Understanding the concept of the therapeutic alliance in group treatment for alcohol and drug problems

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To cite this article: Ninive von Greiff & Lisa Skogens (2017): Understanding the concept of the therapeutic alliance in group treatment for alcohol and drug problems, European Journal of Social Work

To link to this article: http://dx.doi.org/10.1080/13691457.2017.1341388

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Published online: 20 Jun 2017.

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Understanding the concept of the therapeutic alliance in group treatment for alcohol and drug problems

Terapeutisk allians i gruppbehandling för alkohol- och drogproblem

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ABSTRACT
This article investigates how treatment factors are described by different client groups and by treatment staff. The material consists of interviews with clients (n = 81) and treatment staff (n = 18). The analysis focuses on two central themes – the importance of the treatment group and of the treatment staff, along with how these descriptions relate to the concept of the therapeutic alliance. The descriptions differ in parts between the client groups and between clients and staff. Clients as well as staff highlight structural and qualitative aspects of cohesion, but general patterns of how these are expressed in the groups are hard to grasp. However, some exceptions appear; while the clients often relate recognition to own experience of substance abuse, the staff often refer to external aspects of recognition, such as gender and/or experience of parenting. The results indicate that the social preconditions of the group members can influence group cohesion. In the treatment, focus is initially on cohesion and later on making change possible. This might create a dilemma; the homogeneity that initially creates cohesion can also act as a restraint on change. This is described in the results in relation to gender homogeneous client groups in treatment.

KEYWORDS
Substances; recovery; therapeutic alliance; group treatment; alcohol and drug problems; client perspective

ABSTRAKT
I den studie som presenteras har 81 intervjuer gjorts med klienter som beskrivit vad de själva ser som verksamt för sin egen positiva förändringsprocess i samband med att de varit i behandling för missbruksproblem. 18 intervjuer har gjorts med behandlingspersonal som beskrivit vad de bedömer vara de verksamma faktoreerna inom behandlingen. Artikeln fokuserar på två centrala teman som framkommit i intervjuerna; dels behandlingsgrupps betydelse och dels behandlingspersonalens betydelse för en positiv förändringsprocess. Dessa teman relateras till begreppet terapeutisk allians. Både klienter och personal uppmärksammar betydelsen av gemenskap under behandlingen och lyfter fram såväl strukturella som kvalitativa aspekter på hur gemenskap skapas. Det är svårt att se generella mönster men en skillnad som framkommer i materialet är att när klienterna beskriver igenkännande som en central faktor för upplevelsen av gemenskap så betonar de ofta igenkännning relaterat till missbruket. Personalen relaterar igenkännning till att dela mer

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Introduction

The absence of support for specific treatment mechanisms in several large studies on addiction treatment (cf. Project MATCH research Group, 1997; UKATT Research Team, 2005) has brought forward a discussion on common factors. The proposition springing from this discussion is that the effectiveness of treatment interventions lies in the factors that efficient treatment interventions have in common, rather than the specific factors that are connected to the theoretical base for each different intervention. The concept of the therapeutic alliance, initially referring to the patient–psychotherapist relationship (cf. Connors, Carroll, DiClemente, Longabaug, & Donnovan, 1997; Coppock, Owen, Zagarskas, & Schmidt, 2010; Wampold, 2001), has been central in this discussion. The concept holds ingredients such as sense of hope, trust, collaboration and confidence in the relationship (Martin, Garske, & Davis, 2000) and is now extensively used also for the relationship between professionals and clients/patients in other areas, for example psychosocial treatment interventions for alcohol problems. When trying to further understand and operationalize common factors in research on psychosocial treatment interventions, the therapeutic alliance has been broadened to include not only the patient/client–professionals relationship, but also the relationships between the members taking part in the group intervention (cf. Pooler, Qualls, Rogers, & Johnston, 2014).

This broader meaning of the therapeutic alliance is discussed in relation to the results of a Swedish research project investigating positive change processes among clients treated for alcohol and other drug (AOD) problems (von Greiff & Skogens, 2014). When the essential factors for initiating and maintaining a positive change process in relation to the actual treatment were studied, two important themes that emerged were the treatment group and the treatment staff. The way these themes were brought forward in interviews with both clients and staff was related to trust, confidence, acceptance and collaboration – all central components of the treatment alliance concept. However, the descriptions of how these themes were important varied among the client groups and it was suggested that differences could be recognized between clients in varying social positions.

In order to add a gender perspective and deepen the analysis of group differences in the descriptions of important factors for a positive process of change, more client and staff interviews were added to the project. In this extended project, client groups have been compared regarding gender (von Greiff & Skogens, 2017) and social position (Skogens & von Greiff, 2016). The present article investigates how the importance of central treatment factors is described by different client groups and by treatment staff, and how these descriptions relate to the concept of a therapeutic alliance. The specific research questions are:

How do different client groups and treatment staff describe the importance of the treatment group?
How do different client groups and treatment staff describe the importance of the treatment staff?
Background

In an overview of research on the therapeutic alliance, it is concluded that both the conceptualization and measures of the concept are characterized by diversity (Elvins & Green, 2008). However, descriptions of the concept often do emphasize that the relationship is permeated by cooperation, shared goals and emotional bonds (Hatcher & Barends, 2006) as well as characterized by confidence, acceptance and support (Martin et al., 2000). Empirical research has among other things focused on the importance of client and professional characteristics for establishing the alliance (see e.g. Crites-Christoph et al., 2009; Ilgen, McKellar, Moos, & Finney, 2006; Ilgen, Tiet, Finney, & Moos, 2006), but it is difficult to draw any general conclusions (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005). Conditions for early therapeutic alliance have been studied by therapist as well as client background and experiences of alliance, indicating that client motivation and social support are strong predictors for developing alliances (Meier, Donmall, et al., 2005). Further, therapist characteristics generally seem to have less importance, apart from own experiences of substance abuse and working experience. Previous research on the therapeutic alliance in treatment for substance abuse shows that it is important for engagement, motivation and retention (Meier, Barrowclough, & Donmall, 2005). Also, coping strategies and social support among clients are highlighted as important predictors for developing alliance (Garner, Godley, & Funk, 2008; Meier, Barrowclough, & Donmall, 2005).

Group therapy is commonly used in treatment for AOD and the arguments presented for this are often the advantages of using the group as a tool for support as well as for positive pressure, training of social skills and as a forum for self-expression (SAMHSA, 2005). Previous research on group treatment shows that group cohesion is of great importance for the group dynamic and ultimately for the participants' possibilities to change (Burlingame, McClendon, & Alonso, 2011; Greenfield, Kuper, Cummings, Robbins, & Gallop, 2013; Pooler et al., 2014). Burlingame et al. (2011) describe group cohesion from two aspects – structure and quality. The structural aspect refers to cohesion both between group members (horizontal) and between group members and group facilitator (vertical). The qualitative aspect is presented in terms of kind and degree of relationship, and the cohesion between group members is often described as the strongest. However, knowledge concerning whether the cohesion within the group as a whole or between its members is most important and whether this differs among client groups and/or during different stages of recovery is still lacking (Burlingame et al., 2011). From a professional perspective, the importance of focusing not only on individual changes, but also on possibilities for change within the group as a whole is emphasized (Burlingame, Fuhriman, & Johnsson, 2002).

Further, there seem to be different opinions regarding the need for separating the concepts of cohesion and alliance. According to Lorentzen, Sexton, and Høgglend (2004), the quality of the client-therapist alliance is important for positive outcomes and this alliance is independent of group cohesion. Therefore, they argue that negative transferences should not be addressed to the group as a whole; in order to maintain the positive alliance professionals should focus instead on the individual group members. In a study on the importance of alliance (between group members and therapist) and cohesion for treatment outcomes in treatment for depression, the clients only mentioned the importance of cohesion (Crowe & Grenyer, 2008). Thus, previous research does not present clear findings; different client groups and different measurements of alliance, cohesion and outcomes can explain this to some extent.

The importance of collective efficacy is emphasized in a study on clients in group treatment by Pooler et al. (2014) where facilitators for creating cohesion are related to time in treatment and how the treatment is concluded, i.e. the handling of the transition to other sources of support. Different client groups are assumed to differ in ability to handle these kinds of transitions. Further, shared experiences within the group, described as therapeutic, are expressed in various ways during the different phases of treatment. Whilst group cohesion is described as central, the role of the therapist in setting the frames and offering the tools for developing cohesion is still vital. At the beginning of treatment, this concerns creating a safe environment and a feeling of affinity in order to encourage
interaction and to stress the importance of tolerance and of helping and learning from each other. At the middle stage, the focus is on making change possible and setting collective goals. When ending treatment, the authors emphasize the importance of assisting the clients to establish new relationships in which to engage (such as AA groups) and to identify relapse vulnerability.

In the research field of social work with groups, the role of the therapist is often emphasized (Roy & Pullen-Sansfacon, 2016), along with the importance of working actively with relations within the group (Wood, Englander-Golden, Golden, & Pillai, 2010), in order to strengthen group cohesion and facilitate the process of change, including relations outside the treatment context. The importance of relations and the social network for initiating and maintaining change finds strong support in research (cf. Best, Groshkova, Sadler, Day, & White, 2011; Orford et al., 2006; Schön, Denhov, & Topor, 2009; Skogens & von Greiff, 2016; von Greiff & Skogens, 2017), and also the importance of a network of both persons in recovery and those without such connection (van Melick, McCartney, & Best, 2013). Further, research shows that persons with a supportive social network also find it easier to develop positive alliances in treatment (Meier, Donmall, et al., 2005).

Specific groups

It is difficult to draw general conclusions from research about the importance of using homogenous client groups, for example by gender or age. Thus, research is required on the specific needs of different client groups in order to increase the chances of recovery within the treatment context.

Concerning age, the risk of negative effects on younger clients participating in treatment groups with older and more experienced clients have been noted (Andreassen, 2003). Russell and Gockel (2005) emphasize the importance of taking a holistic perspective in supportive interventions directed specifically at women, including interventions that go beyond traditional treatment frames (such as help with housing and child care). However, the authors also stress the importance of seeing both treatment and recovery as a process, and that the suitability of homogeneous client groups therefore can change over time. Further, research on group cohesion and interaction in treatment groups of women alone or of mixed gender shows that the strongest support between group participants is found in the mixed gender groups, expressed by female and received by male clients (Greenfield et al., 2013).

Data and method

In the present study, interviews were conducted with 81 clients, 40 women and 41 men. Data were collected between 2009 and 2011, and between 2013 and 2014. The majority of the interviewees were recruited from seven treatment units with a wide geographical distribution providing residential and/or outpatient care. All the interviewed clients had undergone group treatment and aftercare. Many had also chosen to participate in self-help groups. An important inclusion criterion was that the client had started a positive process of change.

A majority of the units was following or inspired by the twelve-step programme, a method that is the dominate treatment method for AOD problems in Sweden. All clients have participated in group treatment, for some of them this has been a complement to individual treatment. Thirteen of the interviewees were recruited using snowball selection. All but two of these thirteen clients were associated with the AA/DAA/NA community and all had been in treatment. Even if the treatment units that were following or inspired by the twelve-step programme differed very much in terms of the extent to which they actually did so, the common terminology that is used in these programmes might have affected the way the interviewees describe their change process. However, since the focus of the study is comparisons between the important treatment factors as described by the different groups, this was not considered as a problem.

Three of the client interviews were conducted by telephone and one on Skype. Each interview lasted about 30 minutes. During the interviews, the clients were asked to talk about factors they
perceived as important for initiating and for maintaining change. An interview guide was used with general themes rather than specific questions to ensure that the interview covered internal, social and treatment-related factors. Each audio-recorded interview resulted in a report of about 1000 words, written within 48 hours after the interview. To begin with, reports were written by both authors individually and subsequently compared to validate content and form. After this initial validation procedure, the process became that one author conducted the interview while the other author listened to the audio recording and wrote the report. The interviewing author finally checked the report for accuracy.

After re-listening to the interviews and scrutinizing the reports, the material was categorized and summarized. For this article, data categorized as treatment factors were analysed. By picking relevant parts from each client report and iteratively analyzing and compiling these in an increasingly condensed form, subcategories on an aggregated level were created. Brief descriptions, based on the client reports, were written on each treatment theme in order to preserve closeness to the original reports. The procedure enabled a parallel process where both individual and general descriptions could be analysed. During the process we chose to go into detail on specific subcategories close to the original descriptions and also to lift the perspective in order to grasp more general patterns. Nvivo, a software package for qualitative data analysis, was used for thematizations within the groups in focus. Nvivo was also used to validate the condensed descriptions and thematizations made by hand by returning to the reports and comparing the marked sentences on an individual level with the general descriptions on an aggregated level.

For the classification of the clients into marginalized or integrated group, the following criteria were used: Integrated (I): stability regarding work, housing and social network; Marginalized (M): absence of stability regarding work, housing and social network, the vulnerable situation often connected with treatment as a sentence, prostitution and chaotic family situation (such as being thrown out from home or having one’s children placed in out of home care). The clients’ initial position would in all likelihood be altered during their recovery process, but we chose to retain the names of the groups based on initial position in order to be able to follow changes by group.

In the presentation of the results, the following abbreviations are used: MW (marginalized women), IW (integrated women), MM (marginalized men) and IM (integrated men). As shown in Table 1, the MW group is the smallest, which should be taken into account when reviewing the comparisons between the groups presented below. All clients had undergone treatment with the majority interviewed during aftercare. More than a quarter (22 clients) were interviewed after finishing aftercare. The clients are aged between 25 and 71 and the mean age differs between the groups. The mean age for both the integrated groups was 51 years, for the MW 39 years and for the MM 36 years. The male and the female groups are similarly distributed regarding family and occupation. One exception is that having children is more common among the women (29 versus 22).

The following themes were extracted from the client interviews: The Treatment Group, the Treatment Staff, Contextual factors, AA, Individual emotional factors, Time, Method, Coercion, Structure, Aftercare and Other (statements that are related to treatment factors in other ways than the extracted themes).

In addition to the client interviews, 18 individual interviews with treatment staff, recruited from the same seven units as the client interviews, were conducted. The staff interviews were somewhat longer than the client interviews (45–60 minutes) and focused on how the staff perceived the relevance and value of treatment intervention for the client’s positive process of change. As for the client interviews, a guide using general themes was used to ensure that the interview covered

<table>
<thead>
<tr>
<th>Table 1. Number of clients in the four studied groups (n = 81).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marginalized</td>
</tr>
<tr>
<td>----------------</td>
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<tr>
<td>Women (mean age)</td>
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<td>Men (mean age)</td>
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descriptions on situations where the treatment was contributing to a positive change process. The same technique as in the client interviews was used during the interviews as well as in the analysis.

The following themes were extracted from the staff interviews: The Treatment Group, the Treatment Staff, Contextual factors, AA, Time, Method, Structure and routines, Aftercare and Other.

In this article, the expression of the themes the Treatment Group and the Treatment Staff will be further analysed and compared.

The staff interviewees described their professional experience in total, i.e. both from their present position and from earlier engagements in treatment work. Because of this, the staff interviews were not divided according to the client group that the interviewee mainly was working with at present. This means that comparisons between staff working with different groups are not possible. On the other hand, if a division had been used, all statements that refer to earlier experiences with treatment work would need to be excluded from the analysis. Thus, to keep the statements from earlier experience in the analysis, the choice fell on not dividing the staff interviews in accordance with client group.

**Results**

In order to give a transparent overview of the different groups, the results from the client interviews on the two themes the treatment group and the treatment staff are presented in two matrices as well as in the text. In connection to each theme, the results from the treatment staff interviews are

<table>
<thead>
<tr>
<th>MW group</th>
<th>IW group</th>
<th>MM group</th>
<th>IM group</th>
</tr>
</thead>
<tbody>
<tr>
<td>One client (a woman): We accompanied each other and others hooked up – the interaction with the others became a positive force.</td>
<td>To meet others that have been in the same situation and been through the same things – all the shame and the guilt.</td>
<td>Other like-minded, we sit in groups and mirror each other.</td>
<td>The group – the others’ stories and their feelings are important.</td>
</tr>
<tr>
<td>The group sessions: During treatment I had the courage to open up for the first time and get rid of loneliness. The cohesion, sharing, happiness and sorrow, nobody judging you.</td>
<td>The only thing I thought was good (with the group) was listening to how others had made a fool of themselves.</td>
<td>The group therapy is important. Only men – then you have the courage to talk about feelings.</td>
<td>The great cohesion creates a sense of safety that I have been missing.</td>
</tr>
<tr>
<td>Got myself a social network in the treatment group that I have kept after finishing treatment.</td>
<td>The most important was the group. You don’t have the time to get involved in any deeper contact; it’s the cohesion – not the separate individuals.</td>
<td>The group discussions. The group you attend, good treatment staff, these are things that are crucial for the treatment to work out.</td>
<td>The AA meetings as well, but the meetings here during treatment give more.</td>
</tr>
<tr>
<td>Recognition, to be ‘back again’, it gave me hope.</td>
<td>The group therapy.</td>
<td>Without my sponsor and the treatment group, I do not know how this would have ended.</td>
<td>It’s been like a candy store – both from the staff and the other clients.</td>
</tr>
<tr>
<td>So good to meet others – the orientation here, other women that have been exposed to violence; to talk about it is possible only when sitting with other women.</td>
<td>You get the cohesion in AA meetings as well but it was something extra during treatment.</td>
<td>The group exercises, the support from the group, a companionship I have never experienced before.</td>
<td>The group exercises, the support from the group, a companionship I have never experienced before.</td>
</tr>
<tr>
<td>The cohesion here is the important thing, not being judged and stared at, this makes me feel safe.</td>
<td>To talk with others.</td>
<td>To listen to others, to be reminded.</td>
<td>To listen to others, to be reminded.</td>
</tr>
<tr>
<td>I saw those that I earlier had seen on the streets, now they were clean from drugs and happy, this planted a seed in me.</td>
<td></td>
<td>The form of the treatment, group meetings – the feedback from the others.</td>
<td>The form of the treatment, group meetings – the feedback from the others.</td>
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<td></td>
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<td>This is not possible in AA meetings.</td>
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<td></td>
<td></td>
<td>Some of us formed a ‘gang’, we talked a lot and were equal (but with different backgrounds) – so good to see that this problem occurs among all sorts of people.</td>
<td>Some of us formed a ‘gang’, we talked a lot and were equal (but with different backgrounds) – so good to see that this problem occurs among all sorts of people.</td>
</tr>
</tbody>
</table>
presented. Here, we need to point out that the citations in Tables 2 and 3 are chosen so as to illustrate the variation of statements in each group; all statements are not included and the number of statements in each group is not directly proportional to the group’s total number of statements. Each new statement is identified by a change in left margin. Citations of statements in the text are separated by semicolon.

**How is the importance of the treatment group described?**

Statements that in any way describe the client group as an important treatment factor are found in all the investigated groups, although to a greater extent in the MW group (64%) and the IM group (50%) compared with the IW group (23%) and the MM group (37%).

The general pattern that emerges is that sharing own experiences and listening to other group members’ experiences during the treatment group sessions are important and appreciated and give a sense of community and cohesion: The form of the treatment, group meetings – the feedback from the others. This is not possible in AA meetings. Identification is a recurrent theme, referring in many cases to similarities in the experiences connected to the actual addiction problem, but also to similarities regarding social living conditions: To meet others that have been in the same situation, and been through the same things …

A bit surprisingly, only three clients, two in the MW group and one in the MM group, explicitly bring forward gender homogeneous groups as important. There is, however, a difference between the M and the I groups in this sense, since the M groups have experienced gender homogeneous treatment interventions to a greater extent than the I groups.

The statements in the IM group and the MW group are interpreted as describing ‘deeper’ relations and use of the group; they talk for example about ‘safety’, ‘support’, ‘friendship’ and ‘feelings’, while the other groups describe the importance of the group in more general terms – as a forum for sharing and for discussion. In these ‘deeper’ descriptions of cohesion in the IM and MW groups, the group is described as an opportunity to create social networks: Got myself a social network in the treatment group that I have kept after finishing treatment; … a companionship I have never experienced before.
Attending AA meetings and other self-help groups is not treatment intervention and hence is not included in the analysis of important treatment factors. However, this is not clear-cut, since these kinds of meetings often are a part of aftercare. Moreover, attending AA meetings and other self-help groups is mentioned as important by more than half of the interviewed clients and thus is worth mentioning here. It is also interesting that when these meetings are brought up as important for the positive change process, it is the mere attending in itself that is mentioned. Descriptions concerning the group in the treatment intervention are more detailed and some clients also point out differences between AA meetings and treatment intervention group meetings, saying that the sense of connectedness and the response from professionals and group members were stronger in the treatment group.

How do the treatment staff describe the importance of the treatment group?

It is obvious from the staff interviews that group dynamics are used as a working tool. Recognition and empathy between the group members are described as important for strengthening individual motivation: The group based treatment can give motivation – they don’t need to learn from own experience, it becomes ‘real’ anyhow. Recognition is also often described as a tool for letting go of shame and guilt: They recognize themselves in the others. Many of them have felt alone in the world; ‘It is only me being this bad, only I have abused my children’. Further, the group can be used as a tool to reach clients that are hard to get through to; problems that actually concern specific clients can be brought up and discussed in general terms in the group. Group members that are ahead of others in their recovery process bring their experience into the group and serve as inspiration for the other group members, but also as support for the work of the staff in the group: Bearers of tradition – the ones that have changed – they affect the rest of the group. They are open minded, and stand side by side with the staff… You have to take care of that, back it up.

Both the advantages and the disadvantages of gender homogeneous groups were brought forward by staff working with female groups: I think it is better with separate groups. Men benefit from mixed groups because women do put things into words; Female groups where special issues are brought up once a week is a good thing, for example sexual abuse is better discussed in separate groups. At the same time, having mixed groups is important since this is how life itself occurs.

Reasoning on this issue is not at all present among other staff interviews; also, this is mentioned by very few of the clients.

In the staff interviews, the female clients were often described as in a vulnerable situation, for example as victims of abuse. Since the analysis in this article is focused on how the staff describe treatment factors, their descriptions of clients’ situations are not included here. What is included is when the staff talk about how they work with this within the treatment intervention, which actually is not mentioned very often. In a couple of staff interviews, it was brought forward that it is not possible in the treatment context to deal in any deeper sense with problems that might be underlying the actual alcohol problem: To get the client to put things into words, I don’t need to know about everything. We are not supposed to dig up all the dirt! The alcohol problems come first. Old things like abuse can surface, but we don’t carry on working with those things.

How is the importance of the treatment staff described?

When the staff are highlighted as an important treatment factor, their attitudes and responses are brought forward.

It was most common in the MW group to mention the staff as important (64%) compared with the other groups (15–36%, lowest in the IW group). This quantitative difference along with a qualitative difference between the statements in the MW group compared with the others indicates that the members of the MW group to a greater extent found it important to be ‘seen’ and affirmed by the staff: They listen to me, what I want, my needs and attend to these in treatment; I have finished treatment...
but can still come and visit or call whenever I want, they take their time. Having access to the staff, even after finishing the treatment, was sometimes brought up in the MW group. This kind of access was not mentioned at all in the other groups, except by one integrated woman.

Recognition in terms of staff with own experience of AOD problems was mentioned by clients in all groups except the IM group, where this was not mentioned at all. Staff with own experience of AOD problems seem to be most important for the MM group, where it was most mentioned. Statements about this occur also in the two female groups, but seem less important there. In the IM group, experience in terms of professional experience and knowledge was highlighted: Knowledge about what happens in the body; the most important is the specialist knowledge that is taught. This reference to the staff’s knowledge was also stressed by a few women (two IW and one MW) but was not brought up at all in the IM group. In general, the MW group and the IM group emerge as most apart from each other in terms of how the importance of the staff is described. The MW group refers the most to the staff and their descriptions were focused on the staff giving support and a sense of safety.

About one-third of the clients in the IM group also underlined the staff as important for their positive change process but these statements are in general interpreted as descriptions of the treatment staff as professionals, in terms of their professional knowledge and experience. The statements in the MM group on the staff’s importance were very few but more similar to the descriptions in the MW group, where they talk about the staff’s experience of living a life with addiction problems.

**How do the treatment staff describe their own importance for a positive change process?**

Just like the clients, the staff stressed their attitudes and responses as inducing hope and creating conditions for building trustful relationships. They often talked about ‘being professional’, but when scrutinizing what was actually said, a paradox emerges; to go beyond what in an undefined way is described as being professional seems at the same time to define professionalism: High competence and the right skills. Who you are is of course also important. We cross the borders, go outside the box… we are not afraid of using ourselves in our relationships with everyone in the group.

This professionalism is nevertheless diversely described when it comes to how and to what extent to use oneself and there are no patterns in the statements that can be connected to different client groups: We try to do some matching. For example being a mom, having that in common with those in treatment. In some places, before, they worked with alliance through identification – starting with me as a person. Today it is enough with showing empathy and having skills. My personal experience is not that important; I think the treatment staff as persons are extremely important. The clients notice if you are honest.

Statements that refer to the method as important occur, but the essence of the work was described as something else: The name of the method is not so important, that changes after some years. The other, what I do, that is central – I have to make it happen. The knowledge is just the framework; what’s important is the spirit in which we work.

In a majority of the staff interviews the importance of working with the clients’ social situation was described as a prerequisite for maintaining the positive change process that was started during treatment. The strengthening, and sometimes re-establishing, of the clients network was emphasized as important. During the treatment intervention, this was done for example through ‘relative weeks’ as a part of the treatment programme or giving the client-specific homework regarding how they intend to improve their family relations.

Staff working with M client groups also highlighted social factors such as housing, economy, employment and the importance of these parts being included in their treatment programme or dealt with parallel to the treatment intervention: … we are very good at supporting, pepping to call, sitting next to when looking for housing/ … /getting the person into a social setting, having meetings together with employers. We are very active in ‘fixing and trixing’.
Discussion

In this article, the importance of treatment factors for the process of change among clients treated for AOD problems is studied. Four client groups are compared: MM, MW, IM and IW. The analysis focuses on two central themes – the importance of the staff and of the treatment group. These themes were chosen on the basis of results from a previous study on parts of the material (von Greiff & Skogens, 2014) where an extended interpretation of the concept of the therapeutic alliance was suggested, i.e. that alliances are created not only between client and professional but also between group members. The therapeutic alliance has been related in this article to client and treatment staff descriptions of the importance of group cohesion, consisting of such components as being noticed and accepted – a source of reassurance and support. Such components are central parts of the therapeutic alliance concept (Martin et al., 2000).

The staff as an important factor

Highlighting the staff as an important treatment factor is most common in the MW group, who mainly describe the importance of being ‘seen’ and acknowledged by the staff. In contrast, the IM group make appreciative note of the staff having and communicating professional knowledge, for example on consequences of AOD on brain and body. Thus, the former group describes emotional factors as important in relation to the staff whilst the latter group highlights cognitive factors.

These differences in important factors together with the need for a safe environment at the beginning of treatment, pointed out in earlier research (Pooler et al., 2014), probably create a challenging situation if the treatment group is too heterogeneous. Most clients are in a vulnerable state and need attention when entering treatment, regardless of social status. In the initiating phase, when therapists and treatment group are all new to each other, it is probably easier to attend to factors that are important for the client and create this feeling of safety in a more homogenous group. However, the question in what sense the group should be homogenous cannot be fully answered. In the present study, comparisons are done between women and men in different social positions and some differences according to the above are pointed out.

Other aspects of the need of identification and recognition, in earlier research suggested as important for establishing alliance (Meier, Donmall, et al., 2005), have also been put forward in this study. While the clients often describe that own experience of AOD problems among the staff is important for establishing recognition and identification, the treatment staff more often refer to external aspects of recognition, such as gender and/or shared experiences of parenting. The importance of these kinds of experiences and similarities is brought forward by treatment staff both between treatment group members and between staff and clients. However, this is most prominent among treatment staff working with marginalized client groups. Although experiences of AOD problems among the treatment staff were brought forward in all groups except the IM group, it should be noted that this is only mentioned by some clients in each group, a result that in part differs from previous research (cf. Meier, Donmall, et al., 2005).

However, previous research also indicates that external similarities become less important later in the change process and are in many ways replaced by cohesion built on other things, such as sharing the need for change and experiences of AOD problems (Russell & Gockel, 2005; Skogens & von Greiff, 2016). This external homogeneity may thus be more of a factor in treatment interventions and less so in aftercare or in self-help groups (such as AA or NA) where the cohesion and safety lie in the shared problems that the self-help group focus on (Pooler et al., 2014; von Greiff & Skogens, 2014).

The group as an important factor

The importance of the group is similarly expressed in the IM and MW groups, whose descriptions can be interpreted as focusing on establishing new contacts and creating relationships within the group.
In previous research, this is described as qualitative aspects of group cohesion (Burlingame et al., 2011). The other two groups (IW and MM) refer to the group more as a forum for conversation/discussion, which in previous research has been described as structural cohesion (Burlingame et al., 2011). Earlier analyses of the data material where the groups were compared according to factors not related to treatment (Skogens & von Greiff, 2016) can shed more light on this result. In that analyses, the IM and the MW groups were the ones differing the most from each other except in one aspect: they seemed to experience greater loneliness than the other two groups. Thus, they might have a greater need of creating qualitative contacts within the treatment group. At the same time, the social situation differs between these two groups; IM persons have in general an existing social network (a family), while MW persons to a large extent lack family relations. This might imply that they share the experience of loneliness although persons in the IM group feel lonely despite an existing network while the loneliness among the MW group springs from the absence of a network. In turn, this means that having a network is not the same as having access to social support. This could be related to the distinction between social capital and relational capital introduced by Tew (2013) in research on mental health, suggesting that relational capital refers to the quality of one’s current relationships.

Further, the differences between how IW and MM on one hand and MW and IM on the other hand describe the importance of the group can be related to the need of separating the concepts of cohesion and alliance mentioned in previous research (see e.g. Crowe & Grenyer, 2008; Lorentzen et al., 2004). By comparing groups, as in this study, a pattern of different ways of using the treatment group emerges. A possible interpretation of the results is understanding cohesion as a dimension where a stronger cohesion (as in the MW and IM groups) could be seen as an expression of alliance. This is illustrated in Figure 1, where the four studied groups are ordered along this dimension. In the present study, group cohesion was important for all investigated groups but to varying degrees.

Conclusions

The results from the present study indicate that the social preconditions of the group members can influence group cohesion. During the treatment, focus is initially on cohesion and later on making change possible (cf. Pooler et al., 2014) and this might create a dilemma; the homogeneity that initially creates cohesion may also act as a restraint on change. This is described in the results in relation to gender homogeneous client groups in treatment interventions. However, there is a risk that both clients and treatment staff may entrench gender stereotypes. In consequence, the treatment put a lot of focus on handling or processing this type of exposure. This may lead the clients to adjust to this and socialize into a role. The suggestion that forming homogeneous groups at the beginning of treatment has particular benefits, but also increases the risk of negative consequences through stereotyping later in the process might also be relevant here. This finding is in line with previous research regarding the suitability of homogeneous client groups (Russell & Gockel, 2005). Also, different client groups seem to have different needs of establishing strong alliances to other group participants in order to maintain their process of change.

The role of homogeneity as an important tool in establishing alliance during the initial part of treatment, and on the other hand homogeneity as a risk for restraining change in later stages, is a main finding in the study. This knowledge can be useful when treatment groups are composed. Further, treatment staff has an important role during treatment adopting the setting of participants according to group dynamics and how the process of change is proceeding.

Figure 1. Client descriptions of the relation to the other group participants illustrated as a dimension of cohesion.
Notes

1. The project is approved by the Ethical Review Board in Stockholm (No. 2012/5:12).
3. The clients in the marginalized groups are younger than the clients in the integrated groups. Social factors such as work and housing and family relations usually stabilize over time, which means that a young person might not yet have created a more integrated life in this sense. However, the marginalized groups have other factors that are not related to age and that indicate a marginalized position such as prostitution, violence and criminality.
4. The statement on experience in the IM-group does not refer to own but to professional experience.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Swedish Council for Working Life and Social Research under Grant 2012-0014; Forskningsrådet för Arbetsliv och Socialvetenskap

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References


