Addiction Exchange

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Welcome to *Addiction Exchange,* a forum for the exchange of clinical practice and research information among clinicians, scientists, educators, and administrators in the field of addiction. This issue, by guest author Michael Clark of the Center for Strengths in Juvenile Justice, discusses surprising new research findings which show that successful client outcomes don't depend on the type of approach used, but rather on factors that clients bring into treatment. This recently published research from the field of family therapy (Hubble, Duncan & Miller, 1999) is soon to send shock waves across mental health, substance abuse and criminal justice - all of the helping professions. The findings lend optimism to positive therapeutic efforts found in strength-based practice and asset-building initiatives (Clark, 1997, 1998) (Nissen & Clark, in press).

The research, an extensive recent study of therapy outcomes sponsored by the American Psychological Association, is a large "meta-analysis" (a "study of many studies") which looked at *40 years of outcome research.* What they found is that treatment (and prevention work) is effective. But in reviewing over 400 recognized intervention models, none were shown to be more reliable than any other.

The researchers compared various treatment models claiming to be "more effective" to the claims made for the three major medicines to cure headache pain: aspirin, Tylenol and Advil. All of these medications will ease headache pain and work better than taking no medicine at all, but no one drug has proved to be more *effective* than the other two. The same holds true for interventions and treatment models.

What does this research mean? From reviewing literally thousands of research studies on therapy outcomes, it demonstrates that the biggest engine to change is the *client and family* not "us" or our intervention models.

The finding that all treatment models can be equally effective prompted the researchers to look for what *does* matter, or more specifically, what are the active ingredients to positive behavior change? What they found is there are "common factors" that all 400 of these helping models seem to raise - each in their own unique way - because they raise these factors for treatment efficacy. *It is the*

similarities across these models, not the differences, that induce change.

If the contributions to "change" were listed as percentages, the research would determine the breakdown to be:

Client factors 40% (what the client comes in the door with). This includes personal strengths, talents, past problem-solving abilities, social supports, beliefs, resources, fortuitous events, etc. The largest single contributor to change is the client and family. The more we encourage and foster their participation, the more we reap the single largest resource and contribution to change.

Relationship factors 30% (fostering a good alliance between clients and treatment staff). This includes perceived empathy, acceptance and warmth. The researchers cited that most previous studies used the "helpers" (staff) report to determine whether a good alliance was being established. On the contrary, the greatest predictor of success comes from the *client's* report, with the greatest gains (positive final outcomes) found when clients report a positive alliance by the *fourth meeting.*

Expectancy & Hope 15% (the extent that your client believes or expects that your prevention or treatment programming will be beneficial to them). This involves whether our programs can convey "possibility" for change. Hope, optimism, encouragement - extending these can counteract demoralization and improve outcomes with prevention populations. Hubble et al. (1999) also report that hope cannot be increased by "cheerleading." To truly raise hope, then, prevention staff must increase a client's "agency" thinking ("I *can* do this") followed by "pathways" thinking ("Here's *how* I do this").

Model/technique 15%. Finally, and very humbly, what we do as helpers - our strategies and
techniques that models of helping teach us are so important - are one of the *least influential contributors to change.* This is amazing when you consider that most of our universities spend a majority of the time promoting this factor instead of finding more effective ways of eliciting, amplifying and reinforcing the client and family factors. And this 15% is enhanced if these techniques *work to raise the other 3 common factors.* But rather than creating confusion, this finding brings a very introspective and hopeful change in us. Outcomes improve when we instill hope and accommodate our clients rather than requiring the substance-involved client to fit or conform to our favorite model or technique.

This research is a boon to the positive client-centered movement and strength-based strategies. The mystique or complexity surrounding "therapy" can be worked through and shed. Instead, what is truly "therapeutic" (that is, initiating positive behavior change) can become practical and clear and more professionals involved in prevention efforts can begin to build these important alliances and work to enhance these common factors with their families, regardless of their professional discipline. Professional psychotherapy will always have its place, but what is "effective" can be shared by all. *We may not all*

be in the therapy business, but we are all in the "business" of promoting positive behavior change. This issue speaks to the essential ingredients of *behavior change*.

Clark, M. (April 1997) "Strength-Based Practice: A New Paradigm." Corrections Today, 59(2), 201-202.

Clark, M. (June 1998) "Strength-Based Practice: The ABC's of Working With Adolescents Who Don't Want to Work With You." Federal Probation Quarterly, (62)1, 46-53.

Hubble, M., Duncan, B. & Miller, S. (Eds.). (1999). The Heart and Soul of Change: What Works in Therapy. Washington, DC: American Psychological Association.

Nissen, L. & Clark, M. (In Press) "Power of the Strengths Approach in the Juvenile Drug Court." Practice Monograph. Drug Court Programs Office *United States Department of Justice-Drug Courts Program Office*.

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