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Brief report/communication

Differences in client and therapist views of the working alliance in drug treatment

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ABSTRACT

Background: There is growing evidence that the therapeutic alliance is one of the most consistent predictors of retention and outcomes in drug treatment. Recent psychotherapy research has indicated that there is a lack of agreement between client, therapist and observer ratings of the therapeutic alliance; however, the clinical implications of this lack of consensus have not been explored.

Aims: The aims of the study are to a) explore the extent to which, in drug treatment, clients and counsellors agree in their perceptions of their alliance, and b) investigate whether the degree of disagreement between clients and counsellors is related to retention in treatment.

Methods: The study recruited 187 clients starting residential rehabilitation treatment for drug misuse in three UK services. Client and counsellor ratings of the therapeutic alliance (using the WAI-S) were obtained during weeks 1-12. Retention was in this study defined as remaining in treatment for at least 90 days.

Results: Client and counsellor ratings of the alliance were only weakly related (correlations ranging from r=0.07 to 0.42) and tended to become more dissimilar over the first 12 weeks in treatment. However, whether or not clients and counsellors agreed on the quality of their relationship did not influence whether clients were retained in treatment.

Conclusions: The low consensus between client and counsellor views of the alliance found in this and other studies highlights the need for drug counsellors to attend closely to their clients' perceptions of the alliance and to seek regular feedback from clients regarding their feelings about their therapeutic relationship

Key words: therapeutic alliance, drug treatment, retention

BACKGROUND

There is growing evidence that the client-counsellor relationship, or therapeutic alliance, is one of the most consistent predictors of retention and outcomes in drug treatment (for a recent review see Meier, Barrowclough & Donmall 2005). Recent research has accumulated consistent evidence of a lack of agreement between client, therapist and observer ratings of the therapeutic alliance, both in drug treatment (Fenton, Cecero, Nich, Frankforter & Carroll 2001; Luborsky et al. 1996) and in psychotherapy research (Bachelor 1995; Fenton et al. 2001; Hatcher, Barends, Hansell

& Gutfreund 1995; Hersoug, Hoglend, Monsen & Havik 2001; Marziali 1984; Tichenor & Hill 1989). Same-session client and therapist ratings were found to be at best moderately related (reported correlations ranged from 0.09 to 0.43) and the finding appears to be unrelated to the choice of alliance measure (Hatcher & Barends 1996; Hatcher et al. 1995; Hersoug et al. 2001; Luborsky et al. 1996). Tichenor and Hill (1989) aptly described the results of their study using ratings from all three perspectives and different instruments as follows: "Clients, therapists and observers clearly did not agree or come to a consensus on what working alliance was, indicating that measures from different perspectives are not interchangeable" (p.198). Only one study could be located which looked at the development of this disagreement over time, and none in the drug misuse field. Kivlighan & Shaughnessy (1995) reported that therapist and patient scores became closer as time progressed, which they interpreted to mean that patients and therapists came to share the same view of their alliance. Despite the consistent observation that client and therapist views of the alliance do not agree and the consistent finding that the alliance is an important predictor of treatment retention, no detailed investigation has yet been undertaken on whether the degree to which perceptions of the alliance diverge is of importance for the process of therapy. The current study aims to address this by testing whether, after controlling for the overall quality of the alliance, a lower degree of agreement between early client and counsellor ratings of the alliance predicts treatment dropout. A secondary hypothesis is that drug treatment clients and their counsellors come to share a common view of the alliance, as indicated by increasing associations between their scores over time.

METHOD

The Counselling Project was a longitudinal cohort study of consecutive clients entering drug treatment in three residential treatment services between August 2002 and August 2003. These services were selected on the basis of their willingness and ability to accommodate a research project such as the Counselling Project. Two of these treatment services were 12-step (Minnesota model) programmes with scheduled durations of six months, the third was a modified therapeutic community with a schedule programme length of 9 months. Services were located in the NW and SW of England. All services offered an intensive programme (4-8 hours daily) of individual and group counselling.

Information about counsellors was gathered before clients were recruited into the study. Staff brought the study to the attention of all eligible new clients. The researcher then met these clients to further explain the study, and if clients agreed to participate, they were asked to sign a consent form. Exclusion criteria were a) primary treatment focus other than drug addiction (i.e. primary alcohol addiction, gambling or eating disorders), b) inability to read the English language, and c) age less than 18 years. Apart from this, clients were only included if there was at least one complete set (client *and* counsellor form) of the weekly alliance questionnaires (described below). The latter resulted in the exclusion of 24 clients. Four eligible clients refused participation. The remaining clients (n=163) were included. The intake assessment consisted of a structured interview followed by a questionnaire, which clients completed with the researcher. Both clients and counsellors were asked to complete questionnaires about the alliance on a fixed weekday every week. For the purpose of this study, retention was defined as the completion of 90 days of treatment.

Measures

Working Alliance. The alliance was assessed weekly for the first 12 weeks of treatment using the short 12-item client and counsellor version of the Working Alliance Inventory (WAI-S, Horvath 1991; Tracey & Kokotovic 1989). In our sample, the internal consistencies of the WAI-S were: α=0.91, 0.90, and 0.90 for the first three counsellor ratings and α=0.87, 0.88, and 0.88 for the first three weeks of client ratings. The test-retest reliability was published as r=0.83 across a two-week period (Tracey and Kokotovic, 1989). The WAI-S yields a global alliance score, with higher ratings indicating a better therapeutic alliance.

Disagreement Index. In order to be able to test the hypothesis, a Disagreement Index was computed for each of the first 12 weeks of alliance assessments, which indicated the level of disagreement between client and counsellor alliance ratings at each time point. Client and therapist alliance scores were standardised by z-transformation and a difference score was calculated by subtracting the standardised counsellor from the standardised client score. The absolute value of the difference was used, as there was no hypothesis concerning the direction of the disagreement (i.e., a 1 unit difference was treated the same way independent of whether client or therapist scored higher). The larger the Disagreement Index score, the greater the difference between client and counsellor rating.

Retention. Clients were considered to have completed the study treatment if they remained in treatment for a minimum of 90 days, a period that has been associated with positive outcomes in previous research (Gossop, Marsden, Stewart & Rolfe 1999; Joe, Simpson & Broome 1998, 1999). The number of days in treatment was computed for non-retained clients, and both completion status and length of stay are considered in the reported Cox regressions.

Sample characteristics

Counsellors. Twenty-four counsellors, that is all counsellors at each of the three sites, treated the clients in the study, 8 (33%) in Agency A, 5 (21%) in Agency B, and 11 (46%) in Agency C. Thirteen (54%) counsellors were female and the mean age was 41 years (SD=9) Counsellors had an average experience in counselling of 46 months (SD=29) and 16 (66.7%) were accredited counsellors. Thirteen (54%) counsellors described themselves as in recovery or former addicts.

Clients. The 163 clients in the study were predominantly male (n=111, 68%) and in their 20s and 30s (median age 29.9, range 18 to 52). The majority of clients had been using heroin on a daily basis (123, 75.5%) and were injecting drug users (108, 66.3%). Over a quarter of clients were involved in regular problematic alcohol use (defined as >8 units per day for men and >6 units per day for women for at least 3 days a week) in addition to their primary drug problem. The sample was typical for UK drug treatment samples with regard to age, gender and drug use (Gossop, Marsden & Stewart 1998). For 93% of clients this was not their first treatment attempt and a third of clients had at least one previous stay in a residential rehabilitation service. Lifestyle variables pointed to unstable and unfavourable living circumstances for the majority of clients in the study: 29% were either homeless or in unstable living arrangements, 43% had no school qualifications, and three quarters had been unemployed immediately prior to treatment. Illegal activity (apart from illicit drug use) was common, and three-quarters of clients had committed crimes in the three months before treatment entry. The levels of self reported psychological problems were high, and over half had been prescribed medication for such problems (excluding drugs used for substitution and detoxification).

Statistical methods

Pearson correlations were used to indicate the strength of the relationship between counsellor and client alliance scores.

Random-effects models were computed to test whether the strength of the relationship between counsellor and client ratings changed over time.

Cox proportional hazard models were fitted to predict retention from early alliance scores (in short called Cox regression). Survival analysis, rather than logistic regression, was used because information on clients who stayed beyond 90 days was right-censored (i.e. it remained unknown whether clients dropped out at a later stage or whether they completed treatment). Survival analysis is also capable of handling staggered intake (not all clients enrolled at the same time) and endpoints better than other regression procedures. Differences between services were controlled for by entering treatment service as a stratification variable.

RESULTS

Development of differences between client and counsellor views of the alliance over time

Correlations between client and counsellor alliance ratings ranged from r=0.07 to 0.42, with 9 out of 12 correlations in the range of r=0.15 to r=0.30 (see Table 1).

(insert Table 1 about here)

It was expected that the association between client and counsellor scores would increase over time. This was tested by computing random-effects models, which adjust for the repeated nature of the alliance measurements and variations in sample size due to fewer clients remaining in treatment as time progresses. The client alliance scores were used as the dependent variable, and counsellor scores, time, and the interaction between counsellor alliance scores and time were entered as predictors. This in effect tests whether counsellor scores become more or less strongly associated with the client scores over time. Only the interaction term is of interest here: if there is a trend for associations between client and therapist scores to become stronger over time, then the effect of the interaction term is expected to be significant and positive. The results of this analysis (see Table 2) indicate that whilst the interaction term was indeed significant, in contrast to the hypothesis, the association between client and counsellor scores of the therapeutic alliance became weaker rather than stronger over time.

(insert Table 2 about here)

Prediction of dropout by degree of agreement between client and counsellor views of the alliance early in drug treatment

It was expected that a greater extent of disagreement between client and counsellor views of the alliance early in treatment would predict dropout.

In contrast to the hypothesis, the mean disagreement indices for the first three weeks of treatment were no different for those who stayed and those who dropped out (all p>0.20).

Cox regression survival analysis was used to determine whether the level of disagreement between client and counsellor alliance ratings predicted the length of retention in treatment after controlling for overall quality of the alliance as rated by the counsellor and by the client. Contrary to expectations, there was no evidence that higher levels of disagreement early in treatment predict dropout, independent of whether or not the treatment service was controlled for (see Table 2).

(Insert Table 3 about here)

Discussion and Outlook

This study investigated whether the level of agreement between counsellors and clients on the state of their therapeutic relationship changes over time and whether levels of agreement predict the likelihood of dropout from drug treatment. In accordance with the previous literature (Fenton et al. 2001; Luborsky et al. 1996), the overall agreement between clients and counsellors on the quality of their alliance was low, with most correlations in the region of $r=0.20$. Somewhat higher correlations are reported in the wider counselling literature, ranging from $r=0.29$ to $r=0.43$ (Hatcher et al. 1995), possibly indicating that substance users and counsellors differ more than other client groups in their perceptions of how their relationship is going.

The present results on the development of rater agreement over time are in contrast to findings by Kivlighan & Shaughnessy (1995), who reported that therapist and patient scores became closer as time progressed, which they interpreted to mean that patients and therapists came to share the same view of the alliance. In the present study, the level of agreement between client and counsellor alliance scores decreased over the course of the three month period studied, which would suggest that clients' and

therapists' perceptions of the relationship remain different throughout treatment. A recent doctoral dissertation describes the findings of a qualitative study into possible reasons behind the poor agreement between client and counsellor views of the alliance in a psychotherapy sample (Cowle 2003). Cowle's findings suggest that clients and counsellors use a different frame of reference for evaluating the alliance, i.e. clients value the alliance as a personal relationship, whereas for therapists it is more similar to a "business" relationship. Taken together with the finding that the level of disagreement is higher than reported for psychotherapy samples and that it increased over time, this may suggest that the perceptions of the relationship are and remain more different in clients in addiction treatment.

Prior to the current study, no investigation had been carried out to examine whether the degree to which perceptions of the alliance diverge is of clinical relevance for the process and outcome of therapy. In this study, it was hypothesised that the degree of agreement between client and counsellor views of the alliance would predict retention, with clients who agree with their therapists on the state of their relationship doing better. Contrary to expectations, and although the quality of the therapeutic alliance itself was related to retention (Meier, Donmall, McElduff, Barrowclough & Heller submitted), there was no indication that the level of disagreement on the quality of the alliance is related to whether or not a client stays in treatment.

There are some limitations to the generalisability of the study that need to be pointed out. Pragmatic considerations dictated that only three treatment centres could be recruited into the study, which is a small number of services from which to generalise. Service selection was not the result of random sampling, as with such a small sample of services it was considered more important that they reflect the different UK treatment philosophies and be located in different regions (NW and SW England). However, there is no obvious reason for assuming that the underlying mechanisms of the alliance-retention relationship operate differently in "willing" and "unwilling" services. The sample consisted of clients with high problem severity treated in residential rehabilitation treatment services, and the majority of the counsellors in the study were qualified and had several years experience. Findings are best generalised to similar client groups and settings. Also, some clients did not have at least one complete set of client and counsellor alliance ratings, and these clients tended to be those who dropped out very early during treatment. These clients did not differ from study participants with regard to age, gender or drugs used. It is thought unlikely that the loss of these clients would have had an important effect on the findings, as clients dropped

out in the first few days of treatment, that is before they could have established a meaningful relationship with their key counsellor. Nevertheless, the present results can only be applied to those who become at least minimally engaged.

Further research is also needed to address the open question whether differences in client and therapist views are caused by rater bias (e.g. social desirability effects) or whether there is a conceptual difference between clients' and therapists' views of the alliance, i.e. whether clients and counsellors are talking about different kinds of relationship. Although disagreement about the quality of the relationship appeared to be unrelated to retention, this study was unable to test whether it is related to treatment outcome, and this is a question that needs to be addressed in further research.

In conclusion, the low consensus between client and counsellor views of the alliance, and the fact that the agreement grows weaker over time, highlight the need for drug counsellors to attend closely to their clients' perceptions of the alliance and to seek regular feedback from clients regarding their feelings about their therapeutic relationship.

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Tables

Table 1. Correlation between client and counsellor WAI scores over time

Week	Pearson's r	N
1	0.40***	137
2	0.18	117
3	0.29***	123
4	0.24*	102
5	0.26*	88
6	0.16	83
7	0.25	80
8	0.21	59
9	0.42**	49
10	0.19	42
11	0.21	38
12	0.07	38

Table 2. Random-effects model: Trend in the level of disagreement over time

Variable	z	p
Therapist alliance	6.31	0.000
Time	4.26	0.000
Interaction Therapist alliance x time	-3.19	0.001

Note. Dependent variable: Client alliance scores

Table 3. Cox regression: Predicting time to dropout from counsellor rated alliance, client rated alliance and Disagreement Index, without and with adjustment for treatment service

Week	N	Variable	Not adjusted for treatment service		Adjusted for treatment service	
			Exp (B)	p	Exp (B)	p
1	137	Counsellor rated alliance	0.981	0.009	0.981	0.010
		Client rated alliance	0.999	0.918	1.000	0.976
		Disagreement Index	0.935	0.751	0.938	0.763
2	117	Counsellor rated alliance	0.987	0.088	0.985	0.075
		Client rated alliance	0.994	0.404	0.996	0.621
		Disagreement Index	1.042	0.847	1.021	0.922
3	123	Counsellor rated alliance	0.987	0.106	0.983	0.039
		Client rated alliance	1.006	0.455	1.008	0.327
		Disagreement Index	1.170	0.515	1.193	0.494

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