International Journal of Psychosocial Rehabilitation, Vol. 24, Issue 03, 2020
ISSN: 1475-7192

Examining the Therapeutic Alliance: A Case Study At a Drug Rehabilitation Facility

Mohamad Isa Amat*, Nurhafizah Mohd Sukor, Ku Suhaila Ku Johari and Nurfarhah Mohd Najib

Abstract--- *An enhanced understanding of therapeutic alliance in drug treatment settings as a peer support community facilitates recovering counselors (RC) and clients in the passage of recovery. The current study explored the therapeutic alliance between recovering counselors (RC) and their clients in a non-governmental drug treatment and rehabilitation centre. It aims to explore the therapeutic alliance of recovering counselors – client relationships and interaction that influence recovering journey. In this study, recovering counselor (RC) refers to experienced and qualified counselors who have completed a Therapeutic Community (TC) program. An in-depth case study was conducted involving 3 pairs of counselors and clients who volunteered to participate in the study. The data were collected through 16 in–depth interview sessions, observations, and personal reflections. The qualitative data suggest that the experience of therapeutic alliance was represented by three major themes; 1) therapeutic relationship, 2) spirituality, and 3) successful recovery and behavior change. Each pair of counselors-clients reflects a different level of therapeutic experience as the clients make progress from primary treatment to re-entry phases. The findings help to enhance the knowledge on how a therapeutic alliance helps both counselors and clients to flourish as a progressive individual. This study suggested that recovering counselors become a role model for clients to sustain their recovery and motivation for behavior change. However, further investigations are needed to support the current findings. Implications for future study are also discussed.*

Keywords--- *Therapeutic Alliance, Spirituality, Behavior Change.*

I. INTRODUCTION

The therapeutic alliance is considered an integral part of a successful treatment, by facilitating of ability therapeutic response between patients and their counselors (Orlinsky, Ronnestad, & Willutzski, 2004). The counseling relationship is interchangeably known as therapeutic relationship or working alliance (Bordin, 1994). Barrazzone et al. (2012) found that a therapeutic alliance was established in three stages (1) establishing, (2) developing, and (3) maintaining. A collaborative bond between patient and therapist (Krupnick et al., 1996) is considered as "the quintessential integrative variable". In other words, the perceptions of the therapeutic alliance are come from the patient's, the therapist's and outside observers. It is flexible as expressed in such concepts as rupture and repair (Safran J.D, Muran J.C, Samstag, and L.W& Steven. C (2001). Additionally, unconditional positive regard and empathy are factors on the therapeutic role (Rogers, 1951). Remarkably, a few studies have provided evidences in supporting the significant impact of quality therapeutic alliance on the recovering counselors and

Mohamad Isa Amat, Asian Centre for Research on Drug Abuse (ACREDA), Faculty of Leadership and Management, Universiti Sains Islam Malaysia (USIM). E-mail: isaamat@usim.edu.my*
Nurhafizah Mohd Sukor, Faculty of Leadership and Management, Universiti Sains Islam Malaysia (USIM).
Ku Suhaila Ku Johari, Faculty of Education, National University of Malaysia (UKM).
Nurfarhah Mohd Najib, Asian Centre for Research on Drug Abuse (ACREDA), Faculty of Leadership and Management, Universiti Sains Islam Malaysia (USIM).

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

clients (Amat, 2013; Ham, LeMasson, & Hayes, 2013; Ham, 2009). Taylor et al. (2015) also reported that therapeutic alliance develops as a natural process in supporting positive treatment process which influences a successful therapy (Cloitre, Miranda, Stovall-McClough, & Han, 2005; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Meier, Barrowclough, & Donmall, 2004; Oene, Schippers, De Jong, & Schrijvers, 2001).

II. LITERATURE REVIEW

2.1 Therapeutic Alliance

The working alliance can be defined as a collaboration in counseling, which requires altruistic feeling and emotional connections in the process of helping the client (Corsini & Wedding., 2011; Hanson et al., 2002; Munder et al., 2010). Bordin (1994) defines therapeutic alliance based on three essential elements: (1) agreement between client and therapist related to the goals, (2) similar agreement to complete the tasks, and (3) development of a bond between client and therapist. It is important to note that the term therapeutic alliance is typically interchangeable with working alliance. There is a myriad of empirical evidences that support the value of establishing a strong therapeutic patient–clinician alliance. (Orlinsky et al., 2004; Barber et al., 2006 and Barber, Khalsa, & Sharpless; 2010).

Colson et al. (1991) reported that working alliance was difficult with clients who were defiant and oppositional (Bettmann & Jasperson, 2009). Additional factors affecting a positive outcome in the working alliance include strong partnership and treatment commitment (Dinger et al., 2008). Overholser (2002) discussed the core conditions of genuineness, unconditional positive regard, and empathy as the main components of a relationship that lead to a strong working alliance.

2.2 Spirituality

Besides therapeutic alliance, spirituality in drug treatment and addiction recovery has received a considerable attention in recent years. (Dermatis & Galanter, 2016; Giordano, et al., 2015; Ham, 2009; Kurtz & White, 2015; Mustain, & Helminiak, 2015). Within the recovery community, spirituality issues have received a major influence from Alcohol Anonymous (AA) and other twelve step approaches. The twelve-step culture emphasizes on the existence of higher power or God and helps the recovering addicts to reconnect to this superior power over their sense of powerless in managing their addiction towards substance (Alcoholic Anonymous World, 1952). Therefore, there are abundant of substance abuse treatment that have incorporated spiritual element in their program. In recovery, the content of spirituality is translated into sense of gratitude, humility, tolerance, forgiveness, being at home and internally support an individual (Kurtz & White, 2015).

Individuals who are in the process of addiction recovery frequently cite spirituality as a helpful influence. Spirituality and religiousness are also considered multidimensional constructs that can cover cognitive, spiritual, behavioural, existential, social components and ritualistic. (Connors, Tonigan, & Miller, 1996; Miller & Thoresen, 2003). Alexandre B.L, Keith. M and William. L.W (2006) have reported on several group of researchers studies has investigated the role of religion and spirituality that indicate positive for those individuals struggling with chronic, terminal illnesses and also as recovery capital-buffering stress and enhancing life satisfaction. This is supported by

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

other studies (Ellison, 1991) that with strong religious faith compared to those with low or no religious faith will affect their level of life satisfaction, impact of traumatic life events and well-being. Subsequently, evidence in this area often report that religiousness and spirituality are critical factors in the recovery process and can minimizing substance use behavior (Morjaria & Orford., 2002; Margolis R, Kilpatrick A., Mooney B., 2000).

2.3 Motivation for Change and Readiness for Treatment

Motivation can be understood as probability that a person will enter into, continue, and stick fast to a specific change strategy (Miller & Rollnick, 1991). As stated by Miller (1999), motivation approaches described in this Treatment Improvement Protocols (TIP) motivation are (i) key to change (ii) dynamic and fluctuating (iii) multidimensional (iv) influneced by social interactions (v) can be modified (vi) influneced by the clinician's style and (vii) the clinician's task is to elicit and enhance motivation.

The main aspects of motivation to success in substance abuse treatment are desire to seek help, problem recognition and readiness to engage in treatment (Jennifer E.B, Danica K.K, Rachel.D.C, George W.J & Patrick M.F, 2015). Following the suggestions of Miller and Rollnick (1991), unmotivated client is those who not to engage in treatment and client need to responsibility for motivation theirself.

Prochaska and DiClemente (1983) introduced the Trans-Theoretical Model of Behavior Change (TTM) to measure change behavior. During the pre-contemplation stage, individuals do not think their behavior is problematic for them. During the contemplation stage, they have thought seriously about changing their behavior, but no changes in action takes place. After they have time to seriously think about changing their behavior, they start to take initiative by changing it; this is called the preparation stage. When individuals successfully change their behavior, they have moved to the action stage. An individual who can perform a new behavior for more than six months is in the maintenance stage.

A vast number of literature has suggested that therapeutic alliance is a core element of successful treatment process and outcome. Therefore, it is believed that qualified and experienced recovering counselors and clients are necessary to establish the connection and relationship. Ham, LeMasson, and Hayes, (2013) highlighted that the lived experiences of recovering counselors open their doors to help recovering clients to recover, feel a sense of empathy and achieve a level of understanding. This can be successfully obtained by closely establishing contacts with clients, and sharing personal life experience of recovery, which in turn strengthen the therapeutic alliance. Considering this matter, the development of therapeutic relationship for successful drug treatment process and outcome can only be captured through rich and in-depth qualitative inquiry.

Merriam (2009) suggested that, in a qualitative inquiry, it is useful to get sample from which the most can be learned. To learn the most from this study, Romney et al. (1986, p. 326) suggested to select those who "possess a certain degree of expertise about domain of inquiry". Therefore, this study aims (1) to explore the underlying therapeutic alliance of recovering counselors – client relationships and (2) how the interaction could influence recovering journey and treatment outcomes of clients.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

III. MATERIALS AND METHODS

3.1 Research design

Research methodology are the various procedures and selection methods was refers the research problem and its corresponding research questions, and commensurate with the current field of study as shown in the literature review (Carson et al., 2001; McPhail, 2003; Perry, 2001; Yin, 1994; Zikmund, 2000). Following the suggestions of Yin (1994) regarding methods for exploration and understanding of complex issues, case study is an approach that supports deep-rooted and detailed exploration of the therapeutic alliance of recovering counselor – client relationships and how it influences recovering journey.

In a case study, Merriam (2009) suggested that clear boundaries in achieving the aims of the study need to be identified. Miles and Huberman (1994) said a case study refers to a method by looking at "a phenomenon of some sort occurring in a bounded context" (p. 25). The case study is illustrated as a circle with the heart as the focus of the study while the circle "defines the edge of the case: [and consequently] what will not to be studied" (p. 25). The heart of this study lies upon the recovering counselors and clients, and the circle setting boundaries for the study was the residents of Primary Treatment stage within Rumah Pengasih. The study focused on the therapeutic alliance within the counselor–client relationship to discover the interactions of significant factors that characterize the alliance.

This method is useful for data collection and analysis in explaining the phenomena and themes emerged from the data, both at surface and deep levels (Zaidah Zainal, 2007). The study formulated a broad research question that involves understanding how recovering counselors and clients view the process and the nature of the counselor–client relationship in therapeutic alliance, in the absence of nonverbal cues and messages. The experiences of participants were captured through in-depth interviews, observations and document analysis.

3.2 Participants

The participants involved three pairs of recovering counselors and residents who volunteered to partake in the study. Purposive sampling was the procedure used to select the participant who fit the inclusion criteria of the study (Merriam, 2009). For this study, the recovering counselors and residents at the Primary Treatment stage were invited to participate based on several criteria: 1) the residents at the Primary Treatment have spent about four to six months in the treatment center, 2) the residents are physically and mentally healthy 3) They voluntarily participate in the study.

3.2.1 Counselor participants

The inclusion criteria for counselors included those who were 1) having been appointed as fulltime substance abuse counselor by Rumah Pengasih management, 2) having a strong commitment to help residents deal with problems associated with substance abuse, and 3) voluntary participating in this study.

3.2.2 Resident participants

For the residents, the criteria included: 1) 20 years of age or older, 2) having a therapeutic alliance with their counselor, 3) comply with treatment as determined by the program coordinator, 4) still at an early stage of treatment

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

to allow for 3-4 months of participation in the project, 5) medically stable, and 6) participating voluntarily in this study.

Table 1 displays the demographic information of the 3 pairs of counselors and clients. The age of the counselors ranged from 20 to 55 years, while residents' age ranged from 20 to 25 years. All counselors had substantial experiences in recovery with a range from 5 to 16 years and an average of 9 years of experience. All counselors and resident participants were male Muslim.

Table 1: Participants Demographic Information

Participant	Code	Gender	Age	Years in Recovery	Drug of Choice
Pair 1					
Counselor	RC1	Male	50-55	16	Polydrug user
Resident	R1	Male	20-25	-	Heroin user
Pair 2					
Counselor	RC2	Male	20-25	5	Heroin user
Resident	R2	Male	20-25	-	Meth user
Pair 3					
Counselor	RC3	Male	26-30	6	Polydrug user
Resident	R3	Male	20-25	-	Polydrug user

(Source: Data Analysis)

3.3 Research Procedure

This study was conducted at a private treatment and rehabilitation facility called Rumah Pengasih, Kuala Lumpur, Malaysia. A written consent was obtained from the management of Rumah Pengasih prior to data collection.

3.3.1 Research Protocol

Yin (2012) stated that researchers use multiple sources of evidence to support coherent findings. Direct observations of participants' interactions and activities at the centre were conducted. Throughout the series of observation, field notes of the various events were diligently recorded. These observations included the morning meeting, static group, encounter group, praying activities, religious events, outdoor events, and other relevant activities. The interview sessions with participants, were often conducted on the same day as they were observed. Based on the interviews, direct observations, and recorded documents, a case study database was established. The database reported as many aspects of the therapeutic alliance.

To better understand their relationships, each pair of recovering counselors and clients was interviewed separately. These interview sessions occurred three or four times a day throughout the data collection period. The interview questions for recovering counselors included, but were not limited to, those shown below:

1) Tell me briefly about yourself before starting treatment.
2) What motivated you to come to the center?

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

3) Tell me about your working relationship with your client.

4) What do you think your roles and expectations are in this working relationship?

5) What do you think is the strength that contributes most to your working relationship with this particular client?

6) What do you do (as a counselor) that contributes to a successful therapeutic alliance? How do you do it?

7) What are the factors in the environment, residents, and staff which lead to successful therapeutic alliance?

8) How do the spiritual practices you share with your client play a role in your therapeutic alliance?

9) What do you believe about your potential for recovery? How does this influence your therapeutic alliance?

For the client, the interview questions are presented below but were not limited to:

1) Tell me briefly about yourself before starting treatment.

2) What motivated you to come to the center?

3) Tell me about your working relationship with your counselor.

4) What do you think your roles and expectations are in this working relationship?

5) What personal strength did you employ that contributed most to your working relationship with your counselor?

6) What do you (as a client) do to contribute to a successful therapeutic alliance? How do you do it?

7) What are the factors in the environment, residents, and staff which lead to successful therapeutic alliance?

8) What part do the spiritual practices shared by you and your counselor play in your therapeutic alliance?

9) What do you believe about your potential for recovery? How does this influence your therapeutic alliance?

3.3.2 Data collection and analysis

The main data sources for this study were from (a) individual in-depth interviews with the recovering counselors – clients and (b) observational notes.

a) In-depth Interview

Interviews were conducted separately between counselor and clients. The interview protocol was developed following the recommendations of Fontana and Frey (1994) to use a common statement (protocol) for all the participants. The interview sessions occurred three or four times a month, resulted in 16 interviews conducted throughout the data collection period. The interview protocol led to the discussion of the following topics; exploring the underlying therapeutic alliance of recovering counselors – client relationships and how the interaction could influence recovering journey and treatment outcomes of clients.

b) Observation Notes

Direct observations of participants' interactions and activities were employed at the treatment facility. These observations included morning meetings, static group sessions, encounter group sessions, praying activities, religious events, outdoor events, and other relevant activities. Interview sessions with participants were often conducted on the same day as the event visited for taking observational notes.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

3.3.3 Data validation

All interviews were recorded and transcribed verbatim. The following methods were employed to ensure the authenticity and trustworthiness of the data:

i. Member checking: After the initial coding, the data were sent to all the participants (recovering counselors and clients) for verification. This process also helped the researcher during preliminary analysis to anticipate that the whole meaning of an interpretation is accurate (Maxwell, 2005; Merriam, 2009).

ii. Peer review: Merriam (2009) referred peer review as *peer examination*. The peers' comment and feedback were based on their areas of expertise, e.g., contents, methods, processes, logistics, and other concerns.

iii. Triangulation: Data from various sources of interviews, observations and documents were triangulated using a constant comparison method (Stake, 2010).

3.3.4 Categorization and Coding

The purpose of the qualitative study was to examine, interpret and explain the data as it emerged as concepts, constructs, patterns, themes, categories and relationships according to the research aims (Mouton, 2001; Van Vuuren, 2008). After checking and rechecking the accuracy of the transcriptions, the researcher transferred all transcriptions and observational notes in qualitative analysis software called N-Vivo 8. The software allows social sciences researchers to retrieve and code data, and develop theory building and modelling (Jones, 2007).

The coding procedure was completed one step at the time, line by line, within each transcription to identify similar patterns in the data corpus to derive themes or new emerging themes. There were 16 transcriptions produced for each participant. An inductive process occurred when different themes emerged with new subthemes as the coding process took place from participant number one to participant number sixteen.

IV. Result And Findings

The initial analysis revealed a common reaction from the participants regarding the working alliance. All the participants agreed that they were recovering addicts and they believed that they understand themselves better than others. Therefore, they were easily connected to one another and adapted relatively fast in the process. This experience appeared during orientation program (induction) for 3 weeks, followed by 3 to 6 months primary treatment period.

Most of the participants (recovering counselor and clients) shared their working alliance experiences that are manifested through three major themes as presented in Table 2. The three major themes of the working alliance of counseling relationship between recovering counselor and clients are 1) therapeutic relationship, 2) spirituality, and 3) successful recovery and behavior change. These emerging themes yielded several subthemes that explained the working alliance as experienced by the participants.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

Table 2: Themes and subthemes

Themes	Subthemes
1. Therapeutic relationship	a) Family and brotherhood b) Trusting others
2. Spirituality	a) Religious practice in facility b) *Tabligh Jamaat* c) A sense of connectedness d) Fasting in Ramadhan
3. Successful recovery and behavior change	a) Successful recovery b) Motivation for change

Source: Data Analysis

4.1 Therapeutic relationship

A therapeutic relationship between recovering counselors and clients was gradually established from induction week throughout primary treatment period. These relationships, over the time during re-entry phase, encountered lesser meetings as compared to during primary treatment.

a) Family and brotherhood

The nature of the treatment facility fostered deep and healthy bonding between counselors and clients. Both parties were recovering addicts and had faced issues and traumatic experience with their significant others. They specifically related their past issues to an 'unfinished businesses' with their father. The following statement by RC2 illustrates the sense of filial and brotherhood:

"He is only person who care about me. He picked me at roadside and listen to my struggle. Even my family did not care about me. I'd rather listen to him than my dad". [RC2]

The recovering counselors exemplified their quality by showing a sense of understanding and being empathetic with the clients' stories. Role-modeling seems to be a strong motivation for clients to move forward.

b) Problem in trusting others

Recovering addicts had problem in trusting others even among other addicts. Their lives were full of resentment and vengeance because their significant others, specifically father did not trust them. R1 reported that he lost his respect to his father when he got married with his second wife without the consent from his first wife. R1 states;

"It's too painful for me to talk about it. My mother is suffering enough to live as my father got a new and younger wife for his lust" [R1]

When RC1 approached R1 in an outreach meeting, R1 initially indicated his resistance but R1 gradually accepted RC1 as his recovering counselor. This is because RC1 showed his earnest passion to help.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

4.2 Spirituality

Spirituality reflects the participants' sense of filial connectedness and their involvement in the practices of Islam within the facility. The participants were observed to show their act of spirituality into four subthemes: (a) Religious practices in the facility; (b) *Tabligh jamaat* (c) Feeling connectedness and (d) Fasting in Ramadhan.

a) Religious practices in the facility

All participants in this facility were expected to perform prayers collectively. Often, residents were required to lead the congregational prayer when the staff had other job commitment. This activity is part of the spiritual healing component of their recovery. All the Muslim residents and staff, were obliged to pray congregationally without fail. There are five obligatory times of daily prayer. R3 mentioned;

"I never perform my prayer out there consistently until my parents referred me here". [R3]

In addition to these obligatory prayers, residents particularly during Inductions, were expected to recite the *surah* (chapter) of *Yassin* from the Holy Quran after sunset prayers daily. They also recite regular verses from the Holy Quran as part of their *zikr*, or remembrance of Allah's names, or salutations upon the Prophet Muhammad (p.b.u.h).

Residents were also required to attend basic religious seminars organized by the staff or a guest *ustaz* (religious teacher) who came from nearby religious department. These seminars were intended to help residents refresh their knowledge of the religion or to re-learn it. R2 shared his feeling;

"I feel calm and serene when I engage in remembrance of Allah" [R2]

Most of the participants felt a sense of connectedness with religion and calmer when they engaged in religious activities such as praying, reciting the Holy Quran and attending religious seminars or talks in the treatment facility.

b) Tabligh Jamaat movement

Occasionally, the residents and staff had to go out for missionary activities. This is known as *Tabligh Jamaat*. The *Tabligh Jamaat* is an Arabic term which means "society for spreading faith." This movement, originated in India, was developed in response to deteriorating values and negligence of fundamental aspects of Islam (Metcalf, 2002).

The participants mentioned that the connection established with the *Tabligh Jamaat* is as part of their growth in recovery in this facility. The participants shared in detail how they participated in the *Tabligh Jamaat*, and how it influenced their thinking pattern, and behavior management towards recovery. The following two statements by R3 and R2 are some of the examples of self-improvement and self-motivation in recovery.

"*I feel much better after a three-day outing with the Tabligh Jamaat group"*. [R3]

He said he felt more motivated to pray, worship, and stay spiritually connected to God. Before he joined this group, he was too discouraged to pray and felt lost, helpless, and sunk in addiction (R3). Furthermore, participant R2 agreed that the missionary trip made him feel more motivated and energetic. He said there was a positive connection between *Tabligh Jamaat* and his spiritual health. A healthy spirit helped him to cope better and greater in the recovery program provided by the facility.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

c) Sense of connectedness

The participants shared their feeling of connectedness to each other. They had encountered stressful and traumatic experiences with their family members before receiving treatment at the facility. All participants had negative experiences with their fathers by being physically and emotionally abused, being victims of violent behaviors, and humiliated as a human.

"My father bonded my wrists and locked me at a big tree nearby at home and he put red ant nest on my legs because I stole his money" [RC1].

Understanding this feeling of connectedness is a significant element in understanding a person in recovery. The facility provided a therapeutic environment for recovering counselors and clients to re-establish their sense of brotherhood, humanity, love, care and concern. RC2 explained:

"He is the only person who care about me. He picked me at the roadside and listen to my struggle. Even my family did not care about me. I rather listen to him than my dad" [RC2].

RC2 is currently appointed as recovering counselor for R2 and he closely monitors his client as good as his biological brother.

"When I see R2, I could simply reflect him as myself during my early recovery long time ago" [RC2].

The experience of having a recovering counselor through therapeutic alliance has built a sense of connectedness to the client. The client felt that they received love and care from others and as a result, felt a sense of brotherhood.

d) Fasting in Ramadhan

Any Muslim who is capable and physically healthy is obligated to fast during the month of Ramadhan. Fasting refers to engaging in no eating, drinking, deliberate vomiting on purpose, or sexual intimacy. However, all these restrictions are lifted from sunset until before sunrise. Fasting in Ramadhan is challenging for everyone. The difficulty of fasting is even worst for residents, both at primary treatment and re-entry stage. The process was a challenging temptation for R2 and R3 as they were assigned to prepare food for all residents and staff at the facility.

"For the last 3 years I am not ready for fasting. I previously never fasted. I only committed to all bad deeds out there" [R3].

In the recovery world, peer support and peer pressure are significant determinants for the success of fasting during Ramadhan. R2 felt supported during the fasting month when other residents fasted as well. In fact, R2 was able to complete his fast for that practice day. He admitted that, he never fasted when he was out of the rehabilitation program.

"*What I need now is the support from others, especially from other peers, RC2 and my wife*" (R2).

Although fasting is considered a challenging time for the residents, it is the time when they gained more support from their peer resident. A spiritual activity such as fasting, strengthened the bond they built with recovering counselors and other residents in the treatment facility.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

4.3 Successful recovery and behavior change

The participants talked about commitment to recovery as part of their success in treatment. Successful recovery requires dedication and perseverance. Without these elements, recovery ends and addiction will take over. The theme for successful recovery and behavior change comprises of two major subthemes: (a) Role model and (b) Motivation for change.

a) Successful recovery

All the participants mentioned that they were being sick and tired of their craving for drugs. However, the recovery process is never an easy journey. It is full of hurt and pain: physically, psychologically, and spiritually. One participant has made the following claim:

"I came back from my failures because I had become sick and tired. I didn't want drugs any more. I couldn't imagine how I could stand on my own if there were no Rumah Pengasih treatment center. I tell you, relapse is common, but to recover is extraordinary. I pushed myself, I went through the process: cleaning the sewers, cleaning up toilets and all sorts of menial work. Now I am getting back to what I want to be" [RC1].

This experience was similar to another participant who had been referred by his family to Rumah Pengasih after being sick, tired, and dying for years. He wanted a fresh start to his life, a fresh start without drugs. He was curious about what it feels like for those doing virtuous deeds. A good role model is crucial in redeveloping sense of humanity, love, care, and concern for others. R1 shared his accounts:

"I was dying but I wasn't alive. It was too horrible to recall, I felt my life was meaningless…. To some extent, I felt I was fatigued, I used to feel exhausted, but during my second admission, I was extremely exhausted. I wanted to live without drugs. I wanted to feel what it is like to be kind to myself and to others. That's what I am looking for" [R1].

Based on the experience shared by the participants, a successful recovery in drug addiction is a lengthy and demanding journey. A successful recovery requires one's commitment in his or her entire life, with unswerving dedication and full perseverance. Stopping recovery only occurs when the person dies.

b) Behavior change

The participants reported that the treatment of drug addiction is a complex process because addiction is considered a chronic disease. The residents tried to support and strengthen psychological ties with other addicts to reduce their chances of relapse. For every recovering addict, recovery needs to be strengthened and prolonged. A longer stay in the recovery facility will provide better space for an addict to relearn or redevelop effective strategies to deal with their daily lives after leaving the facility. It is very common for those who are new to a recovery program to have strong urges towards drugs.

It is very common for them to require for external support from parents and spouses, as well as peers in the recovery process, to move forward especially during early stage or stabilization or transition (Gorski, 1989a). Gradually the person in recovery process will redevelop their internal motivation towards drug free lifestyle. R2 illustrates;

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

"Initially, I didn't care at all. I did not mind my recovery. For example, when there was an event for former residents to play street soccer with Rumah Pengasih to help me avoid relapsing, I chose to meet with old friends. I had missed them and missed the drugs. That was why I relapsed, and within those three months I relapsed over and over". [R2]

Three clients who voluntarily participated in the study were at early stage of drug treatment. It is not unusual for clients to experience initial rejection and denial before they were able to get back in program. In this case, all three clients agreed they were in denial and rejected during initial treatment.

V. DISCUSSION

This was a qualitative case study on therapeutic alliance between recovering counselors and recovering clients at residential drug treatment. While it limits to counselors' and clients' perspective of therapeutic alliance, the study extends to support the existing evidence by exploring at how the therapeutic alliance was developed. Recovering counselors' experience including what they interpreted the clients' reaction and response during primary drug treatment program was delivered.

The findings show that the foundation of a therapeutic process lies upon a natural process of supporting a positive treatment, a condition for successful recovery. Both counselors and clients have shown strong attachment style as a source of motivation and inspiration in sustaining recovery through family and brotherhood bonding. The attachment between counselor and client through role-modeling is helpful in nourishing the feeling of security in the relationship (Taylor, Rietzschel, Danquah, & Berry, 2015). Therapeutic alliance is a critical ingredient for successful treatment outcome for those who had faced traumatic experience and undergone substance abuse treatment (Horvarth & Symonds, 1991). Since the clients of this study had traumatic experience with their fathers, the recovering counselors can self-assess the strength of therapeutic alliance in terms of how they experience the relationship (Watts, Sullivan, & Chatters, 2018).

The aspect of spirituality also plays a vital role in facilitating the therapeutic alliance for both the recovery counselor and client (Ham, 2009; Amat, 2013). The current study continues to provide an evidence that counselor's openness to spirituality enhance the quality of recovery (Ham, 2009). While Ham (2009) focused his study on spirituality of Christianity and Buddhism, the current findings emphasize on the necessity of spirituality in the religion of Islam. The current study revealed that spirituality and religion both were used interchangeably to foster a sense of gratitude, humility, tolerance and forgiveness between counselors and clients throughout the induction, primary treatment and re-entry phases. Being spiritually connected is believed to help the clients to feel internally supported (Kurtz & White, 2015) and thus, reduce episodes of relapse (Dermatis & Galanter, 2016).

The findings of this study are consistent with the study of Ellison (1991), indicating that recovering counselors and clients who have strong religious faith compared to those with low or no religious faith will affect their level of life satisfaction, impact of traumatic life events and well-being. Spirituality and religiousness are also considered multidimensional constructs that can cover cognitive, spiritual, behavioural, existential, social components and ritualistic that influence the lifestyle of recovering counselors and clients (Connors, Tonigan, & Miller, 1996; Miller & Thoresen, 2003).

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

The therapeutic alliance also give impact to the treatment readiness and motivation. This is owing to the fact that motivation is always considered a subjective matter to evaluate the stages of change. In fact, an individual client's motivation is defined and interpreted differently. (DiClemente, Schlundt, Genmell 2004; Miller & Rollnick, 2013). The recovering counselors became role models for the clients to be motivated and ready to make a change by sharing their individual experiences when they were once a resident. residents (Perfas, 2003; Perfas 2012).

The participants involved in this study were relatively small, with the population of residents (76 residents at that point of study). This study managed to examine 3 individual recovering counselors and 3 individual clients at the primary treatment stage. The recovering counselors showed a strong commitment to help clients who are new in the recovery process. The recovering counselors also possessed a sense of empathy in identifying themselves with assigned clients. Having a personal experience in recovery has helped the recovering counselor to talk openly with clients which in turn strengthened the therapeutic alliance (Ham, LeMasson, & Hayes, 2013; Ham, 2009).

This was an in-depth study that required a lot of on-site sessions to conduct interviews, make observations, and record field notes. A study of this nature, ideally, should require researcher to be on the site for four to six months to enable rich and in-depth data collection. The data in the current study were collected for approximately three months. Expanding the time frame for data collection is highly recommended for future study. In addition, conducting a longitudinal study through rigorous observations and field notes may be advantageous to gain great depth of responses regarding the working alliance, hence, improving the trustworthiness of data.

Most Malaysian residential drug treatment and rehabilitation facilities have strict regulations about allowing students and researchers to conduct studies among protected populations, such as recovering addicts. Therefore, initial contact with these facilities is crucial. The current study could not have been accomplished without the assistance of Dato' Dr. Abd. Halim Mohd Hussin, a director general of National Anti-Drug Agency, Malaysia (NADA). He is also an Advisory Board member of Rumah Pengasih and has a respectable professional relationship with the president, Dato' Mohamad Yunus Pathi.

The current research was based on a case study. A different approach of methodology for future research could be employed based on community-based participatory research (CBPR), using a Photovoice approach, as part of advocacy efforts for recovering-addict populations. According to Wang, Cash, and Powers (2000), photovoice is an advocacy effort focusing on the process of how people find and symbolize themselves as a community and how they can improve their quality of life.

A longitudinal study is another appropriate option to help understand the subject and the issues relating to working alliance. A year-long study or a five-year study would be helpful to understand the dynamics of the relationships and their directions. The results would be an advantage for rehabilitation programs in understanding any relapse patterns observed or factors prolonging sobriety.

VI. CONCLUSIONS

This study unfolds three major themes namely therapeutic relationship, spirituality, and successful recovery and behavior change. All the recovering counselors and clients in this study had negative experiences dealing with

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

significant others in their lives, particular mention was made of fathers. The clients and counselor met at this facility to '*fix*' their bad experiences by creating new working relationships and returning to the nature of healthy family relationships. They intentionally nurture the familial role in therapeutic relationships to compensate for bad experiences that most addicts have had due to a lack of a nurturing environment or positive role models. Both sides, however, may experience risks that contribute either positively or negatively to this relationship.

The facility had fostered a strong family spirit within a community context. In modern families, members tend to be more individual and self-focused. The culture, behavior, and what is considered as good conduct are different for this facility community than the '*real world*' community outside of the facility. For recovering addicts to maintain their sobriety, they must establish support at the family level, where every family member can contribute.

ACKNOWLEDGEMENTS

This research uses data from a Fundamental Research Grant Scheme (FRGS) funded by Ministry of Education Malaysia through the Fundamental Research Grant Scheme (FRGS). Project Code: FRGS - ACREDA - 50714-50. This Project lead by Mohamad Isa Amat at the Universiti Sains Islam Malaysia, with permission from local private drug treatment and rehabilitation facility. Special acknowledgment is due to Dato' Mohd Yunus Pathi a director of the facility in providing access to the clients. No direct support was received from grant for this analysis.

DECLARATION OF CONFLICTING INTERESTS

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

REFERENCES

[1] Alexandre B. Laudet, Keith M & William L. White (2006). The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Step Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems. *Alcohol Treat Q*.2006; 24(1-2): 33–73.

[2] Amat, M. I. (2013). *Recovery journeys of counselors and clients: A case study of the therapeutic alliance in a drug treatment and rehabilitation centre in Malaysia* (Order No. 3563468). Available from ProQuest Dissertations & Theses Global. (1399993761).

[3] Appelbaum, A (1972). A critical re-examination of the concept of "motivation for change" in psychoanalytic treatment. *International Journal of Psychoanalysis*. 1972; 53:51-59.

[4] Barrazzone, N., Cavanagh, K., & Richards, D. A. (2012). Computerized cognitive behavioural therapy and the therapeutic alliance: A qualitative enquiry. *British Journal of Clinical Psychology*, 51(4), 396–417.

[5] Bettmann & Jasperson (2009), Adolescents in Residential and Inpatient Treatment: A Review of the Outcome Literature. *Child and Youth Care Forum 38*(4):161-183.

[6] Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp.13–37). New York: John Wiley & Sons.

[7] Carson, D., Gilmore, A., Perry, C. & Gronhaug, K., (2001). Qualitative Marketing Research. *London: Sage Publications.*

[8] Corsini, R. J. & Wedding, D. (2011). Current Psychotherapies. (5th ed.). *Belmont, CA: Brooks/Cole Cengage Learning.*

[9] Colson D.B, Carol.C, Thomas M, Flynn O, Patricia S.H, Mary M.P, Lolafaye C (1991), Perceived Treatment Difficulty and Therapeutic Alliance on An Adolescent Psychiatric Hospital Unit. *American Journal of Orthopsychiatry Mental Health & Social Justice.*

[10] Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H. (2005). Beyond PTSD: Emotion regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. *Behavior Therapy, 36,* 119-124.

[11] Cloitre, M., Stovall-McClough, K. C., Miranda, R., & Chemtob, C. M. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 12,* 411-416.

[12] Connors G, Tonigan S, Miller W. A (1996). Measure of Religious Background and Behavior for use in behavior change research. *Psychology of Addictive Behaviors; 10:90–*96.

[13] Dermatis, H., & Galanter, M. (2016). The Role of Twelve-Step-Related Spirituality in Addiction Recovery. *Journal of Religion and Health*, *55*(2), 510-521.

[14] Ellison C. Religious involvement and subjective well-being (1991). *Journal Health Social Behavior*; 32:80–99.

[15] Etikan. I, Sulaiman & Rukayya.S.A (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*; 5(1): 1-4.

[16] Fontana, A., & Frey, J. H. (1994). Interviewing. The art of science. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361–376). Thousand Oaks: Sage.

[17] Giordano, A. L., Prosek, E. A., Daly, C. M., Holm, J. M., Ramsey, Z. B., Abernathy, M. R., & Sender, K. M. (2015). Exploring the Relationship Between Religious Coping and Spirituality Among Three Types of Collegiate Substance Abuse. *Journal of Counseling & Development*, *93*(1), 70-79.

[18] Ham, C. C., LeMasson, K. S., & Hayes, J. A. (2013). The Use of Self-Disclosure: Lived Experiences of Recovering Substance Abuse Counselors. *Alcoholism Treatment Quarterly*, *31*(3), 348-374.

[19] Ham, C. C. (2009). *The wounded healer: A phenomenological investigation of the recovering substance abuse counselor* (Order No. 3380910).

[20] Horvath, A. O., & Symonds, D. (1991). Relation between working alliance and outcome: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149.

[21] J.A. Maxwell (2005). Qualitative Research Design: An Interactive Approach. *2nd ed. (Sage Publications, Thousand Oaks.*

[22] Jennifer E.B, Danica K.K, Rachel.D.C, George W.J & Patrick M.F (2015). Effectiveness of the Treatment Readiness and Induction Program for Increasing Adolescent Motivation for Change. 50: 38 – 49.

[23] Jones, ML (2007). Using software to analyze qualitative data. *Malaysian Journal of Qualitative Research,* 1(1), 64-76.

[24] Krupnick JL, Sotsky SM, Simmens S, Moyer J, Elkin I, Watkins J, Pilkonis PA (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal Consulting Clinical Psychology. 64 (3):*532-9.

[25] Kurtz, E., & White, W. L. (2015). Recovery Spirituality. *Religions*, *6*(1), 58-81.

[26] Leibert, T.W., Smith, J.B., & Agaskar, V.R. (2011). Relationship between the Working Alliance and Social Supports on Counseling Outcome. *Journal of Clinical Psychology*, *67*(7), 709-719.

[27] Margolis R, Kilpatrick A, Mooney B. A retrospective look at long-term adolescent recover: Clinicians talk to researchers. *Journal of Psychoactive Drugs*. 2000;32:117–125.

[28] McPhail, J. (2003). MGT8400 Research Methodology Study Book. *Toowoomba, Australia: USQ, December.*

[29] Merriam, S. B. (2009). Qualitative research: A guide to design and implementation. *San Francisco, CA: Jossey-Bass.*

[30] Merriam, S. B. (2009). Qualitative research: A guide to design and implementation. *San Francisco, CA: Jossey-Bass.*

[31] Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, *100*(3), 304–316.

[32] Metcalf, B. D. (2002). Traditionalist islamic activism: Deoband, tabligh, and talibs. *Netherlands: Leiden ISIM (International Institute for the Study of Islam in the Modern World).*

[33] Miles, M. & M. Huberman. (1994). Qualitative data. Thousand Oaks. Sage Publications.

[34] Miller W. R (1999). Enhancing Motivation for Change in Substance Abuse Treatment. *Center for Substance Abuse Treatment (U.S) : DIANE Publishing.*

[35] Miller W. R & Thoresen C (2003). Spirituality, religion and health: An emerging research field. *American Psychologist. 2003;* 58:24–35.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020

[36] Miller W. R. and Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. *New York: Guilford Press.*

[37] Miller W. R, Del Boca FK (1994). Measurement of drinking behavior using the Form 90 family of instruments. *Journal of Studies on Alcohol Supplement*. ; 12:112–118.

[38] Miller W. R. Motivation for treatment (1985): A review with special emphasis on alcoholism. *Psychological Bulletin; 98*(1):84–107.

[39] Morjaria A, Orford J. The role of religion and spirituality in recovery from drink problems: A qualitative study of Alcoholics Anonymous members and South Asian men. *Addiction Research & Theory*. 2002;10:225–256.

[40] Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., Barth, J. (2010). Working alliance inventory-short revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology and Psychotherapy*, 17, 231-239.

[41] Mustain, J. R., & Helminiak, D. A. (2015). Understanding spirituality in recovery from addiction: Reintegrating the psyche to release the human spirit. *Addiction Research & Theory*, *23*(5), 364-371.

[42] Orlinsky, Ronnestad, & Willutzski (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–389). *New York, NY: John Wiley & Sons.*

[43] Oene, G. H., Schippers, G. M., De Jong, C., & Schrijvers, G (2001). Retention in substance dependence treatment: The relevance of in-treatment factors. *Journal of Substance Abuse Treatment*, 20, 253-261.

[44] Perfas, F. B. (2003). Therapeutic community a practice guide. *Lincoln, NE: iUniverse Inc.*

[45] Perfas, F. B. (2012). Deconstructing the therapeutic community: A practice guide for addiction professionals. *Red Hook, NY: Hexagram Publishing.*

[46] Perry, C. (2001). Case research in marketing. *The Marketing Review*, 1: 303–323.

[47] Prochaska, J. O., DiClemente, C. C. (1983). Stage and process of self–change in smoking: Towards an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395.

[48] Rogers, C. (1951). Client-centered therapy: Its current practice, implications and theory. *London:Constable.*

[49] Romney, A. K., Weller, S. C., & Batchelder, W. H. (1986). Culture and consensus: A theory of culture and informant accuracy. *American Anthropologist,* 88(2), 313–338.

[50] Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 406–412.

[51] Stake, R. E. (2010). Qualitative research: Studying how things work. *New York: Guilford Press.*

[52] Tasca, G. A., Compare, A., Zarbo, C., & Brugnera, A. (2016). Therapeutic alliance and binge eatingoutcomes in a group therapy context. *Journal of Counseling Psychology, 63*(4), 443–451.

[53] Taylor, P. J., Rietzschel, J., Danquah, A., & Berry, K. (2015). The role of attachment style, attachment to therapist, and working alliance in response to psychological therapy. *Psychology and Psychotherapy, 88*(3), 240-253.

[54] Urbanoski, K. A., Kelly, J. F., Hoeppner, B. B., & Slaymaker, V. (2012). The role of therapeutic alliance in substance use disorder treatment for young adults. *Journal of Substance Abuse Treatment, 43*(3), 344–351.

[55] Wang, C. C., Cash, J. L. & Powers, L.S. (2000). Who knows the streets as well as homeless? Promoting personal and community action through photovoice. *Health Promotion Practice, 1*, 81-89.

[56] Watts, J. R., O'Sullivan, D., & Chatters, S. J. (2018). Strengthening the working alliance for clients with substance use disorders and child maltreatment histories. *Journal of Mental Health Counseling*, *40*(1), 58-74.

[57] Yin, R., (1994). Case study research: Design and methods (2nd ed.). *Beverly Hills, CA: Sage Publishing.*

[58] Zaidah Zainal (2007). Case study as a research method. *Jurnal Kemanusiaan bil 9.*

[59] Zikmund, W.G. (2000). Business Research Methods, *6th Ed., New York: Dryden Press.*

[60] Zilcha-Mano, S., Muran, J. C., Hungr, C., Eubanks, C. F., Safran, J. D., & Winston, A. (2016). The relationship between alliance and outcome: Analysis of a two-person perspective on alliance and session outcome. *Journal of Consulting and Clinical Psychology*, *84*(6), 484–496.

DOI: 10.37200/IJPR/V24I3/PR200838
Received: 14 Jan 2020 | Revised: 02 Feb 2020 | Accepted: 08 Feb 2020