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## Article 83

### **An Integrated Relational Model of Substance Abuse Counseling in an Outpatient Setting**

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#### **Abstract**

Historically, there has been a lack of formalized substance abuse counseling models in outpatient counseling settings beyond the 12-step model of treatment that honor the therapeutic relationship. An Integrated Relational Model of Substance Abuse Outpatient Counseling is proposed based on the therapeutic relationship and counseling for solutions. Person-centered therapy, motivational interviewing, and solution-focused therapy are integrated into a proposed phased model to use in outpatient counseling. The structure and application of the model is described, including goals, objectives, and intervention tools for each phase of counseling that honors the power of the therapeutic relationship.

*Keywords:* substance abuse counseling, relational model, application

Addiction is a serious and growing problem in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 136.9 million Americans over the age of 12 drink alcohol regularly and 24.6 million use some type of illicit drug (SAMHSA, 2014). Of these substance users, approximately 22.7 million people over the age of 12 were seeking or needed substance use treatment in 2013 (SAMHSA, 2014). The need for a variety of treatment options has been growing as a result; however, the development of systems of care in substance abuse treatment outside of a 12-step framework is relatively new (Center for Substance Abuse Treatment [CSAT], 1999b; Hester & Miller, 2003). Most of the early treatment approaches in addiction counseling focused on the “problem” of substance use and the client’s denial and resistance to treatment. Clients who did not accept that they had a substance abuse problem were said to be in “denial” and interventions were designed to confront client resistance in order to get them to “surrender” to the treatment process (Berg & Miller, 1992; CSAT, 1999b; W. R. Miller, Wilbourne, & Hettema, 2002). This approach left out two of the most important aspects of therapy related to successful treatment outcomes;

the client and the therapeutic relationship (Ackerman et al., 2001; Hettrema, Steele, & Miller, 2005; Lambert & Barley, 2001; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996; S. D. Miller, Mee-Lee, Plum, & Hubble, 2005; W. R. Miller et al., 2002; Prochaska & Norcross, 2007; Tohn & Oshlag, 1996).

Over the last 45 years, six models of addiction have emerged to direct treatment for substance using clients; (a) moral model, (b) medical model, (c) spiritual model, (d) psychological model, (e) sociocultural model, and the (f) biopsychosocial-spiritual model (CSAT, 1999b; Hester & Miller, 2003; Straussner, 2014). The moral model of addiction assumed that addiction was a result of a moral and religious crisis. Individuals who abused substances were thought to have chosen to violate the moral, religious, and legal codes of conduct and the “treatment” of choice was punishment (Hester & Miller, 2003). However, with the changing social landscape of the 1960s and research efforts directed at substance use and other medical diseases, various new models of treatment emerged. The medical model frames addiction as a chronic and progressive disease that has biological and physical causes, with treatment focused on the physical aspects of the disease, utilizing medication, detoxification, and symptom reduction. The spiritual model of addiction developed simultaneously to the medical model and grew out of the 12-step self-help movement. In this model, substance use is seen as a result of meaningless and spiritual emptiness with treatment focused on spiritual connection, the limitations of the self, and transcending the self to achieve recovery. The psychological model of addiction is centered on psychopathology, emotional dysfunction, and problems in learning. Treatment entails psychodynamic therapy designed to promote insight and cognitive-behavioral therapy focused on changing beliefs and behaviors that reinforce substance use. The sociocultural model of addiction emphasizes the environment as reinforcing substance use. Treatment emphasizes changing the environment of the addict through systems driven interventions and advocacy at the policy level (Berg & Miller, 1992; CSAT, 1999b; W. R. Miller et al., 2002).

Each of these competing models of addiction has been determined to have value and, as a result, a comprehensive biopsychosocial-spiritual model has been developed (CSAT, 1999b; Hester & Miller, 2003; W. R. Miller, Forcehimes, & Zweben, 2011; Wallace, 1990). The biopsychosocial-spiritual model is a multi-determined approach that integrates the proven elements of the previous models while leaving out those things not supported by addiction treatment research (CSAT, 1999b; Hester & Miller, 2003). There are several assumptions to consider when working with clients from the biopsychosocial-spiritual approach, including ensuring that treatment strategies are client centered and individualized, focusing on the client’s strengths and competencies. Therapists are increasingly using empathy as a therapeutic tool rather than exerting power and control to break down the client’s “resistance” to therapy, which has been found to be more effective (W. R. Miller et al., 2002; Straussner, 2014; White & Miller, 2007). These changes have built a foundation of therapy that emphasizes collaboration and the therapeutic relationship (CSAT 1999b; W. R. Miller et al., 2002).

The biopsychosocial-spiritual approach to substance abuse treatment has constituted a paradigm shift in the addictions field. Within this model, three systems of therapy have emerged in outpatient substance abuse treatment settings; person-centered therapy, motivational interviewing, and solution-focused therapy (Adams & Grieder, 2005; Berg & Miller, 1992; CSAT, 1999a, 1999b; W. R. Miller & Rollnick, 2013; W. R.

Miller et al., 2002; W. R. Miller, Zweben, DiClemente, & Rychtarik, 1999). In these three systems of therapy, clients are assumed to have the strengths, resources, and the capability of solving their own problems. These systems of therapy redefine the notion of client resistance, placing responsibility on the therapist to join with the client in the treatment process. Strategies that engage the client to formulate their own goals for change are utilized in these therapies allowing the client to become a partner rather than an adversary in the therapy process. Within this context, clients become an integral part of the treatment process, co-creating a treatment plan built on the therapeutic relationship (Adams & Grieder, 2005; Bankart, 2007; S. D. Miller et al., 2005, Prochaska & Norcross, 2007; Straussner, 2014).

Addiction treatment built on the client's strengths and active participation in the therapeutic process has offered many ways of working with substance using clients in outpatient therapy, but few formalized models or approaches exist that can help clinicians organize their counseling practice (Hester & Miller, 2003; W. R. Miller et al., 2011). The lack of formalized models has left outpatient clinicians searching for structured, effective, and evidence-based ways of working with substance abusing clients that center on the therapeutic relationship. To address this gap in outpatient substance abuse treatment (Clark, 2002; Hester & Miller, 2003; W. R. Miller et al., 2011), an Integrated Relational Model of Substance Abuse Counseling that utilizes the strength-based approaches of motivational interviewing and solution-focused therapy in a person-centered foundation is proposed. The proposed integrated approach moves away from a deficit model and focuses on the strengths of the client and the therapeutic relationship, as has been suggested in the literature (Adams & Grieder, 2005; Bankart, 2007; Berg & Miller, 1992; CSAT, 1999a, 1999b; Elliot & Freire, 2007; Hettema et al., 2005; Metcalf et al., 1996; W. R. Miller & Rollnick, 2013; W. R. Miller et al., 1999; Moyers, Miller, & Hendrickson, 2005; O'Hanlon & Weiner-Davis, 2003; Prochaska & Norcross, 2007; Rogers, 2007; Tohn & Oshlag, 1996).

### **An Integrated Relational Model of Substance Abuse Outpatient Counseling**

The proposed integrated approach to work with substance using clients in outpatient therapy is based on three counseling approaches; the person-centered approach, motivational interviewing, and solution-focused therapy.

#### **Person-Centered Therapy**

Carl Rogers' person-centered approach to therapy is built on a foundation that all people move toward self-actualization given the conditions of unconditional positive regard. Person-centered therapy rests on the belief that if the necessary and sufficient conditions to bring about change exist in the therapeutic relationship, then the discrepancy between the real and ideal self, created by conditions of worth, will close, and the client will move toward health and well-being (Prochaska & Norcross, 2007). The person-centered approach forms the basis of the therapeutic relationship; the one factor that has consistently been shown to positively affect treatment outcomes (Ackerman et al., 2001; CSAT, 1999b; Lambert & Barley, 2001; Metcalf et al., 1996; S. D. Miller et al., 2005; Moyers et al., 2005; Prochaska & Norcross, 2007). The therapeutic conditions in person-centered therapy are necessary in building the therapeutic

relationship and can be used in many theoretical approaches to build the therapeutic alliance (Bankart, 2007; Prochaska & Norcross, 2007; Silberschatz, 2007). One such therapy orientation that builds on the strengths of the person-centered approach is motivational interviewing (CSAT, 1999b; W. R. Miller & Rollnick, 2013).

### **Motivational Interviewing**

Motivational interviewing has been described by Miller and Rollnick (2013) as a therapeutic style and a way of being with clients rather than a set of techniques or a specific theory. Motivational interviewing is an approach that emphasizes collaboration with clients and stresses empathy as the central relationship building component rather than confronting the client's resistance to change. Motivational interviewing is designed to evoke motivation and autonomy in clients by meeting them where they are in the change process and then developing discrepancy between the current state and the desired state. The client's autonomy is honored in motivational interviewing and the client directs the process with the therapist acting as a collaborator and "ambassador." The client is respected as being "in charge" of the process and "trusted" to move toward health and wellness (CSAT, 1999b; W. R. Miller & Rollnick, 2013; W. R. Miller et al., 1999).

Motivational interviewing as a therapeutic approach redefines resistance as an interaction and motivational problem, not an inherent client-based deficit. Resistance is seen as an opportunity for the therapist to fully understand the client's point of view. This allows the client freedom to explore all sides of the presenting issue and all options available to them to solve the problem. Supporting self-efficacy is critical and requires the therapist to recognize the client's strengths, past solutions to problems, and the client's inherent abilities (CSAT, 1999b; W. R. Miller & Rollnick, 2013). These same concepts highlight a solution-focused theoretical orientation (S. D. Miller, Hubble, & Duncan, 1996; Shafer & Jordan, 2014).

### **Solution-Focused Therapy**

In solution-focused therapy, the client's worldview is honored and clients are assumed to have the strengths and the resources to make the necessary changes to improve the "complaint" that brings them into therapy. Solution-focused therapy embraces the future by helping clients draw on their strengths and resources to solve their own problems. The focus on clients' strengths and resources move this model away from the medical model of therapy where the focus is on the problem. Solution-focused therapy emphasizes iatrogenic health; clients come into counseling able to solve their own problems (Berg & Miller, 1992; S. D. Miller et al., 1996; Shafer & Jordan, 2014).

Change in solution-focused therapy, as well as in person-centered motivational interviewing, is seen as inevitable, utilizing the natural occurring change in clients' lives to bring about solutions to the problems they bring into therapy (W. R. Miller & Rollnick, 2013; O'Hanlon & Weiner-Davis, 2003; Shafer & Jordan, 2014). Exception building is a key concept and technique in the solution-focused therapy model. Therapists are directed to work with the client to find the exceptions to the problem, focusing on the times when the problem is not occurring. These exceptions are used to encourage the client to do more of what works rather than solve what is wrong (O'Hanlon & Weiner-Davis, 2003; Shafer & Jordan, 2014). The therapist's job in solution-focused therapy is to help the client better understand and utilize their strengths. The therapist does not impose their

values or ideals onto the client and does not take the position of expert, which is reserved for the client. Within this frame therapists are involved with the clients in a co-construction of a solution to the problem (W. R. Miller & Rollnick, 2013; O'Hanlon & Weiner-Davis, 2003; Shafer & Jordan, 2014).

### **An Integrated Relational Approach**

A predictor of treatment success is the client's subjective experience of the therapeutic bond and experience of success early in treatment (S. D. Miller et al., 2005). Research in the alcohol treatment field has shown that client engagement is the best predictor of treatment outcome, accounting for 50–66% of the variance in outcome of alcohol treatment (W. R. Miller et al., 2002). Accurate empathy has also been shown to improve treatment outcomes in alcohol treatment (Hettema et al., 2005; W. R. Miller et al., 2002). Any therapeutic approach used with substance using clients must address these critical issues of client engagement. S. D. Miller et al. (2005) suggested that therapists adopt a strength-based, problem-solving approach to maximize treatment engagement and minimize the risk of client deterioration in treatment. This supports an integrated relational approach to substance abuse counseling in an outpatient setting.

The integrated approach combines several commonalities between the three therapies found when examining them together, including:

- the client's worldview is honored;
- the therapeutic relationship is necessary and key to therapeutic progress;
- the client is seen as the "expert" in the therapeutic relationship;
- the emphasis is on cooperation with the client rather than confrontation;
- the client's strengths are emphasized and amplified;
- clients are seen as capable and motivated to move to wellness;
- there is a belief in the client's ability to change and find solutions to the issues that brought them into therapy;
- the therapist's task is to meet the client where they are;
- the responsibility for change lies with the client within a therapeutic relationship fostered by the therapist;
- the emphasis is on the client's freedom of choice;
- goals and expectations for therapy are articulated;
- the therapist must work within the client's frame of reference.

In addition to the similarities between the approaches laying the foundation of the integration of the models, the tasks of the three approaches form a complementary bond that creates a system of therapy grounded in the therapeutic relationship. The task of person-centered therapy is to convey unconditional positive regard and empathy for the client, creating a "radical" acceptance of the client building the therapeutic relationship, the key to therapeutic change. The task of motivational interviewing is to raise discrepancy and increase a client's motivation for change by addressing the client's ambivalence and their hesitancy to move forward toward their goals. The task of solution-focused therapy is to identify and amplify change and solutions. These three tasks form the foundation of an integrated relational approach to substance abuse treatment.

**Structure and Application:  
Integrated Relational Model of Substance Abuse Outpatient Counseling**

A phase model of treatment has been used in outpatient counseling across a wide variety of issues, including depression, trauma, and behavioral issues (Boy & Pine, 1999; Cepeda & Davenport, 2006). The Integrated Relational Model of Substance Abuse Outpatient Counseling is a three-phase model consisting of engaging the client in treatment, examining the client’s past skills and strategies for addressing substance use issues, and developing and implementing an action plan with clear objectives and discharge planning. This phase module integrates the concepts of the person-centered approach, motivational interviewing, and solution-focused counseling (see Table 1).

Table 1

The Integrated Relational Model of Substance Abuse Outpatient Counseling

Phase	Goals	Objectives
<b><u>Phase I: Engaging the Client</u></b>		
Person-centered therapy Motivational interviewing	Client engagement Accurate empathy Unconditional positive regard Client change talk	Build rapport and collaboration Complete client history, intake, and assessment Develop an understanding of issues from the client’s point of view Provide feedback regarding the client’s current situation Identify past successes Client begins to take responsibility for change
<b><u>Phase II: Examining Past Skills and Strategies</u></b>		
Solution-focused therapy Motivational interviewing	Identify treatment options Identify and develop discrepancy	Identify past solutions, skills, and strategies Develop list of treatment options Explore ambivalence Explore exceptions to the problem Build commitment to a treatment option Reinforce self-efficacy and commitment to change
<b><u>Phase III: Developing and Implementing an Action Plan</u></b>		
Motivational interviewing	Develop action plan Prepare for discharge	Create and carry out an action plan; evaluate and revise as needed with the client Prepare for discharge identifying client strengths and successes

### **Phase I: Engaging the Client**

Phase I of the integrated approach includes engaging the client in substance use treatment using a person-centered foundation and motivational interviewing. Utilizing the person-centered techniques of empathy and unconditional positive regard and the motivational interviewing practice of empathy and building collaboration lays the foundation for clients to trust the therapeutic process, setting the stage for examining discrepancies. In this phase, clients are assessed using a holistic approach that is client centered. Engaging the clients in this way builds the therapeutic alliance and sets the stage for interventions that are directive in promoting change in Phases II and III.

**Client and clinician's tasks.** The key tasks in Phase I are to build rapport with the client, complete a client history, develop an understanding of the client's issues from the client's point of view, and determine the client's stage of change. The clinician's task in this process is to utilize person-centered concepts that show the client unconditional positive regard and listen very carefully to what the client shares. The development of empathic understanding helps put the client at ease and allows the clinician to understand the client's frame of reference regarding the substance use issues they are struggling with.

**Clinician's tools.** The tools clinicians can use to accomplish these tasks include using tools found in the motivational interviewing literature (see Table 2). Tools such as reflective listening using OARS (open-ended questions, affirming, reflecting, and summarizing), taking a "not knowing stance" with the client, exploring the client's values and goals within the framework of assessment of the issue that brings them into counseling, and completing a stage of readiness change questionnaire (Connors, DiClemente, Velasquez, & Donovan, 2013; Hanson & El-Bassel, 2014; W. R. Miller & Rollnick, 2013). After a thorough evaluation in Phase I, clinicians move the client into Phase II.

### **Phase II: Examining Past Skills and Strategies**

The integrated approach in Phase II builds on Phase I by continuing to build the relationship through designed interventions based in motivational interviewing and solution-focused techniques (see Table 2). In Phase II, clients are directed to examine their ambivalence for change, identify past solutions, skills, and strategies that have worked, and begin to identify treatment activities. This is done through providing empathic feedback regarding personal risks and rewards of substance use, identifying personal responsibility for change, offering nonjudgmental reflections and summaries, developing a menu of treatment options, and encouraging self-efficacy that is centered on positive change (Connors et al., 2013; W. R. Miller & Rollnick, 2013, Shafer & Jordan, 2014).

**Client and clinician's tasks.** Consistent with solution-focused therapy techniques, the feedback to clients in Phase II includes any information about the client's success in avoiding substance use and positive changes they have already made. Options given in treatment also follow the solution-focused therapy format. Therapists should elicit from the client what has worked in the past and exceptions to the identified problem (S. D. Miller et al., 1996; Shafer & Jordan, 2014). Clients are directed to recall times of substance free living and reflect on the skills and strategies used during these times. These situations can be included in the menu of options for change that are presented to the client, helping them resolve substance related issues. The therapist's role in



presenting options is to enhance the client’s ability to make informed choices that are more in line with the client’s own stated goals and values.

**Clinician’s tools.** In Phase II, clinicians have tools at their disposal that are used in both solution-focused therapy and motivational interviewing (see Table 2). Asking the client exception questions and having them describe life as if a miracle occurred focuses the client on solutions rather than on the problems (Shafer & Jordan, 2014). Clinicians can engage the client using a decisional balance exercise where the client focuses on both the rewards and consequences of their substance use as well as the rewards and consequences of changing their substance use pattern. This has been used very successfully in motivational interviewing to help the client move out of ambivalence and into commitment for change (W. R. Miller & Rollnick, 2013). Therapist must also be attuned to the client’s language, listening for and reinforcing language that argues for change while ignoring language that sustains the problem. Clinicians can use the acronym DARN to remember to look for client’s statements about “desire” to change, “ability” to change, “reasons” to change, and the “need” to change. This motivational interviewing technique is very helpful for clinicians to structure their listening (W. R. Miller & Rose, 2009).

Table 2

Intervention Tools to Use in the Integrated Relational Model of Substance Abuse Outpatient Counseling

Phase	Intervention Tool	Source
<b><u>Phase I: Engaging the Client</u></b>		
Person-centered therapy	OARS	W. R. Miller & Rollnick, 2013
Motivational interviewing	Values card sort	W. R. Miller & Rollnick, 2013
	Readiness to Change Questionnaire	Heather & Honekopp, 2008
	Not knowing stance	Shafer & Jordan, 2014
	Readiness ladder	Connors et al., 2013
<b><u>Phase II: Examining Past Skills and Strategies</u></b>		
Solution-focused therapy	Agenda mapping	W. R. Miller & Rollnick, 2013
Motivational interviewing	Decisional balance	Hanson & El-Bassel, 2014
	Looking for exceptions	Berg & Miller, 1992
	DARN language	W. R. Miller & Rollnick, 2013
		W. R. Miller & Rose, 2009
	The miracle question	Shafer & Jordan, 2014
		Hanson & El-Bassel, 2014
<b><u>Phase III: Developing and Implementing an Action Plan</u></b>		
Motivational interviewing	Change Plan	W. R. Miller & Rollnick, 2013
	Discharge Plan	Adams & Grieder, 2005
Person-centered therapy		

### **Phase III: Developing and Implementing an Action Plan**

Using a motivational interviewing frame and solution-focused therapy techniques in Phase II of the integrated model assumes that therapists will be developing goals with the client that address the client's substance use. Questions and interventions to use with clients in Phase III are selected based on their usefulness in finding solutions to the client's problems and that move the client forward on their self-designed goals. Goals are then established using a solution-focused approach where goals that are important to the client are concrete, realistic, and achievable, allow the client to have early success in treatment, and include the presence rather the absence, of something (Hanson & El-Bassel, 2014; Shafer & Jordan, 2014).

**Client and clinician's tasks.** The two major tasks for the client and clinician in this phase are the development of a change plan and a discharge plan that outlines when clients will be ready to terminate treatment. Questions used to develop the change plan are focused on highlighting pre-session change and finding exceptions to the problem (Berg & Miller, 1992). A change plan based on motivational interviewing concepts is consistent with the client's stated goals and values, is concrete and specific, and is written with the client (W. R. Miller & Rollnick, 2013). The change plan should be reviewed and revised frequently to help elicit the client's self-efficacy for change and to avoid the continuance of things that are not working. The discharge plan is also created with the client and reviewed frequently. The client and clinician's task is to know where treatment is going and when it will be done (Adams & Grieder, 2005).

**Clinician's tools.** The tools clinicians use in Phase III consist of change plans and discharge plans (see Table 2). The change plan involves capturing the client's commitment to the plan, activation steps, and implementation of the plan. A change plan is often thought of as a treatment plan; however, it encapsulates more than a treatment plan because it addresses how the client will fit the change into their life. Formalized treatment is one part of the change plan, but it also includes everyday life tasks as well. In addition to the change plan, the discharge plan is developed with the client to capture what needs to happen to determine when formal treatment should conclude. Discharge plans capture the end goal that clinicians have with clients but is not the necessarily the end of the client's work in recovery. This continues well beyond the end of formal treatment, highlighting the continued need for support in recovery that is based on the client's own resources outside of counseling.

Self-efficacy and the therapist's belief in the client's ability to change, consistent with person-centered therapy, constitutes crucial therapeutic elements in the Integrated Relational Model of Substance Abuse Outpatient Counseling. Any opportunity the therapist has to encourage and reinforce the client's ability to change is taken. Therapists help clients identify how they have already been successful and identify the strengths and resources that they can bring to the issue of substance use. In this way, clients are challenged to examine their motivation and are challenged to change while maintaining the therapeutic relationship.

Goldfried and Davila (2005) have shown that the therapeutic relationship and counseling techniques together facilitate the process of change rather than either one separately. The proposed Integrated Relational Model of Substance Abuse Outpatient Counseling has as the main tenet the foundation of the therapeutic relationship and the client's ability to change and find solutions to their substance use problems. The

approach also emphasizes early success in treatment and the client's subjective experience of the therapeutic bond as critical to a favorable treatment outcome (S. D. Miller et al., 2005; W. R. Miller et al., 2002). In an integrated relational approach to substance abuse counseling, the change process is created through establishing an optimal therapeutic alliance, producing the expectation that therapy will help and affirming that change has and will continue to occur, honoring the client's own journey of self-discovery.

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