal sensitivity of the information being asked. As a research participant you will be asked questions about your experiences in substance use disorder treatment and within the drug court program. While answering these questions, you may feel distress if you are reflecting on negative experiences. Because this study is about your experiences with drug court, there is a risk that someone around you might learn about your probationer status if they

see you participating in this study. Be sure to keep the study materials and phone interview private.

As an individual who is on probation for drug-related offenses, there are some behaviors that would violate the terms of your probation. Exploring illegal behavior is not the purpose of this research study, but if information like that is unintentionally shared or overheard, it could pose a legal risk. Please note that as a researcher it is my goal to protect your confidentiality at all times. We will use strict data security practices to help keep your identifying information private, but there is always a risk for your information to be viewed by other individuals not involved in the research study. Please note that no information shared during this study will be released back to the courts, mental health providers, or probation officers. Information shared will be always kept private by the interviewer and members of the research team.

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

CONFIDENTIALITY

We will do our best to protect the confidentiality of the information we gather from you, but we cannot guarantee 100% confidentiality.

Any data collected during this research study will be kept confidential by the researchers. Your interview will be audio-recorded using a Zoom audio software and then transcribed. The researchers will code the transcripts using a pseudonym (false name). The recordings will be uploaded to a secure password-protected computer in the researcher's office. The researchers will maintain a list that includes a key to the code. The master key and the recordings will be stored for 5 years after the study has been completed and then destroyed.

WHO CAN I TALK TO?

If you have any questions or concerns about the research, please feel free to contact Courtney Zongrone at czongrone@vt.edu, or by phone at 540-947-1880. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact the Virginia Tech HRPP Office at 540-231-3732 (irb@vt.edu).

Please print out or save a copy of this information sheet for your records.

If you would like to potentially participate in this study, please click on the next arrow to complete the recruitment survey. If you do not wish to participate, please exit the survey at this time.

Appendix D: Recruitment Survey

Inclusion Criteria Information

What is your age?

Are you currently enrolled as a participant through your local Drug Court program?

- ○ Yes
- ○ No

Have you completed at least one month of the required substance use disorder treatment?

- ○ Yes
- ○ No

Demographic Information

Please write your first name only.

How do you identify your gender?

Please specify your race

- ○ American Indian and Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Pacific Islander
- ○ White

- ○ Multiracial
- ○ Prefer not to say

What is your current employment status?

- ○ Employed full time
- ○ Employed part time
- ○ Unemployed looking for work
- ○ Unemployed not looking for work
- ○ Retired
- ○ Student
- ○ Disabled

Contact Information

What is the best phone number to be able to reach you to communicate about your participation in this study?

Are voice messages allowed to be left on the phone number that you provided?

- ○ Yes
- ○ No

Are text messages allowed to be sent to the phone number that you provided?

- ○ Yes
- ○ No

Appendix E: Interview Protocol

VIRGINIA TECH

Semi-Structured Interview Protocol
(IRB #21-1075)

Title of Project: **From Compliance to Alliance: Strengthening the Working Alliance in Mandated Treatment**

Investigator(s): Courtney Zongrone

Laura E. Welfare, PhD

Materials: Semi-Structured Interview Protocol

Description: The following semi-structured interview protocol will be used to guide the consent and interview processes in a discussion-like format; thus the questions below represent the content that will be explored during the interview; however, the exact language and question order may vary as the discussion between the interviewer and the participant unfolds.

Semi-Structured Interview Protocol

Introduction:

[Conduct participant/interviewer introductions and informal small talk]. Thank you for coming in today. I will be taking some notes while we talk, but to make sure I accurately capture what you are saying, I would like to record our conversation. Do I have your permission to start recording?

[Start recording devices]

Reviewing Consent:

So before you completed the recruitment survey, there was an information sheet on that first page. Did you have an opportunity to review that form? Do you have any questions before we begin the interview?

- If participant has questions: [allow participants to ask questions and review consent form before beginning]
- If participant has no questions: [continue to question protocol]

Question Protocol:

First of all, I would like to thank you for taking the time to come speak with me today. As outlined in the consent form, the purpose of this study is to further understand your experiences as a participant in the drug court program. Essentially, we want to understand how your experiences in being required to receive substance use disorder treatment may influence your ability to engage in treatment and relationship with your treatment provider. Keep in mind that there are no right or wrong answers; this interview is about understanding you and your experiences. If you have any questions at any time, please do not hesitate to ask.

[If the participant does not have any further questions, the investigator will begin the interview protocol.]

Initial experiences in drug court program and SUD treatment

1. I'd first like to start by asking you about your experiences leading up to your enrollment with drug court. Would you mind sharing with me about how you referred to the program and what that process was like for you?
2. Have you had any previous treatment for substance use or mental health counseling in the past?

Experiences in SUD treatment and relationship with counselor(s)

3. A requirement of the drug court program is to complete substance use disorder treatment, how do you feel about that?
4. Do you feel as though you have a say in what your goals are for your substance use disorder treatment?
5. Do you feel as though you have a say in what you do while in treatment in order to accomplish your goals while in substance use disorder treatment?
6. Do you feel respected and cared for by your counselor(s) who provides you substance use disorder treatment?
7. Do you feel like you can be honest with your counselor(s)?

Reflecting on the overall experience

8. Are there any aspects of the drug court program that you find most challenging?
9. If you were to use one or two words to describe your experiences in drug court, what word would you use?
10. What improvements, if any, would you suggest to enhance your experiences while receiving mandated substance use disorder treatment as a participant in drug court?

Conclusion Protocol:

Well, that last question marks the end of the interview process. Before I turn off the recording, is there anything else you would like to share or go back to related to your experiences in drug

court?

- if no: proceed to end the recording.
- if yes: continue recording until participant has finished sharing their experiences.

Thank you for that, I will now turn off the recording.

[investigator will turn off the audio recorder]

Again, I would like to thank you for your time and participation in this research study. Your experiences in mandated treatment matter and hopefully this research can help support others have positive experiences. Now that we have concluded the interview, I will send you the $10 Visa. I would like to confirm the email address you would like this gift card to be sent to. Can you share that with me now. [Participant provides email address]. Great, thank you for that. I will email that to you shortly. Please do not hesitate to reach out to me if you have any questions or concerns.

[Interview process concluded]