A Change-Focused Approach for Judges

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The American Psychological Association (APA) supported a research initiative that assembled the world's leading outcome researchers to review forty years of psychotherapy outcomes and detail the subsequent implications for direct practice. The initial findings of this research indicate that treatment *is* effective in helping human problems. The authors of this study, Mark Hubble, Barry Duncan, and Scott Miller observe effective catalysts of positive behavior change: "Study after study, meta-analysis, and scholarly reviews have legitimized psychologically-based or informed interventions. Regarding at least its general efficacy, few believe that therapy needs to be put to the test any longer."

Clinical outcome authors and researchers, Ted Asay and Michael Lambert, commenting on previous studies report, "These reviews leave little doubt. Therapy is effective. Treated patients fare much better than the untreated." These studies parallel research regarding the efficacy of treatment delivered by drug courts. Steven Belenko, reporting on drug court outcomes for the National Center on Addiction and Substance Abuse, found that there is a reduction in drug use and criminal activity while participants are in drug court programs.

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Common Factors

Having concluded that treatment is effective, the APA's study made a second finding that is at least equally significant: None of the numerous treatment models studied has proven to be reliably better than any other. Barry Duncan and Scott Miller report: "Despite the fortunes spent on weekend workshops selling the latest fashion, the competition among the more than 200 therapeutic schools amounts to little more than the competition among aspirin, Advil, and Tylenol. All of them relieve pain and work better than no treatment at all. None stands head and shoulders above the rest." This conclusion has been repeatedly upheld in subsequent studies.

If no theory or model can claim that it is better than the others, then what accounts for the overall efficacy of treatment? Researchers, including Michael Lambert and Mark Hubble, sifted through four decades of outcome data to postulate that the beneficial effects of treatment largely result from processes shared by the various models and their recommended techniques. Simply put, similarities, rather than differences, in the various models seem to be re-

sponsible for change. Each of the varied treatment models aids change by accessing certain common factors that, when present, have curative powers. Lambert concluded from extensive research data that there were four of these common factors:

- Client factors—the client's preexisting assets and challenges;
- Relationship factors—the connection between client and staff;
- Hope and expectancy—the client's expectation that therapeutic work will lead to positive change; and
- Model/technique—staff procedures, techniques, and beliefs.

These factors that raise the effectiveness of treatment are transtheoretical—that is, all of the various treatment theories and approaches recognize their importance to some degree. Without intentionally focusing on them, all therapies seem to be more effective when they promote these common factors in their own unique ways.

Hubble, Duncan, and Miller speak to this important research finding:

> In 1992, Brigham Young University's Michael Lambert proposed four therapeutic factors...as the principal elements accounting for improvement in clients. Although not derived from strict statistical analysis, he wrote that they embody what empirical studies suggest about psychotherapy outcome. Lambert added that the research base for this interpretation for the factors was extensive; spanned decades; dealt with a large number of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues.

Hubble, Duncan, and Miller also drew upon Lambert's earlier work that rated some factors as more influential in changing behavior than others and ascribed a weighting scale to them. Lambert then ranked and prioritized the common factors according to their amount of influence on positive behavior change.

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Client Factors

According to Lambert, client factors—not what offenders and their families receive from staff, but what they possess as they enter the doors of our drug courts and agencies—are the largest contributor to behavior change (forty percent). Client factors are both internal (optimism, skills, interests, social proclivities, aspirations, past successes) and external (a helpful uncle, employment, membership in a faith community). Client factors also include fortuitous events that are controlled by neither the drug court staff nor the program participant: an abusing boyfriend moving out and away from the

family, a chance school or employment experience instilling renewed interest, a lesson "hitting home" as, for example, when a close friend or peer is seriously harmed by illicit drug use.

The difficulties of encouraging referrals to participate in treatment are two-fold: first, staff must build trust and find effective methods to encourage those in treatment to participate. Second, staff must be persuaded to break the 'norm' of dictating behavior, and allow participants increased choice and autonomy.

Many treatment programs are not individualized (regardless of their claims), nor do they offer true choices in programming. Furthermore, staff often resists client input. The views and opinions of probationers may be markedly different from those of staff. Consequently, staff may be resistant to seeking and integrating input from participants about "what works" in their own treatment. Staff should recognize that acknowledging and accepting the beliefs and positions of a participant is not the same as agreeing with or acquiescing to them.

Such an approach affirms the participant's role in his or her treatment. Indeed, the common-factors research confirmed just this point: that it is the drug court defendant and his or her family, not the staff or providers, who make treatment work. This finding does not conclude that program structure or staff efforts are useless. It does suggest, however, that the instruction in interventions and treatment models offered by universities and training institutes may be more effective if coupled with a focus on the input of those actually in treatment.

Duncan and Miller summarize this research by noting the real 'engine' of change is the client, thus implying that our time might be better utilized by finding more ways to employ the client in the process of change. Ironically, what it takes to realize difficult behavior change in the real world is not always fostered or modeled during staff-client interactions. Change rests with a participant's full participation, energy and commitment. However, if staff assumes a role where their ideas and expertise consistently trump those of the client, the participant is relegated to a passive role. If client's experiences and know-how are subjugated to the wisdom and methods of the professional, then the term drug court "participant" could well be in danger of becoming an incongruous or contradictory term.

Many research endeavors examine the process of engagement and work with voluntary clients. This context is not always comparable to the mandated nature of drug court efforts. Drug court clients are generally conceived of as "involuntary," where withdrawal from substance use is a non-negotiable mandate. While keeping our directives in focus, it is important to consider we have more latitude in allowing greater participant input, both in how one might strive for sobriety and how one might sustain it.

Therapeutic Relationship Factors

Relationship factors, or therapeutic alliance, make up about thirty percent of the contribution to change. *Alliance* means the extent that the counselor and client can collaborate. Conditions that engender an alliance include reciprocal understanding, mutual affirmation, emotional attachment and respect. *Relationship* means the strength of the alliance that develops between the program participant and staff. Relationship factors include perceived empathy, acceptance, warmth, and self-expression.

Perceived Empathy

Communication studies consistently report that verbal communication is prone to error; the listener does not always receive the complete message. Parts of the intended message are either inadequately articulated by the speaker or incorrectly understood by the listener. A dialogue between two people resembles listening to a cell phone that crackles with static from weak reception: even if one listens closely, much of the transmission will be garbled or missing.

Perceived empathy involves a drug court participant's belief that they are listened to and understood. Relationships develop as staff becomes committed to understanding their clients and make consistent efforts toward "filling in the gaps" of communication. An important technique for improving communication is "reflective listening," in which the staff member constantly checks the accuracy of what he or she believes the client has said. This author believes that most staff members, regardless of whether they have previously been trained in reflective listening, seldom, if ever use this technique. The technique is simple to understand but difficult to use consistently and correctly.

Evidence shows that "accurate empathy" is a condition of behavior change. William Miller and Stephen Rollnick state: "Accurate empathy involves skillful reflective listening that clarifies and amplifies the client's own experiencing and meaning, without imposing the therapist's own material. Accurate empathy has been found to promote therapeutic change in general and recovery from addictive behaviors in particular." Compliance can occur without the program participant feeling understood, but real change cannot.

Perceived empathy is a term that corrects a previous bias in research. Most outcome studies measured empathy and the strength of the staff-client alliance through counselor reports. But in fact, the drug court participant's assessment of the alliance matters more. Experts on the therapeutic relationship and authors of the 1999 book "*How Clients Make Therapy Work: The Process of Active Self-healing,*" Karen Tallman and Arthur Bohart, report "[f]indings abound that the client's perceptions of the relationship or alliance, more so than the counselor's, correlate more highly with therapeutic outcome." Further research completed at the University of Quebec by Canadian psychologist Alexandra Bachelor found that the client's perception of the alliance is a stronger predictor of outcome than the counselor's view.

The tendency to privilege staff evaluations over clients' perceptions occurs frequently in justice work. For example, while providing onsite technical assistance to an established juvenile drug court, the author experienced a chance encounter with a group of juvenile probationers who were milling outside the court building awaiting their weekly progress review hearings. The author began an impromptu conversation, inquiring as to their personal evaluations of their drug court program. Their responses were both forthcoming and enthusiastic. Encouraged, the author brought this information to the next staff meeting, only to find that the program staff members immediately dismissed this important information because of its source.

Acceptance

Acceptance relates to the extent that any treatment program fits into the participant's and family's worldview and beliefs. Kazdin (1980) found that the client's ability to accept a particular procedure is a major determinant of its use and ultimate success.

More recent studies found a greater acceptance of treatment and better compliance with interventions when rationales were congruent with clients' perceptions of themselves, the target problems, and the clients' ideas for changing their lives.

An acid test for any drug court program lies in the answer to the question, "To what extent are interventions predetermined?" That is, are participants turned into passive recipients of prepackaged programming, or is programming flexible enough that it may be customized to the individual? Progressive drug court programs make an effort to include clients and promote their participation. In workshops on strength-based programming, many staff is surprised to learn that they have more leeway to alter and adapt programming than they first believed. The results of this effort can be remarkable. As solution-focused therapy expert John Murphy notes, "The notion of acceptability reflects good common sense: people tend to do what makes sense to them and what they believe will work. It is hardly profound to suggest that the best way to determine what is appealing and feasible for people is "to ask *them*" (Emphasis added). In this "asking" profound differences in efficacy are realized. Solution-focused therapists Ben Furman and Tapani Ahola report that the counselor-client relationship is developed and the alliance strengthened as clients and their families are allowed to have a say in defining the problem[s], setting goals, and deciding what methods or tasks will be used to reach those goals.

Drug court team members have extenuating circumstances to consider when allowing client participation at this advanced level. In the mandated arena of drug court programs, abstinence from drugs and alcohol is a primary goal that is non-negotiable—the goal remains in force whether the participant agrees or not. However, the drug court can still seek the client's thoughts and possible ideas for his or her ideas to achieve that goal. Drug

courts should be analogous to a job hunter who wanders a community career fair looking for the most interesting and profitable "fit" with prospective employers. Programs should allow choices to be made across a "smorgasbord" of treatment options, allowing the referral to choose the option that is most relevant to them. Being allowed to choose (or collaboratively design) a treatment option that makes sense to the participant—aligned with the participant's age, gender, culture, way of thinking/life experiences—will increase the participant's motivation to participate. John Murphy is clear as to this effort, "[t]he therapeutic alliance is enhanced by... [t]ailoring therapeutic tasks and suggestions to the client instead of requiring the client to conform to the therapist's chosen model and beliefs." A previous justice article on strength-based practice argues that programs need to stay close to the probationer's and family's definition of the problem (and their own unique methods), as they are the ones who will be asked to make the necessary changes. Researchers who have studied the influence of hope and expectations on counseling outcomes, C.R. Snyder, Scott Michael, and Jennifer Cheavens echo this idea, arguing that staff must listen closely to program participants. If staff do not, they may establish therapeutic goals "that are more for the helper than for the helped."

Warmth/Self-Expression

These two conditions for building relationships are intertwined. Extending warmth (attention, concern, and interest) occurs in tandem with allowing a drug court client's self-expression. All staff must understand and embrace a long-held credo from the counseling field: Listening is curative. As Karen Tallman and Arthur Bohart report, "Research strongly suggests that what clients find helpful in therapy has little to do with the techniques that therapists find so important. The most helpful factor [is] having a time and a place to focus on themselves and talk." Others have found that giving traumatized individuals a chance to "tell their story" and engage in "account making" is a pathway to healing. A rather obscure but interesting earlier study showed that paying juvenile delinquents to talk into a tape recorder about their problems and experiences led to meaningful improvements in their behavior, including fewer arrests.

Staff would be wise to critically examine their methods in building alliances with participants, both programmatically and individually. Duncan and Miller state emphatically, "Clients' favorable ratings of the alliance are the best predictors of success—more predictive than diagnosis, approach, counselor or any other variable."

Hope and Expectancy

The next contributor to change (fifteen percent) is hope and expectancy; that is, the referral's hope and expectancy that change will occur as a result of entering drug court programming. This author believes that in practice, staff may encourage hope and expectancy by (1) conveying an attitude of hope

without minimizing the problems and pain that accompany the offender's situation; (2) turning the focus of treatment toward the present and future instead of the past; and (3) instilling a sense of empowerment and possibility to counteract the demoralization and passive resignation often found in drug court participants who have persistent problems.

Conveying an Attitude of Hope Without Minimizing the Problem

Instilling hope has more complexity than simple encouragement. Participants need to believe that taking part in drug court programming will improve their situation. Therefore, during the orientation phase of programming, many successful drug court programs provide convincing testimonials of success and program efficacy. Researchers on the condition of hope, Snyder, Michael, and Cheavens, indicate that the new client must sense that the assigned staff member, working in that particular setting, has helped others reach their goals.

Troubled participants and their families often feel "stuck" in problem states. This feeling can be based partly on negative attitudes that allow no escape from problems (i.e., "I *can't* change," "You don't understand—I *have* to hang out with my using friends"). Strength-based work may instill hope while also acknowledging problems and pain. One strength-based strategy encourages staff to allow the participant's problem to coexist with the emerging solution. In many instances within remedial drug court work (and throughout the helping professions), there is a mindset to conquer, eliminate, or "kill" the problem. Oftentimes it is helpful and much more expedient to allow the problem to remain, to coexist with an emerging solution or healthy behavior that is being developed.

Bill O'Hanlon, a strength-based author and therapist, describes a helpful metaphor that originated in an old vaudeville routine: Two ingratiating waiters approaching the narrow kitchen door repeatedly defer to the other. "After you," one offers. "No, please, after you," the other replies. Finally, at the same moment, they both decide to act and turn into the door simultaneously, only to wedge their shoulders in the small opening. O'Hanlon advises adult staff to consider the idea of "creating a second door" and allowing conflicting feelings and conditions to coexist. A client could feel scared and hopeless about his ability to begin abstinence from drugs and yet marshal the confidence to avoid using "just for today." A painfully shy young woman may simultaneously fear the crowded gathering and yet find the courage to join it. Trying to convince the shy client that there's "no need to be shy," or that there's "nothing to be afraid of," is an uphill climb with dubious results. The conflicting dichotomies of continuing drug use or movements toward sobriety, hesitancy or action, fear or confidence may exist as "both/and" rather than being framed as an "either/or" choice. Staff need not eliminate the negative to instill the positive.