

**The Therapeutic Alliance in Substance Abuse Counseling From a Therapist's Perspective:
A Qualitative Phenomenological Study**

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Abstract

Substance use disorder poses a global public health challenge, with treatment dropout and relapse often undermining long-term recovery. A key predictor of successful outcomes in addiction treatment is the therapeutic alliance, but the specific therapist behaviors that foster and sustain a strong relationship, particularly in the context of substance abuse treatment, are not well-defined. This study explores strategies and the behaviors used to establish, develop, and maintain the alliance in substance use counseling, guided by self-determination theory. The population of interest included addiction treatment clients at risk for disengagement and professionals seeking effective engagement strategies. A qualitative methodology was employed using Interpretative Phenomenological Analysis to explore the lived experiences of 15 licensed addiction counselors practicing in Israel. Data were collected through semi-structured interviews and analyzed using a six-stage coding process to identify relevant themes. Findings highlighted the importance of authentic presence, empathic connection, transparency, and emotional safety during initial sessions. Long-term maintenance of the alliance was supported by relational consistency, validation of effort, and autonomy-supportive behaviors that respected client pacing and agency. These results indicate that the therapeutic alliance is not merely a byproduct of effective treatment but a critical mechanism for promoting recovery. This study contributes to the literature by operationalizing relational behaviors aligned with the psychological needs of relatedness, autonomy, and competence. Implications include prioritizing relational skill development in therapist training programs and examining how these behaviors influence client outcomes across diverse populations and treatment contexts.

Keywords: therapeutic alliance, substance use disorder, interpretative phenomenological analysis, therapist behaviors, addiction counseling, self-determination theory, client engagement

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Chapter 1: Introduction

Substance abuse represents a significant financial burden on healthcare systems (National Institute on Drug Abuse [NIDA], 2010; Winograd et al., 2022). In the United States, the cost of addressing substance abuse in 2003 was estimated at \$21 billion, with public funds accounting for 77% of these expenses (French et al., 2008). Over the past 15 years, the annual economic impact of substance misuse has increased substantially, with estimates reaching \$249 billion for alcohol misuse and \$193 billion for illicit drug use. These costs represent an unprecedented and ongoing burden on public health systems and society, and a dramatic escalation over the past 15 years, with combined costs totaling approximately \$442 billion (Li et al., 2023).

In Israel, substance use has also been on the rise, mirroring global trends. A report in the Israeli media outlet *Haaretz* reported that approximately 15% of the Israeli population struggles with addiction, with nearly one-fifth of those affected under the age of 35 (Kashti, 2022). More recent data indicate that about 27% of Israeli adults reported cannabis use, 2% reported use of other illegal drugs, and approximately 0.25% reported heroin use (Davidovich et al., 2023). These statistics are particularly relevant to the present study, as reflect the Israeli context and affect the perspectives of Israeli therapists working directly with this growing and complex clinical population. While Israel still maintains lower overall alcohol consumption compared to other OECD countries, the rising trend is concerning. A *Jerusalem Post* article noted that alcohol consumption also increased significantly, with a 25% rise reported over the past two decades (Bingham, 2022). Moreover, approximately 25% of Israelis increased their consumption of addictive substances following exposure to emotional stress from the October 7 attack and ongoing conflict (Lev-Ran, 2024). Opioid consumption has also surged dramatically, with Israel

becoming the top-ranked country in the world per capita for use, which has propelled the national healthcare system to seek immediate interventions (Vargas, 2023).

The economic burden of substance abuse extends across multiple societal domains, including healthcare expenditures, criminal justice involvement, employment disruption, decreased productivity, and significant familial and social consequences, alongside the persistent risk of overdose-related fatalities (McGraw, 2021; Rosenbloom, 2018). Engagement in treatment is further impeded by numerous barriers, including socio-demographic challenges, financial limitations, confidentiality concerns, legal ramifications, and client ambivalence (Adeniran et al., 2023). Substantial disparities exist between individuals who do and do not receive treatment, with estimates ranging from 3:1 to 13:1 (Farhoudian et al., 2022).

The pervasive effects of substance abuse complicate treatment by impacting various aspects of an individual's life (NIDA, 2020). It is vital to understand substance use disorder (SUD), as recurrence of use is often mistakenly equated with treatment failure rather than recognized as a feature of a complex, chronic condition characterized by cyclical patterns of relapse and remission (Heilig et al., 2021). Education about the disorder, its triggers, and management strategies is essential in chronic disease care (Lev-Ran, 2024). Integrated care is particularly critical for effective SUD treatment, as it allows medical, psychological, and social services to address the multifaceted nature of addiction. Similar to chronic illnesses such as diabetes and hypertension, the enduring nature of SUDs necessitates sustained treatment over time, with ongoing assessment and adjustment of therapeutic approaches (Volkow & Blanco, 2023).

As the quality of the therapeutic relationship has been shown to play a critical role in addiction treatment adherence (Steuwe et al., 2023), it is essential to strengthen the evidence

base supporting the central role of the therapeutic alliance (TA) in successful SUD treatment. Leveraging the TA effectively may enhance outcomes. A TA is the collaborative relationship between a therapist and a client, characterized by mutual trust, respect, and understanding. The current study explores research identifying the relationship between counselor techniques and the TA, linking alliance, therapy techniques, and outcome (Crits-Christoph & Connolly, 1999; Saraiya et al., 2023). A vigorous TA enhances client engagement, improves retention, and contributes to better clinical outcomes (Dellazizzo et al., 2023; Hammarberg et al., 2023). Other research found that as patients felt heard and began to improve, the alliance was seen to be a more accurate predictor of outcome (Gaston et al., 1991; Gibbons et al., 2010; Horvath & Symonds, 1991).

Research demonstrates that a strong TA is characterized by a high level of trust, mutual respect, and alignment on therapeutic objectives, all of which contribute to better treatment outcomes, especially in SUD contexts (Hatcher & Gillaspay, 2023; Strupp & Anderson, 2022). Moreover, beginning any therapeutic intervention with a strong relationship produces favorable effects in the patient and continues to influence subsequent sessions; establishing a strong TA early, often within the first session, can shape the trajectory of subsequent interactions and strongly influence whether clients remain committed to therapy (Del Río Olvera et al., 2022).

It is crucial that motivation is established to promote client engagement, change, and adherence to therapeutic interventions (Norcross & Lambert, 2019). The TA plays a pivotal role as a motivational process within the therapeutic context. It is not only a relationship of trust and collaboration, but also a critical factor that influences a client's motivation to engage in the treatment process (Hammarberg et al., 2023). Integrating Prochaska and DiClemente's Stages of Change Model into this framework provides a deeper understanding of how the TA can be

strategically aligned with a client's readiness to change (Prochaska & Norcross, 2013). Their model identifies five stages (precontemplation, contemplation, preparation, action, and maintenance) through which individuals typically progress when modifying behavior, such as overcoming SUD (DiClemente, 2018). It highlights that clients may not be ready to fully engage in treatment at the outset, which necessitates a tailored approach by the therapist to match the client's current stage of change.

Combining Prochaska and DiClemente's Stages of Change Model with TA techniques aligns well with current research (Prochaska & Norcross, 2013). By viewing the TA as a motivational process, therapists can better facilitate meaningful change and enhance adherence to therapeutic interventions. This aligns closely with the principles of self-determination theory (SDT), which emphasizes the importance of satisfying psychological needs for autonomy, competence, and relatedness.

SDT provides a critical framework for understanding the basis of this study. Developed by Deci and Ryan (1985), SDT posits that individuals have basic psychological needs for autonomy, competence, and relatedness, which are essential for fostering motivation and psychological well-being. Vansteenkiste et al. (2020) added that fostering autonomy, competence, and relatedness within the TA significantly improves treatment adherence and recovery outcomes. In the context of SUD treatment, a TA that supports these needs can enhance clients' intrinsic motivation to engage in and adhere to treatment. Autonomy is supported when clients feel they have control over their treatment choices; competence is fostered through the development of skills and mastery over challenges related to their substance use; and relatedness is nurtured through a strong, empathetic therapist-client relationship. Thus, the TA can be viewed

as a conduit through which these psychological needs are met, leading to better treatment outcomes (Deci et al., 2017).

Moreover, Teixeira et al. (2022) found that positive feedback and an empathetic therapeutic environment significantly improve treatment engagement and outcomes by supporting competence and relatedness. Similarly, Chan et al. (2023) emphasized the role of autonomy-supportive counseling in sustaining engagement in SUD recovery by giving clients a sense of control over their recovery choices. Deci and Ryan (2000) further elaborated on how satisfying basic psychological needs enhances intrinsic motivation, which plays a critical role in successful SUD treatment. Mills et al. (2021) applied SDT to problem gambling and found that meeting these psychological needs increased motivation for change, illustrating the importance of competence in overcoming challenges and sustaining engagement. Combined, these studies underscore the importance of SDT in SUD treatment by highlighting how a strong therapeutic alliance can fulfill these psychological needs and lead to better client engagement, motivation, and long-term recovery.

Furthermore, Kennedy and Gregoire (2009) explored the relationship between SDT and the Transtheoretical Model of Change (TTM) in addiction treatment (Bowler, 2022; DiClemente, 2018). Their findings highlighted that higher levels of internal motivation, as described by SDT, were significantly associated with progressing to the action or contemplation stages, rather than remaining in precontemplation. This underscores the importance of fostering intrinsic motivation in addiction (Kennedy & Gregoire, 2009). Similarly, Mills et al. (2021) applied SDT in the context of problem gambling, demonstrating that frustration of basic psychological needs is closely linked to maladaptive behaviors like problem gambling. Their study indicated that increased susceptibility to external pressures and lower perceived control over choices lead to

greater frustration of these needs, resulting in psychological distress and problems (Mills et al., 2021).

Park and Kim (2011) also explored the effectiveness of a group counseling program based on SDT, aimed at reducing internet addiction among high school students. Their findings indicated significant improvements in self-determination and a reduction in internet addiction behaviors, further validating the application of SDT in counseling interventions (Park & Kim, 2011). Moreover, Markland et al. (2005) discussed how MI in counseling aligns with the principles of SDT. Both approaches emphasize the innate human tendency toward personal growth and the facilitation of behavior change through psychological integration. This alignment highlights the effectiveness of combining MI with SDT in counseling practices (Markland et al., 2005).

Statement of the Problem

The problem addressed in this study was a significant gap in the existing research regarding the lack of specificity in therapist actions and behaviors that effectively establish and maintain a TA in SUD treatment. Although the importance of a strong TA has been well documented, particularly in relation to client engagement, treatment adherence, and positive treatment outcomes, there remains limited clarity regarding the specific therapist behaviors that contribute to the development and maintenance of this alliance, especially during critical early sessions (DeAngelis, 2019; Norcross & Lambert, 2019).

This gap in understanding is particularly consequential in addiction counseling, where establishing an effective TA is both challenging and essential for treatment success. Inadequate TAs have been associated with reduced client engagement, increased resistance to treatment, and higher rates of premature termination (Park et al., 2020). When clients feel misunderstood or

disconnected from the therapeutic process, their likelihood of disengagement increases, further exacerbating the challenges associated with recovery (Hauber et al., 2020).

Addressing this gap is critical for improving treatment outcomes among individuals with SUD, particularly those with co-occurring psychiatric conditions. A strong TA has been shown to significantly predict treatment retention and overall success in this population (Finsrud et al., 2022; Flückiger et al., 2018). Failure to identify and articulate the specific therapist behaviors that support alliance formation risks perpetuating ineffective practices and contributing to broader societal consequences, including increased strain on public health systems and persistent treatment inequities (Pilevari & Zahedi, 2021). Consequently, therapists' behaviors that enhance the TA, such as flexibility and the ability to adapt interventions to individual client needs (Meier et al., 2005), warrant further empirical exploration.

Purpose of the Study

Despite the established importance of TA, there is a gap in understanding the specific therapist behaviors that effectively strengthen the alliance in SUD treatment. This study addressed that gap by examining therapist-identified strategies that support engagement, trust, and collaboration in SUD counseling (Falkenström et al., 2014; Farhoudian et al., 2022). Existing literature has identified the importance of the TA but offers limited specificity regarding the concrete therapist behaviors that contribute to its formation and maintenance, particularly during the initial sessions when engagement is most fragile.

The purpose of this study was to examine therapist behaviors that support the development and maintenance of the TA in SUD treatment, guided by the principles of SDT (Deci & Ryan, 1985). By exploring how the TA could fulfill the basic psychological needs of clients, this study aimed to provide insights into improving engagement, motivation, and long-

term recovery in SUD treatment. This qualitative study employed interpretative phenomenological analysis (IPA) to explore the lived experiences of counselors as they described how they establish and maintain therapeutic alliances with clients in SUD treatment (McInally & Gray-Brunton, 2021; Peat et al., 2019). The focus of this research was to understand, from the therapist's perspective, the actions and relational strategies perceived as most effective in establishing a strong TA. Based on these identified actions, the study anticipated the emergence of themes associated with strong TAs and the identification of variables contributing to effective therapeutic relationships.

The strength of the TA has traditionally been measured using instruments that assess key relational elements between therapist and client, including mutual agreement on treatment goals, the bond between client and therapist, and the collaborative engagement in therapy tasks. Commonly used instruments include the Brief Revised Working Alliance Inventory (Hatcher, R. L. & Gillaspay, 2023), California Psychotherapy Alliance Scale (Marmar et al., 2023), Penn Helping Rating Scale (Luborsky et al., 2022), and the Vanderbilt Therapeutic Alliance Scale (Strupp & Anderson, 2022). Although these instruments provide valuable quantitative assessments of alliance strength, the present study focused on therapists' subjective experiences and interpretations rather than formal alliance measurement.

The TA usually develops within the first five sessions, peaking around the third session. During this phase, collaboration and mutuality are usually fostered, goals are agreed upon, and the client develops confidence in the therapist and the therapeutic process. This study involved semi-structured interviews with approximately 14 to 20 English-speaking counselors working in drug rehabilitation centers and private practice settings throughout Israel. Participants were

selected based on their professional experience providing treatment to individuals with substance use disorders and comorbid conditions.

This sampling approach allowed for in-depth exploration of therapists' perspectives within the specific cultural and clinical context of addiction treatment in Israel. By investigating the perceptions and experiences of counselors, the study sought to reveal how therapists navigated challenges such as client engagement and resistance, and what specific actions they believed were most effective in enhancing the TA. Ultimately, this study addressed a critical gap in the literature by identifying and describing therapist behaviors that contribute to the formation and maintenance of effective therapeutic alliances in substance use disorder treatment, as perceived by practicing clinicians (Andersson et al., 2023; Kelly, 2015; Rübzig et al., 2021; Zaller et al., 2022).

Introduction to Theoretical Framework

SDT provides a comprehensive framework for understanding human motivation, particularly in contexts where sustained behavior change and engagement are required (Ng et al., 2012). The theory has been widely applied across domains such as education, work, and healthcare, and has demonstrated particular relevance in clinical contexts involving motivation, engagement, and psychological well-being. SDT posits that individuals have three basic psychological needs essential for fostering intrinsic motivation and psychological well-being, and that function synergistically: autonomy, competence, and relatedness (Deci & Ryan, 2017). When these needs are satisfied, individuals experience optimal motivation, engagement, and psychological health (Deci et al., 2017). Conversely, when these needs are thwarted, motivation and well-being may diminish, negatively affecting their engagement in therapeutic processes and treatment outcomes (Vansteenkiste et al., 2020).

Guided by SDT, this study explores how therapist behaviors that support clients' psychological needs for autonomy, competence, and relatedness may enhance therapeutic engagement and promote more favorable SUD treatment experiences and outcomes (Abildsnes et al., 2021; Vansteenkiste et al., 2020). From an SDT perspective, specific propositions are particularly relevant to strengthening the TA. First, the satisfaction of psychological needs is associated with stronger TAs. Creating an environment that supports autonomy, competence, and relatedness can lead to stronger TAs, especially in the initial sessions of SUD treatment (Deci et al., 2017). Second, therapists who support client autonomy by involving them in treatment decisions and respecting their volition can enhance engagement and reduced dropout rates. Autonomy-supportive environments foster higher motivation and adherence to treatment protocols (Deci & Ryan, 2017; Ng et al., 2012). Third, providing positive feedback and recognizing client achievements may strengthen clients' sense of competence, fostering intrinsic motivation crucial for sustained engagement and recovery in SUD treatment (Teixeira et al., 2012). Finally, fostering a strong sense of relatedness between the client and therapist may build trust and emotional support, which is critical for reducing relapse rates and improving long-term outcomes in SUD treatment (Vansteenkiste et al., 2020).

In contrast, inadequate TAs reduce client engagement and increase resistance to treatment, thus raising the likelihood of treatment failure (Park et al., 2020). In SUD treatment, weak TAs hinder progress, increase dropout rates, and lead to relapse and poorer outcomes (Goldberg et al., 2020). There are many other challenges that therapists face that can contribute to a weaker TA (Landrum et al., 2012), such as clinicians who work in addiction treatment report high levels of job-related psychological distress, which undermines establishing a trusting TA and adversely impacts the quality of care for patients (Reyre et al., 2017). These challenges

highlight the importance of identifying therapist behaviors that support both clinician well-being and effective alliance formation.

Guided by SDT principles, this study aimed to explore the subjective experiences of therapists regarding the TA and to examine how a strong TA could improve client engagement, motivation, and long-term recovery in SUD treatment. A strong alliance can be examined through therapist behaviors (mutual trust and respect, agreement on the goals and tasks of therapy, and collaboration and shared decision-making), the impact of emotional responses, client characteristics, integration of professional training, and adaptive communication strategies. In the context of SUD treatment, SDT provides a clinically relevant framework for understanding how therapist behaviors may influence client engagement and motivation. By supporting autonomy, competence, and relatedness within the TA, therapists may create relational conditions that foster sustained participation in treatment. Accordingly, SDT offers an appropriate theoretical lens for examining therapist-identified behaviors that contribute to the establishment and maintenance of the TA in SUD counseling.

Introduction to Research Methodology and Design (Nature of the Study)

Interpretative Phenomenological Analysis (IPA) is a qualitative approach that allows for an exploration of how individuals understand significant experiences, emphasizing both the participants' accounts and the researcher's interpretive role (Deci & Ryan, 1985). This qualitative study employed IPA to examine how therapists made sense of their experiences establishing and maintaining a TA in SUD treatment. IPA has been effectively employed in several seminal works within the field of drug abuse and TA research.

For example, Shinebourne and Smith (2011) utilized IPA to explore the experiences of addiction and recovery, providing deep insights into the personal journey of individuals

overcoming substance abuse. McNally and Gray-Brunton (2021) employed IPA to understand how counselors develop TAs with clients suffering from SUD, emphasizing the importance of empathy, genuine interaction, and personalized treatment approaches in building strong therapeutic relationships. Peat et al. (2019) used IPA to examine the challenges faced by counselors in engaging resistant clients, revealing strategies that enhance therapeutic outcomes despite initial client resistance. Collectively, these studies demonstrate IPA's capacity to capture the complex, lived experiences of both clients and counselors in substance abuse treatment contexts. They provide a foundation for the current study's focus on identifying counselor behaviors and strategies that foster a strong TA.

Given the challenge posed by weak TAs in SUD treatment, which can hinder treatment progress, elevate dropout rates, and lead to relapse and poorer outcomes, this study aimed to identify the specific counselor behaviors that contribute to strong therapeutic relationships crucial for meeting clients' psychological needs. By exploring how counselors navigate challenges like client engagement and resistance, this research sought to supplement the research literature regarding effective counselor attributes and techniques in SUD treatment contexts.

The interaction between therapists and clients is central to psychotherapy and provides a critical context for understanding how therapeutic relationships are formed and sustained. IPA is particularly well-suited to examining this interaction, as it focuses on how individuals make sense of their experiences within relational and professional contexts. Through an interpretive lens, IPA acknowledges the active role of the researcher in exploring participants' meaning-making processes, rather than attempting to uncover an objective or essential account of experience. This approach aligns with the present study's aim of understanding how therapists

understand and describe their experiences of building and maintaining therapeutic alliances in substance use disorder treatment.

Participants were recruited using a purposive convenience sample, targeting English-speaking therapists in Israel, drawn from local psychotherapist networks and rehabilitation centers. These participants were all certified to work with SUD populations and with experience treating clients with comorbid conditions. The study aimed to include between 10 and 15 counselors. Purposive sampling was employed to ensure in-depth insights from individuals with relevant knowledge and experience regarding the therapeutic alliance in SUD treatment. This approach is particularly appropriate for phenomenological studies, as it enables a rich, nuanced understanding of the phenomenon under investigation.

Research Questions

The following research questions guided this qualitative study and were designed to explore therapists' experiences and meaning-making processes related to the therapeutic alliance in substance use disorder treatment.

1. What therapist behaviors and strategies are most effective in establishing a strong therapeutic alliance during the initial sessions of SUD treatment?
2. How do therapists perceive and describe the behaviors and strategies that support the maintenance of a strong therapeutic alliance throughout the course of SUD treatment, in light of client characteristics and their own clinical insights?

Significance of the Study

The significance of this study lies in its contribution to the qualitative literature on SUD treatment by illuminating therapist-identified behaviors that support the development and maintenance of the TA. The findings of this study contribute to the theoretical framework by

providing empirical evidence on specific counselor behaviors and strategies that effectively establish and maintain strong therapeutic relationships. This is particularly critical in SUD treatment, where weak TAs often result in treatment resistance, higher dropout rates, and increased relapse incidents (Goldberg et al., 2020; Park et al., 2020). Addressing these challenges may enhance client engagement and improve treatment outcomes.

Moreover, this study also addresses a critical gap in existing literature regarding the specific therapist behaviors most effective in forming TAs, particularly during initial sessions with clients who may be oppositional or present with comorbid psychiatric conditions. The research was expected to inform evidence-based recommendations and guide clinicians in their practice, ultimately leading to improved patient care, sustained sobriety, and reduced relapse rates post-treatment (Norcross & Lambert, 2018; Flückiger et al., 2018). By clarifying effective therapeutic strategies, the study benefits both clients and therapists, helping clinicians navigate the complexities of SUD treatment while mitigating the societal and economic impacts of untreated SUDs (Li et al., 2023; McGraw, 2021).

Additionally, the results of this study advance the guiding framework of SDT by offering practical applications and empirical support for the theory's principles in the context of SUD treatment. By exploring how the fulfillment of psychological needs for autonomy, competence, and relatedness through strong TAs can enhance treatment outcomes, this study contributes to a deeper understanding of SDT within clinical practice. This study's insights enrich existing literature by offering detailed descriptions of effective therapeutic practices, thus bridging the gap between theory and practice.

The benefits of addressing the study's problem, achieving the study's purpose, and answering the research questions are multifaceted. By identifying and promoting effective

therapist behaviors and strategies, the study aimed to enhance the therapeutic process, leading to better client retention, higher treatment adherence, and improved long-term recovery rates. Furthermore, the findings offer valuable guidance for training programs and professional development, equipping therapists with the skills necessary to build strong alliances with their clients from the outset. This, in turn, leads to more effective treatment protocols and better overall outcomes for individuals struggling with SUDs. By understanding and enhancing the components of the TA, this research can contribute to more effective SUD treatments and improved clinical outcomes, ultimately benefiting clients, therapists, and society.

Definitions of Key Terms

Autonomy

The need to feel in control of one's own behavior and goals, reflecting a sense of volition and self-endorsement of actions. Supporting clients' autonomy by involving them in decision-making processes can lead to greater engagement and commitment (Deci & Ryan, 2017).

Client Engagement

The degree to which clients are actively engaged in and committed to their treatment process, including their willingness to participate and collaborate with the therapist (Norcross & Lambert, 2014).

Competence

To feel effective in one's activities and to attain valued outcomes. Enhancing a client's sense of competence can significantly increase their intrinsic motivation for treatment and recovery through positive feedback and recognition of progress (Teixeira et al., 2012).

Empathy

The ability to understand and share the feelings of another person. In therapy, it is essential to build a strong TA (Cox & Reichel, 2023).

Relatedness

The need to feel connected to others, to love and care, and to be loved and cared for. Establishing a strong TA, where clients feel understood and supported, is crucial for fostering relatedness and enhancing treatment outcomes (Ng et al., 2012).

Substance Use Disorder (SUD)

A medical condition characterized by an inability to control the use of a substance despite harmful consequences. It affects brain function and behavior, leading to an individual's inability to control their substance use (National Institute of Mental Health[NIMH], 2024).

Therapeutic Alliance (TA)

The collaborative relationship between a therapist and a client is characterized by mutual trust, respect, and understanding. The TA can be measured by looking at the bond between client and therapist, and the collaborative approach and agreement on treatment goals and treatment tasks (Stubbe, 2018). TA is crucial in promoting client engagement, motivation for change, and adherence to therapeutic interventions (Flückiger et al., 2018; Norcross & Lambert, 2019).

Summary

This study enhanced understanding of TAs in the treatment of SUDs by identifying specific counselor behaviors and strategies that establish and maintain strong therapeutic relationships. Addressing these behaviors is critical to mitigating treatment resistance, reducing dropout rates, and preventing relapse (McInally et al., 2021; Peat et al., 2019). Improving TAs

can lead to better client engagement and more successful treatment outcomes (Goldberg et al., 2020; Park et al., 2020).

The findings contribute to the field by providing empirical evidence on effective counseling practices, informing both theory and practice. Specifically, the study advances the SDT framework by demonstrating how fulfilling clients' psychological needs for autonomy, competence, and relatedness through strong TAs can improve treatment outcomes. This empirical support enriches the existing literature on SDT in clinical settings (Deci & Ryan, 2017). The implications of this study benefit both clients and therapists. For clients, enhanced TAs support retention, adherence, and long-term recovery. For therapists, the findings offer practical guidance for developing and sustaining effective therapeutic relationships, promoting more successful treatment protocols (Flückiger et al., 2018; Norcross & Lambert, 2019). Broader societal benefits include reduced economic and social impacts of untreated SUDs. Overall, this study provides actionable recommendations to inform therapeutic practices, improve client outcomes, and advance the field of addiction counseling.

Chapter 2: Literature Review

The problem addressed in this study was a significant gap in the existing research regarding the lack of specificity in therapist actions and behaviors that effectively establish and maintain a TA in SUD treatment. Despite the established importance of TA, the role of the TA in enhancing treatment outcomes for patients with SUDs, there is a void in available literature that identifies specific therapist behaviors that effectively strengthen the alliance in SUD treatment. This study addressed that gap by examining therapist-identified strategies that support engagement, trust, and collaboration in SUD counseling (Falkenström et al., 2014; Farhoudian et al., 2022). This literature review examines existing research on the impact and challenges of TAs in promoting engagement, motivation, and long-term recovery in SUD treatment.

Therapeutic Alliance (TA)

The TA is widely recognized as a critical factor in successful psychotherapy, particularly in the treatment of SUD. Strong TAs lead to better client engagement, lower dropout rates, and improved treatment outcomes (Flückiger et al., 2018; Goldberg et al., 2020). However, clients with SUD often present challenges such as ambivalence, distrust, comorbid psychiatric conditions, and societal stigma, complicating the formation of a strong alliance (Cazalis et al., 2023). Therapists' behaviors, including empathy, active listening, and collaboration, are key to build a supportive environment, especially in the critical initial sessions. Techniques such as MI, CBT, and aligning therapeutic strategies with the client's stage of change strengthen the TA by fostering trust and collaboration (DiClemente, 2018). SDT plays a vital role, emphasizing the need to support client autonomy, competence, and relatedness, which drives intrinsic motivation and long-term recovery (Deci & Ryan, 2017).

Research indicates that a therapist's interpersonal skills are among the strongest predictors of TA effectiveness, especially in challenging situations (Anderson et al., 2009; Schöttke et al., 2017). Barber et al. (1996) and Saraiya et al. (2023) examined therapist competence using expressive techniques and the alliance's role in predicting symptom change in patients receiving supportive-expressive psychotherapy for major depressive disorder. Alliance was measured at Sessions 3 and 6 using a modified Helping Alliance questionnaire. Saraiya et al. (2023) found that TAs improved in skills-based interventions such as relapse prevention for substance abuse. Barber (1995) reported that alliance measured at Session 3 did not significantly predict subsequent symptom trajectory on the Beck Depression Inventory (BDI); however, there was a trend suggesting that alliance at Session 6 could predict symptom improvement (semi-partial $r = -.25$, $p = .10$), with stronger alliances associated with greater reductions in BDI scores. Many studies demonstrating positive outcomes in alliance-based interventions involved highly trained therapists who consistently formed strong alliances with clients (Crits-Christoph & Connolly, 1999).

Steuwe et al. (2023) observed that although dropouts and treatment completers initially reported similar levels of alliance on the Child Session Rating Scale (C-SRS), their scores diverged significantly over time, suggesting that the development and maintenance of a strong alliance is essential throughout the course of treatment. Other tools, such as the Working Alliance Inventory (Hatcher & Gillaspay, 2023) and Vanderbilt Therapeutic Alliance Scale, offer methods for measuring the strength of the TA (Strupp & Anderson, 2022). While these tools measure TA, they do not specifically recommend the therapist behaviors needed to create and maintain this alliance. This study aims to move beyond measurement by identifying concrete

therapist behaviors and interpersonal skills that foster strong TAs, offering actionable insights for clinical practice and professional training in SUD treatment.

Theoretical Framework

SDT provides a comprehensive framework for understanding motivational processes critical for successful SUD treatment. Developed by Deci and Ryan (1985), SDT posits that the satisfaction of three basic psychological needs, autonomy, competence, and relatedness, is essential for fostering intrinsic motivation, engagement, and long-term well-being. In the context of TAs, SDT offers a lens to examine how therapist behaviors can create environments that support these needs, enhancing client motivation, treatment adherence, and outcomes (Herchenroeder et al., 2024).

SDT has been widely applied in healthcare, demonstrating that autonomy-supportive counseling, where clients are given control over treatment decisions, enhances motivation and engagement (Chan et al., 2023; Deci et al., 2015). Providing competence support through positive feedback and recognition further strengthens intrinsic motivation and adherence to treatment protocols (Teixeira et al., 2020). Fostering relatedness between client and therapist builds trust and emotional support, reducing relapse risk and improving treatment outcomes (Vansteenkiste et al., 2020; Abildsnes et al., 2021). In SUD treatment, applying SDT principles to TAs enables therapists to cultivate supportive relational conditions that promote sustained recovery.

SDT can be utilized to explore the role of intrinsic motivation in substance use recovery. In a meta-analysis, Chan et al. (2023) analyzed 66 studies that comprised a total of 72 independent samples with individuals ages 25 to 65, mostly from Western cultures. More than 92% used SDT as a framework, creating more generalizability that validates SDT as a context

within the discipline of addiction counseling. This further indicates that autonomy-supportive counseling, which gives clients control over their treatment choices, significantly enhances motivation and long-term engagement, demonstrating SDT's applicability to SUD treatment.

SDT is a macro-level theory of human motivation that has since evolved into a comprehensive framework that addresses the role of motivation in various behavioral contexts, including health, education, and SUD treatment. In the context of SUD treatment, a TA that supports these needs has been shown to enhance intrinsic motivation, increase client engagement, and improve long-term recovery outcomes (Deci & Ryan, 1985; Vansteenkiste et al., 2020). SDT offers a valuable lens through which to explore the therapist behaviors and strategies that facilitate a strong TA, especially in the critical early sessions where the foundation for treatment success is established.

Recent literature supports the application of SDT in SUD treatment. Chan et al. (2023) emphasize the importance of autonomy support in healthcare settings, linking it to better treatment outcomes and higher patient satisfaction. Deci et al. (2015) provide evidence that autonomy-supportive interventions in therapeutic settings enhance client engagement and adherence to treatment protocols. Teixeira et al. (2020) show that competence support through positive feedback and recognition significantly boosts intrinsic motivation, essential for sustained engagement in health-related behaviors. Vansteenkiste et al. (2020) discuss the broader implications of need satisfaction in promoting well-being and reducing psychological distress, directly relevant to therapeutic processes in SUD treatment. Abildsnes et al. (2021) highlight the importance of integrating SDT into SUD treatment strategies to create supportive environments that enhance clients' psychological needs, thereby improving therapeutic alliances and treatment outcomes.

The application of SDT to addiction treatment, specifically SUDs, is based on the premise that addiction often develops in environments where psychological needs are not adequately supported, leading individuals to seek maladaptive ways to cope (Deci & Ryan, 2012). In this context, SDT provides a framework for understanding how fostering autonomy, competence, and relatedness in therapeutic settings can promote sustained recovery by enhancing intrinsic motivation to change.

Key Concepts and Their Relationships in SDT

The key concepts of autonomy, competence, and relatedness are integral to understanding how SDT fosters a strong TA. Autonomy is crucial in SUD treatment, as clients who feel they have control over their treatment decisions are more likely to engage meaningfully and adhere to therapeutic interventions. An autonomy-supportive environments enhance intrinsic motivation, leading to better treatment outcomes (Deci & Ryan, 1985; Horvath & Symonds, 1991). Competence, which involves the client's belief in their ability to overcome challenges, is bolstered when therapists provide positive feedback and skill-building opportunities. This directly contributes to a more effective TA, as clients feel empowered and capable of managing their recovery (Vansteenkiste et al., 2020). Relatedness, the sense of connection with the therapist, is equally important, as a strong therapeutic bond can reduce feelings of isolation, promote trust, and increase engagement in treatment (Deci & Ryan, 2017). Together, these psychological needs help shape a TA that enhances both client motivation and treatment retention.

The interrelationship between these needs is critical in determining whether motivation will be autonomous (self-determined) or controlled. Studies suggest that when autonomy, competence, and relatedness are nurtured within a treatment setting, individuals experience

greater intrinsic motivation, leading to better treatment outcomes, including reduced substance use, increased treatment retention, and longer periods of sobriety (Best et al., 2020; Deci & Ryan, 2017). This foundational understanding of these psychological needs provides a natural bridge to exploring how SDT can inform and strengthen therapeutic approaches in substance use disorder treatment.

To introduce the role of SDT within SUD treatment, it is essential to understand the significance of the core psychological needs of autonomy, competence, and relatedness. The interrelationship among these needs is foundational in determining whether an individual's motivation will be self-directed (autonomous) or influenced by external pressures (controlled). Research suggests that when treatment environments actively support these needs, individuals experience enhanced intrinsic motivation, with an increased motivation that leads to improved treatment outcomes, including reduced substance use, longer engagement in treatment, and extended periods of sobriety (Blevins et al., 2016; Deci & Ryan, 2017).

Autonomy. Autonomy refers to the degree to which individuals feel in control of their own actions and decisions. In addiction treatment, autonomy-supportive environments allow clients to feel that they are the primary agents of their recovery process, leading to greater engagement and adherence to treatment (Ryan et al., 1995).

Competence. Competence refers to the individual's belief in their ability to successfully overcome challenges. In the context of SUDs, fostering competence through skill-building and self-efficacy interventions is crucial for empowering clients to manage their recovery (Gustafson et al., 2014).

Relatedness. Relatedness involves the sense of connection and belonging to others. For individuals with SUDs, relatedness can be a significant driver of recovery, as supportive

relationships with therapists, peers, and family members provide the emotional foundation necessary for maintaining sobriety (Deci & Ryan, 2008).

Application of SDT to the Present Study

The present study uses SDT as its guiding theoretical framework to explore how the TA can be enhanced in SUD treatment by fostering autonomy, competence, and relatedness. Given the significant role that the TA plays in treatment success, SDT provides a valuable lens through which to examine the behaviors and strategies employed by therapists to meet these core psychological needs (D'Alfonso et al., 2020; Deci & Ryan, 1985). By focusing on how autonomy-supportive environments improve client motivation, this research aims to offer specific, actionable insights into how therapists can strengthen their alliances with clients, ultimately improving treatment engagement and outcomes (Herchenroeder et al., 2024).

In the context of SUD, autonomous motivation (driven by internal values) is particularly important for long-term recovery, as clients who feel a sense of ownership over their treatment are more likely to remain committed to sobriety. For example, studies have shown that clients who experience higher levels of autonomy-support are more likely to engage in self-regulated behavior, which is crucial for sustained recovery (Chan & Ginsburg, 2011). Moreover, competence is fostered when clients receive positive feedback and skill-building opportunities that help them feel capable of managing their addiction. Relatedness is nurtured when clients feel a genuine connection with their therapist, which can mitigate feelings of isolation that often accompany addiction (Herchenroeder et al., 2024).

A growing body of evidence supports the effectiveness of SDT in enhancing treatment engagement and facilitating recovery across various healthcare contexts, including SUD treatment. Teixeira et al. (2022) demonstrate that interventions incorporating positive feedback

and fostering an empathetic therapeutic environment, thereby supporting clients' needs for competence and relatedness, significantly improved engagement and adherence. Likewise, Chan et al. (2023) underscored the critical role of autonomy-supportive counseling in promoting sustained motivation and long-term participation in SUD treatment. Collectively, these studies suggest that SDT-informed therapeutic strategies can guide specific therapist behaviors aimed at strengthening the TA and ultimately improving treatment outcomes among individuals with SUDs. This supports the present study's aim of identifying the specific therapist actions that satisfy these psychological needs during the early stages of the therapeutic relationship, offering practical insight into how SDT-informed behaviors can strengthen alliances and foster sustained client engagement in SUD treatment.

While SDT is widely recognized for enhancing treatment engagement through autonomy-supportive environments, not all studies show unequivocally positive results. For example, some research highlights that under certain conditions, external social and regulatory pressures, such as court-mandated treatment programs, may undermine autonomous motivation, reducing engagement in treatment (Herchenroeder et al., 2024). This is particularly evident in criminal justice settings, where individuals often perceive treatment as coercive rather than self-directed, leading to controlled forms of motivation and lower long-term adherence (Adams & Volkow, 2020). Similarly, Kelly et al. (2017) found that individuals entering treatment due to external pressures, such as family ultimatums or employment threats, exhibited lower intrinsic motivation and higher rates of early dropout compared to those who entered voluntarily. Moreover, Urbanoski (2012) highlighted that perceived coercion in mandated treatment contexts can negatively affect treatment satisfaction and engagement, further suggesting that the success of SDT-based interventions may depend on clients' perceived autonomy and voluntary

participation. These findings collectively underscore the importance of creating autonomy-supportive environments even in mandated or high-pressure contexts to maximize the effectiveness of SUD interventions.

Additionally, the COVID-19 pandemic revealed significant disruptions in access to substance use treatment services, which caused variations in SDT's effectiveness across different populations. In some cases, regulatory changes improved access to medication-assisted treatments (MOUD), but in others, disruptions caused by structural and social changes negatively impacted treatment engagement (Patel et al., 2024). This is one limitation of SDT, that it does not account for social and cultural factors that influence motivation and behavior. In a meta-analysis of SDT-informed interventions led to heterogenous findings. Indicating that the effects of SDT interventions varied across different contexts and groups (Ntoumanis et al., 2021). These nuanced findings suggest that while SDT's principles are broadly effective, its application may require careful consideration of external factors, particularly in high-pressure or low-autonomy environments. These findings collectively underscore that SDT-informed interventions are most effective when clients perceive a meaningful degree of choice and autonomy, and when structural and cultural conditions support, rather than constrain, need satisfaction (Herchenroeder et al., 2024; Wild et al., 2016; Adams & Volkow, 2020; Kelly et al., 2015; Urbanoski, 2012; Patel et al., 2024; Ntoumanis et al., 2021). At the same time, research integrating SDT into SUD treatment has demonstrated that when autonomy, competence, and relatedness are supported, clients show greater engagement, better adherence, and improved long-term outcomes (Ng et al., 2012; Teixeira et al., 2022; Chan et al., 2023; Mills et al., 2021; Vansteenkiste et al., 2023). This balance of evidence highlights both the promise and the contextual limitations of SDT and directly supports this study's integration of SDT into SUD treatment.

Relevance of Self-Determination Theory in SUD Treatment

SDT's emphasis on autonomy, competence, and relatedness aligns with the essential components of a strong therapeutic alliance, particularly in the context of SUD treatment. In addiction counseling, fostering autonomy involves providing clients with a sense of control over their treatment decisions, which can enhance their intrinsic motivation to engage in therapy. Competence is supported when therapists offer positive reinforcement and skill development opportunities, empowering clients to feel capable of overcoming challenges related to their substance use. Finally, relatedness is nurtured through the development of a trusting and empathetic relationship between the therapist and the client, which is critical for promoting a safe and supportive environment for recovery (Deci & Ryan, 1985; Deci et al., 2017). This theoretical emphasis on psychological need fulfillment closely aligns with the current study's goal of understanding how therapists practically implement behaviors that support autonomy, competence, and relatedness. By identifying the specific therapist actions that satisfy these needs, the study seeks to clarify how such behaviors directly contribute to forming and maintaining a strong therapeutic alliance in the context of SUD treatment.

Research has consistently shown a correlation between psychological needs that are met and the likelihood that clients will remain engaged in treatment, experience greater motivation for change, and achieve better long-term recovery outcomes. Ng et al. (2019) found that autonomy-supportive environments significantly enhanced motivation and treatment adherence in addiction therapy. Furthermore, Chan et al. (2020) emphasized the importance of autonomy and relatedness in sustaining client engagement during long-term recovery from substance use disorders. Mills et al. (2021) applied SDT to problem gambling and found that fulfilling clients' psychological needs led to increased motivation for change and improved engagement with

therapeutic interventions. Kennedy and Gregoire (2009) explored the relationship between SDT and the TTM, concluding that higher levels of intrinsic motivation, as described by SDT, were significantly associated with progress to the action and contemplation stages of addiction recovery.

Despite the compelling evidence supporting the role of psychological need fulfillment in promoting engagement and recovery, translating these principles into practice remained a substantial challenge for therapists working with clients who have SUDs. Such clients often present with ambivalence, distrust, and complex interpersonal histories that make it difficult to establish a strong TA early in treatment (Dellazizzo et al., 2023; Hammarberg et al., 2023). Research indicates that many therapists struggle to balance the need for directive interventions with the necessity of fostering an autonomy-supportive, empathic environment, which is essential for enhancing intrinsic motivation (Meier et al., 2020). Additionally, high rates of comorbid psychiatric disorders among individuals with SUDs further complicate the establishment of trust and rapport, increasing the risk of early dropout and treatment resistance (Stewart et al., 2025).

Studies have shown that without a solid TA, clients are more likely to disengage, regardless of the theoretical orientation or evidence-based methods employed (Horvath & Luborsky, 1993; Flückiger et al., 2018). Moreover, therapists often report feelings of frustration and burnout when facing persistent resistance or repeated relapses, which can further hinder the development of a collaborative therapeutic relationship (Landrum et al., 2012). These barriers emphasize the importance of identifying specific therapist behaviors that effectively build and maintain a TA, even under challenging circumstances. Addressing these struggles is critical not only for improving immediate treatment engagement but also for promoting sustained motivation

and long-term recovery. By exploring therapists' perspectives on the behaviors and strategies that foster strong alliances, this study seeks to fill a critical gap in understanding and provide actionable guidance for clinical practice. These findings underscore the relevance of SDT in SUD treatment, particularly in guiding therapists toward behaviors that enhance the TA by fulfilling clients' psychological needs. In turn, this fosters greater client motivation and engagement, ultimately leading to more effective treatment outcomes (Chan et al., 2019; Vansteenkiste et al., 2023).

While SDT is generally effective, some studies emphasize that its success in fostering motivation and engagement is contingent on specific contexts. For instance, in environments where external pressures, such as court-mandated treatment or social stigma, are prominent, the ability to foster autonomous motivation might be compromised. Such situations may lead to controlled motivation, which is less effective in sustaining long-term behavioral change (Chan et al., 2019; Patel et al., 2024). Jochems et al. (2016) found that SDT was stable over time and across different diagnostic groups with severe mental illness (SMI), explaining 18% to 36% of the variance in treatment engagement, psychosocial functioning, and quality of life. These findings suggest that SDT can be a useful basis for interventions in mental health care for outpatients with SMI. To balance the success of SDT with SMI, there are other studies that suggest there were no significant relationships between the subjective measures of motivation and the objective measures of engagement (Best et al., 2020; Thai et al., 2024). Studies that examined the effects of motivation on actual participation in treatment as opposed to just showing up indicated that when clients buy in to the treatment process and participate, their motivation is engaged and higher treatment success is reported (Munson et al., 2022).

These findings support the central premise of this study, that the effectiveness of SUD treatment is closely linked to how therapists engage clients in ways that support their psychological needs. By identifying specific therapist behaviors that align with SDT principles, especially within varied clinical and motivational contexts, this research seeks to uncover how TAs can be strengthened even when external pressures threaten client autonomy. The study's focus on the therapist's perspective offers critical insight into how SDT-informed strategies are applied in real-world settings to foster client engagement and promote sustained recovery. Some studies, such as those by Ng et al. (2019) and Mills et al. (2021), rely on self-reported data, which introduces potential biases and questions the accuracy of the findings.

Additionally, these studies primarily focus on homogeneous populations, limiting the generalizability of the results across diverse cultural or treatment settings. For instance, factors such as external pressures in court-mandated treatment environments can impede the application of SDT's principles, as seen in the findings of Chan et al. (2019). Despite these weaknesses, the consistency in the results across varied contexts strengthens the overall validity of the conclusions. Future research should aim to address these limitations by incorporating more diverse samples and utilizing objective measures of motivation and engagement to complement self-reported data.

Alternatives to SDT and Justification for its Selection

Several alternative frameworks could be applied to SUD treatment, including the TTM (Prochaska & DiClemente, 1982) and CBT models (Wilmots et al., 2020). TTM, for instance, emphasizes stages of readiness to change and has been widely used in addiction treatment. However, while TTM is useful for understanding readiness for change, it lacks the depth of SDT's focus on the underlying psychological needs that drive motivation (DiClemente et al.,

2017). Similarly, CBT models focus on cognitive restructuring and behavioral modification, but do not adequately address the broader motivational dynamics and relational aspects crucial for SUD recovery.

Transtheoretical Model (TTM). Developed by Prochaska and DiClemente (2017), TTM provides a stage-based framework for understanding the process of behavioral change. The model categorizes individuals into five stages: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1982). In the context of SUD treatment, TTM is beneficial because it helps therapists identify where a client is in their readiness to change and tailor interventions to their stage. For instance, a client in the precontemplation stage may benefit from MI techniques, while someone in the action stage might need skill-building to maintain sobriety (Velasquez et al., 2005).

Moreover, TTM is widely used in clinical settings because it offers a structured way to guide clients through their recovery journey. It can help clients make sense of their addiction and set realistic goals based on their stage of readiness. Research has demonstrated the utility of TTM in improving client motivation, particularly through motivational interventions that align with a person's current stage of change (Norcross et al., 2020). This model also emphasizes relapse prevention by helping clients recognize that relapse is part of the cycle of change, allowing for compassionate and non-judgmental treatment approaches (Velasquez et al., 2019).

In the context of SUD treatment, a TA that supports the psychological needs outlined by SDT can be instrumental in helping clients progress through the change stages (Chan et al., 2019; Prochaska & DiClemente, 2013). Dellazizzo et al. (2023) highlight the critical role of the TA in fostering client engagement at various stages of change, particularly in SUD treatment, and confirm that an individualized therapeutic approach is essential for moving clients from

precontemplation to active change. Research by Hammarberg et al. (2023) supports the integration of motivation-focused models, like Stages of Change, with the TA to enhance client motivation and facilitate transitions through the various stages. They found that the alignment of treatment strategies with the client's readiness for change was crucial in achieving positive outcomes in SUD treatment.

For example, in the precontemplation stage, where clients may not yet recognize the need for change, the alliance can foster a nonjudgmental environment that encourages self-reflection and awareness. As clients move to the contemplation and preparation stages and begin to recognize their substance use as problematic and start planning for change, the therapist can support their autonomy by involving them in treatment decisions, thereby enhancing their sense of control over the process. In the action stage, where clients actively modify their behavior, the TA can bolster their competence through positive feedback and skill development, reinforcing their efforts and promoting sustained engagement. Finally, in the maintenance stage, where the focus is on preventing relapse, the sense of relatedness nurtured through a strong, empathetic therapist-client relationship becomes crucial in providing ongoing support and motivation (Ingersoll, 2024; Lev Arey et al., 2022).

However, despite its utility, TTM lacks the emphasis on the psychological needs of autonomy, competence, and relatedness that are central to SDT. While TTM does provide a map for understanding behavioral change, it focuses more on the sequence of change rather than the underlying motivational factors driving the behavior. For example, TTM doesn't address how clients' sense of competence might fluctuate during recovery or how their connections with others (relatedness) impact their progress (Ryan & Deci, 2017). In contrast, SDT offers a more comprehensive understanding of the motivational processes behind these stages, particularly in

how autonomy-supportive environments and competence-building strategies can help clients sustain motivation through all stages of change (Vansteenkiste et al., 2020).

TTM also tends to treat relapse as a somewhat inevitable part of the change process, which can sometimes lead to lower expectations for treatment success (Prochaska et al., 2018). SDT, on the other hand, emphasizes sustained intrinsic motivation, which can help mitigate relapse by enhancing a client's sense of autonomy and competence throughout the treatment process (Chan et al., 2023). While TTM provides a valuable framework for understanding behavioral change, SDT's ability to address the deeper psychological needs that foster long-term engagement makes it a more suitable choice for examining therapeutic alliances in SUD treatment.

Cognitive Behavioral Therapy (CBT). CBT is one of the most extensively researched models for treating SUD. It focuses on identifying and modifying maladaptive thought patterns and behaviors associated with substance use. It is effective in helping clients develop coping strategies, recognize triggers, and restructure their thinking to avoid relapse (Magill et al., 2019). The strengths of CBT lie in its structured, goal-oriented nature, which can offer clients immediate tools to manage cravings and avoid high-risk situations (Wilkinson et al., 2021). CBT also incorporates behavioral strategies like reinforcement and self-monitoring, which have been shown to be effective in reducing substance use and improving treatment retention (Lee et al., 2020).

CBT's practical focus makes it particularly useful for individuals who need immediate, actionable strategies for managing their addiction. It has a robust evidence base showing that cognitive restructuring and behavioral interventions can lead to significant reductions in substance use (Magill et al., 2019). Additionally, CBT is effective across various forms of

substance use, making it versatile in clinical settings (Wilkinson et al., 2021). For clients struggling with cognitive distortions, such as all-or-nothing thinking or catastrophizing, CBT offers a powerful tool to challenge these thought patterns and replace them with more adaptive cognitions (Magill et al., 2019).

Despite its strengths, CBT does not focus as much on the relational and motivational dynamics critical for long-term engagement in treatment, particularly in the context of SUDs. While CBT emphasizes cognitive restructuring, it lacks SDT's emphasis on the psychological needs that drive sustained motivation, especially autonomy and relatedness. For example, CBT often operates in a more directive manner, where therapists provide structured guidance to clients, which can sometimes undermine a client's sense of autonomy if not handled carefully (Ng et al., 2019). SDT, on the other hand, emphasizes autonomy-supportive environments where clients are encouraged to take an active role in their treatment decisions, enhancing their intrinsic motivation to engage in and sustain the recovery process (Ryan & Deci, 2017). By fostering a strong therapist-client relationship that supports relatedness, SDT helps ensure that clients feel emotionally supported throughout their recovery, which has been shown to improve treatment outcomes (Chan et al., 2023).

Therefore, while CBT provides valuable tools for managing addiction, SDT offers a more comprehensive framework that integrates relational, environmental, and motivational factors, making it a better choice for exploring therapeutic alliances in SUD treatment. SDT was chosen for this study because it provides a more holistic approach to understanding motivation, emphasizing not only the cognitive processes involved in behavior change but also the relational and environmental factors that support intrinsic motivation. By highlighting the importance of autonomy, competence, and relatedness, SDT offers a more comprehensive framework for

understanding how therapeutic relationships can foster long-term recovery, making it a better fit for the present study's focus on the therapeutic alliance.

The research on TTM and CBT highlights key strengths and weaknesses in their application to SUD treatment. TTM's strength lies in its structured, stage-based framework, which helps both therapists and clients navigate the recovery process by identifying readiness to change and tailoring interventions accordingly (Prochaska & DiClemente, 2013). In the Prochaska and DiClemente research (2013) on tobacco use, participants were chosen randomly and assigned to groups based on their current stage of change, which clearly represented the clients; the further along participants were in the stages of change, more were able to quit smoking. The study demonstrated that the more action that was taken (moving further along in the stages of change), the more effective therapy was and more patients saw longer cessation in smoking than in earlier stages of change groups.

Studies have shown that TTM can be effective in improving client motivation and setting realistic goals, particularly when interventions like MI are aligned with the client's stage of change (Norcross et al., 2020). However, a significant weakness of TTM is its limited focus on the deeper psychological processes that drive motivation, such as autonomy, competence, and relatedness, which are central to long-term recovery (Ryan & Deci, 2017). The model's emphasis on relapse as an expected part of the change process can sometimes diminish expectations for sustained success (Prochaska et al., 2018).

Similarly, CBT's strength is its focus on cognitive restructuring and behavioral strategies, which are highly effective in helping clients identify and modify maladaptive thought patterns and behaviors. Wilmots et al. (2020) investigated adolescent experiences of the therapeutic relationship within the context of successful CBT for moderate to severe depression. Employing

IPA, the research draws on a subset of interviews from a randomized clinical trial with 77 participants. Using randomized participants from the community allows this study to better represent adolescents usually encountered there; however, only five interviews were purposively sampled and analysed using IPA. The benefits of it being a randomized trial may be surpassed by its small sample size (15), which can affect its applicability to the greater population, limiting the generalizability of the findings. The findings underscore the significance of a therapeutic relationship characterized by respect for autonomy, individuality, and an emotional connection, with therapists balancing friendliness with professionalism to successfully achieve an egalitarian, collaborative dynamic. This approach facilitated adolescents' engagement in CBT's cognitively and emotionally demanding tasks. Ultimately, the study offers insights into fostering effective therapeutic relationships in CBT, supporting adolescents' treatment adherence and improving therapeutic outcomes.

CBT has been extensively researched and has shown positive outcomes across various forms of addiction treatment (Lee et al., 2020). However, like TTM, CBT does not sufficiently address the relational and motivational dynamics critical for long-term engagement, particularly the need for autonomy and relatedness, which are emphasized by SDT (Deci & Ryan, 2017). Moreover, while CBT is effective for some, it may be less helpful for individuals in severe distress, as it requires logical and rational thinking, which can be challenging for people in heightened emotional states. Unlike approaches that prioritize relational and motivational dynamics, CBT's directive nature may hinder the sense of autonomy essential for fostering intrinsic motivation in SUD recovery (Ng et al., 2019). SDT highlights the importance of addressing basic psychological needs, such as autonomy and relatedness, in sustaining long-term treatment engagement (Deci & Ryan, 2017). Herchenroeder et al. (2024) reviewed SDT's

application in SUD treatment and suggested that traditional methods like CBT may not fully meet these needs, particularly for individuals struggling to engage with its cognitive demands, emphasizing that integrating SDT principles can enhance motivation and support recovery by addressing emotional and relational needs overlooked in standard CBT. Notably, limitations in the study's diversity and heterogeneity across study designs indicate a need for more standardized approaches in assessing these findings across populations.

Additionally, a meta-analysis by Ray et al. (2020) examined the efficacy of CBT for alcohol and other drug use disorders in combination with psychopharmacological interventions. While CBT demonstrated effectiveness, the analysis noted that its directive nature might not sufficiently support clients' autonomy, potentially impacting sustained engagement when done alone. The authors suggest that incorporating autonomy-supportive elements, as proposed by SDT and pharmacological treatment, could address this limitation and foster better long-term outcomes.

Overall, while both TTM and CBT offer valuable frameworks for understanding and addressing SUD, their limitations in addressing the deeper psychological needs of clients highlight the importance of integrating models like SDT, which provides a more comprehensive approach to fostering long-term motivation and recovery. The evidence supports the premise that the TA is not merely a supportive feature of treatment but a central mechanism through which change occurs. Therapists who skillfully build trust, foster collaboration, and align with client goals are more likely to maintain engagement and reduce dropout rates. For individuals with SUD, who often present with ambivalence and complex interpersonal histories, this alliance becomes even more critical. Therefore, identifying the therapist behaviors that contribute to

strong alliances is essential for improving treatment adherence and recovery outcomes in SUD contexts.

Importance of the Therapeutic Alliance in Psychotherapy

The TA serves as a foundational component in the success of psychotherapy, especially within the context of SUD treatment. Research consistently highlights TA as a predictor of positive treatment outcomes, patient engagement, and long-term adherence across various therapeutic modalities (Dellazizzo et al., 2023; Flückiger et al., 2018; Goldberg et al., 2020). A strong TA fosters an environment of trust, empathy, and collaboration, enabling clients to feel safe, valued, and understood (Bordin, 1979; Hatcher & Gillaspay, 2006; Rogers, 1951). For clients struggling with addiction, this alliance is particularly critical, as it provides a stable relational foundation that supports their motivation to engage actively in the treatment process. While TA is universally recognized as vital in therapeutic settings, its role in SUD treatment encounters unique challenges due to the complex and often co-occurring psychological issues in this population. This section delves into the historical evolution of TA in psychotherapy, examining the theoretical foundations that underscore its importance and its application across diverse therapeutic approaches.

Historical Context and Foundations

Freud (1913) introduced the idea of the therapeutic relationship as an essential part of psychoanalysis, primarily through the concept of transference. In Freud's model, the therapeutic relationship enabled clients to project feelings and attitudes from past relationships onto the therapist, enabling unconscious patterns to surface within a safe, structured environment. This relationship was considered foundational, as it allowed for deep exploration of the psyche and promoted healing by bringing these projections into awareness (Claney, 2024). While Freud's

approach emphasized the analytical role of the therapist as a somewhat detached observer, the relationship's therapeutic importance was nevertheless central. Freud believed that through the bond established between therapist and client (therapist-centered), patients could confront and work through unresolved conflicts, leading to lasting change (Ikmen & Halfon, 2022). This foundational emphasis on the therapeutic relationship, introduced by Freud and further refined over time, underscores the importance of exploring specific therapist behaviors that cultivate strong alliances, a central aim of this study in understanding how such behaviors support client motivation and engagement within substance use disorder treatment.

Rogers (1951) further revolutionized the therapeutic relationship by shifting from a therapist-centered to a client-centered approach. He emphasized the need for empathy, unconditional positive regard, and congruence (authenticity) from the therapist. These qualities fostered an environment where clients felt deeply understood and accepted, which Rogers believed was critical for personal growth and self-actualization. He identified empathy and the therapist's genuine, compassionate presence in creating therapeutic bonds that become healing forces in their own right, beyond the interpretative methods of Freud (Rogers, 1951). These foundational ideas laid the groundwork for TA, now recognized as a key factor across nearly all forms of therapy. The TA emphasizes collaboration, trust, and a shared commitment to the therapeutic goals, underscoring that a strong, empathetic, and supportive bond between therapist and client is often predictive of therapeutic success, regardless of the specific modality employed.

Bordin's model (1979) of the TA was also transformative in psychotherapy, emphasizing that TA is essential across all therapeutic modalities and not bound to any specific technique. He argued that a strong TA hinges on three core elements: agreement on goals, agreement on tasks,

and the emotional bond between therapist and client. Agreement on goals involves a shared understanding and alignment regarding the therapy's objectives, ensuring that both therapist and client are working toward outcomes that are meaningful and relevant to the client's needs. Agreement on tasks includes mutual commitment to the steps necessary to achieve these goals, such as specific interventions or therapeutic exercises. Finally, the bond refers to the empathetic, trust-based connection between therapist and client, creating a supportive environment where clients feel understood and safe to explore personal issues (Bordin, 1979). Bordin's work shifted focus from techniques to relational dynamics, demonstrating that a solid therapeutic relationship, built on these elements, is universally applicable and essential for effective therapy. His model underscored that TA is not technique-specific but a vital, adaptable component of any therapeutic approach, which remains a foundational concept in psychotherapy research and practice (Maisto et al., 2020).

Together, Rogers' (1951) emphasis on empathy, authenticity, and unconditional positive regard, and Bordin's (1979) tripartite model of goals, tasks, and bond, offers a strong conceptual foundation for understanding the TA. In this current study, these contributions serve as guiding frameworks for identifying the interpersonal qualities and strategic behaviors that counselors employ to build strong alliances, particularly in early sessions of substance use disorder treatment. The interview questions are shaped by these theoretical underpinnings, exploring how therapists foster trust (Rogers), negotiate shared goals and tasks (Bordin), and adapt their relational stance to meet client needs in challenging contexts. By grounding an inquiry in both relational and structural elements of the alliance, the dissertation study aims to generate nuanced insights into the therapist's actions that most effectively support client engagement and long-term recovery.

Contemporary Research on TA

Flückiger et al. (2018) conducted a comprehensive meta-analysis on the therapeutic alliance's impact on treatment outcomes, synthesizing data from 306 studies with 295 independent samples and approximately 30,000 clients. The analysis reveals an overall weighted average effect size of ($r = .278$), indicating that the alliance accounts for about 8% of variance in treatment outcomes, a stable finding that aligns with previous meta-analyses over time despite methodological advancements and the diversity of therapy contexts. Notably, alliance assessments taken later in therapy (closer to the end) correlated more strongly with outcomes ($r = .30$) than early assessments ($r = .22$), suggesting the alliance's predictive strength increases toward therapy's conclusion.

The meta-analysis examined 35 outcome measures, with variances across them, such as the Beck Depression Inventory's adjusted ($r = .28$) and a lower ($r = .17$) correlation for risk behavior outcomes, mainly in SUD studies. The alliance-outcome correlation also varied by client diagnosis; SUD samples had one of the lowest correlations ($r = .14$), whereas diagnoses like borderline personality disorder showed higher correlations (up to $r = .32$), indicating the alliance's impact may differ by diagnostic group. The analysis incorporated 39 alliance measures, with the Working Alliance Inventory (WAI) used most frequently, showing an average correlation of ($r = .24$) across 150 studies. Client-rated alliances ($r = .25$) predicted outcomes slightly more strongly than observer ratings ($r = .22$) (Prusiński, 2022). Moderator analyses revealed that factors like study design, treatment type, diagnosis, and publication year influenced the alliance-outcome relationship, with CBT showing an adjusted correlation ($r = .20$) while interpersonal therapy (IPT) had a higher correlation ($r = .28$). These findings underscore the

TA's robust, stable impact across adult psychotherapy contexts, with variations tied to specific client populations, assessment timing, and methodological factors.

Regardless of the treatment modality or specific issues being addressed, stronger TAs are consistently linked to positive outcomes across age groups (Duncan et al., 2010; Wampold, 2015). A recent meta-analysis by Karver et al. (2018), involving 2,149 participants in child and adolescent therapy, confirmed this with a positive and significant association between TA and treatment outcomes ($r = .19$, $d = 0.39$). Researchers found that their studies aligned with the broader adult literature ($r = .21$ to $r = .28$) (Flückiger et al., 2018; Horvath & Symonds, 1991a; Martin et al., 2000) and previous meta-analyses in child and adolescent studies (Shirk & Karver, 2003; Shirk et al., 2011). The impact of a strong TA extends to treatment retention and client engagement (Campbell et al., 2015). For instance, research by O'Keeffe et al. (2020) showed that lower prioritization of TA can lead to increased dropout rates in adolescent therapy. Given the established link between higher retention and engagement levels and successful outcomes (Shirk & Karver, 2003), TA plays a crucial role in achieving effective and sustained therapy outcomes.

These findings underscore that while the specific treatment modality may differ, the strength of the TA consistently predicts positive client outcomes across a range of approaches (Flückiger et al., 2018; Norcross & Lambert, 2019). This suggests that the interpersonal dynamics between therapist and client, particularly the quality of their collaboration and bond, may be more influential than the chosen intervention model itself (Wampold & Imel, 2015). As such, understanding how therapists foster a strong alliance becomes essential for improving engagement and long-term success, particularly in substance use treatment where dropout rates remain high. Building on this foundation, Swift and Callahan's research (2010) further

illuminates the critical role of the TA by examining its predictive value in early treatment termination and client satisfaction.

The findings from Swift and Callahan's (2010) study on client preferences and the Falkenström et al. (2014) research on working alliance outcomes complement each other by reinforcing the critical role of both client preferences and the TA in treatment success. The author used a large dataset from a primary care psychotherapy practice to study the relationships between alliance and outcome using piecewise multilevel path analysis. The root mean square error of approximation (RMSEA) was 0.00 and the *P*-value for test of close fit ($RMSEA < 0.05$) was 1.00, indicating a strong positive relationship between the independent variables related to the individual participant (Jak et al., 2021). Swift and Callahan (2010) investigated client preferences (66 clients ranging from ages 18 to 65) for therapy variables, finding a willingness to sacrifice some empirical support in favor of key relational factors, such as a strong therapeutic bond, therapist empathy, and the opportunity for more active participation in sessions. It should be noted that only 49% were more concerned that the therapist was empathetic and accepting as opposed to 38% who favored TA as the most important factor in therapy. These results should be accepted cautiously as the participants in this study were from a university and may not be generalizable to the wider public. Furthermore, one comes away with the idea that in some cases clients seek out the process rather than the therapeutic outcomes. Thus, the authors concluded that tailoring therapy to incorporate client preferences for these relational elements could lead to improved engagement and reduced dropout rates, highlighting that clients highly value the quality of the therapeutic relationship (Swift & Callahan, 2010).

Falkenström et al. (2014) similarly focused on the TA, specifically testing its impact on therapy outcomes while accounting for prior symptom improvement. Their study demonstrated

that a robust working alliance predicted further symptom reduction, even when controlling for initial symptom levels and early improvement. This suggests that alliance strength influences outcomes beyond any early symptom changes, which was particularly true for patients with personality issues, who showed even stronger positive outcomes when the alliance was strengthened. Both studies emphasize Bordin's model (1979), aligning on the importance of the alliance components: bond, task, and goal agreement (Falkenström et al., 2014). Together, they underscore that prioritizing a strong, personalized TA, aligned with client preferences, enhances therapy outcomes and patient engagement across various psychological contexts.

These findings highlight the essential role of client preferences and the strength of the TA in promoting positive therapy outcomes and sustained engagement. Both Swift and Callahan's (2010) emphasis on tailoring therapy to relational preferences and Falckenström et al.'s (2014) evidence of alliance-driven symptom reduction reinforce the significance of cultivating a personalized, collaborative, and empathetic therapeutic environment. These insights directly inform the present study's research questions, which aim to explore therapists' perceptions of the specific behaviors and strategies that foster strong TA during initial sessions and throughout treatment with clients facing substance use disorders. By examining how therapists intentionally build and maintain these alliances, particularly in contexts where client motivation and engagement are fragile, this study seeks to address critical gaps identified in the literature and to provide actionable guidance for enhancing treatment effectiveness.

The question at this point is while there is the aforementioned research signifying that goals, bonds, and tasks must be agreed upon to build a therapeutic relationship, how important is the actual connection? Therapists are encouraged to establish rapport with their clients and show support by highlighting their capability to find answers and strengths, but also cooperate as a

team in working towards mutual goals and tasks of treatment (Leibovich et al., 2020; Ortega & María, 2023; Strappini et al., 2022; van Herwaarden et al., 2022). Identifying the client's main concern and understanding it from the client's perspective enhances the bond between the therapist and client (Leibovich et al., 2020). These studies confirm these ideas clearly and set for the therapist a daunting goal of establishing this rapport and doing so quickly so that the client engages and stays in treatment (van Benthem et al., 2020).

It is important to note that these studies provide valuable insights into the relationship between TA and treatment outcomes across various therapeutic approaches and conditions, and contain both positive and negative factors in their findings. In their initial study, (Leibovich et al., 2020) emphasize that supportive techniques can enhance the TA within the same session, which is significantly associated with symptom reduction in patients with major depressive disorder (MDD). The authors posit that the TA mediates the impact of supportive techniques on symptom improvement, although the study focuses on a single session and the high prevalence of personality disorders among participants limits generalizability. The ongoing nature of the randomized controlled trial (RCT) also precludes a complete analysis of treatment assignment as a control variable, and the study's exclusive focus on interpersonal mechanisms underscores a gap in understanding the role of intrapersonal factors. These limitations foster a need for further investigation into how therapists perceive and apply specific alliance-building strategies in real-world clinical contexts. By focusing on the lived experiences of therapists working with clients with substance use disorders, this study aims to identify concrete, effective behaviors that strengthen the TA from the outset. In doing so, it seeks to bridge the gap between theoretical understanding and practical application, ultimately guiding clinicians in fostering greater client engagement and improving long-term treatment outcomes.

In contrast, the systematic review and meta-analysis by Strappini et al. (2022) examine the TA in the context of CBT for patients with obsessive-compulsive disorder (OCD). Findings reveal a modest effect size for the alliance's impact on post-treatment outcomes, especially in relation to task and goal alignment rather than the therapeutic bond. The review highlights significant variability in alliance measurement and outcome reporting, underscoring a need for refined studies with larger sample sizes and temporal alliance assessments. Similarly, a broader systematic review reiterates the importance of goal alignment within the alliance and reports a modest correlation between TA and outcomes across various disorders and treatments. However, methodological inconsistencies across studies, such as timing of alliance measurement and potential ceiling effects from high alliance scores, present challenges in interpreting the alliance's precise role in treatment efficacy (Strappini et al., 2022).

TA is widely recognized as a critical factor in successful therapy across various populations, with significant implications for both psychological well-being and clinical outcomes. Prusinski (2022) explored the relationship between TA and well-being, life satisfaction, and flourishing in individual psychotherapy, emphasizing that TA's multidimensional nature (agreement on goals, assigned tasks, and therapeutic bonds) fosters trust, adherence to treatment, and improved client functioning. The study found that TA had a low but positive correlation with psychological well-being, with eudaimonic well-being (e.g., autonomy, relationship-building, and life purpose) being more profoundly impacted than mere symptom relief. However, it highlighted the limited empirical focus on how TA contributes to long-term flourishing and the challenges of relying on subjective patient-therapist evaluations. In contrast, Howard et al. (2021) conducted a systematic review and meta-analysis of TA in psychological therapy for PTSD, revealing that TA consistently predicts PTSD outcomes ($r =$

0.34) across both in-person and remote therapies, with attachment patterns, coping styles, and psychophysiological variables serving as predictors. Despite PTSD-related challenges, such as avoidance, mistrust, and disrupted social bonds, the study found that clients can form strong alliances, and trauma-focused therapies often result in stronger TA when conducted with therapist competency. Both studies affirm that TA is a universal predictor of therapy success, yet they diverge in their focus: Prusinski (2022) centers on TA's broader implications for flourishing and life satisfaction, while Howard et al. (2022) examine its role in PTSD-specific contexts. These findings align with current research on TA as a robust determinant of therapy outcomes but extend the discussion by addressing unique variables, such as predictors in PTSD populations and TA's impact on long-term well-being. Future research should integrate these perspectives, exploring the mechanisms underlying TA's effectiveness, the role of individual client and therapist factors, and the development of tailored strategies to foster strong alliances across diverse therapeutic contexts (Howard et al., 2022; Prusinski, 2022).

Building on these insights, it becomes clear that translating SDT principles into practice requires therapists to embody specific relational qualities and interpersonal skills that go beyond standard interventions. In SUD treatment, where clients frequently present with ambivalence, distrust, and complex psychosocial histories, the ability to create and sustain a strong therapeutic alliance is especially critical (Flückiger et al., 2018; Meier et al., 2020). Essential therapist qualities include empathy, authenticity, flexibility, and cultural humility, which together support the psychological needs of autonomy, competence, and relatedness central to SDT (Hammarberg et al., 2023; Deci & Ryan, 2017). Research suggests that therapists who adaptively balance structure and autonomy support are more effective at engaging resistant clients and reducing dropout rates (Dellazizzo et al., 2023; Stewart et al., 2022). Additionally, fostering an

environment of mutual respect and shared decision-making not only strengthens the alliance but also enhances clients' sense of ownership over their recovery journey (Norcross & Lambert, 2018). The integration of these qualities into clinical practice aligns with the goals of this study, which aims to identify and describe the specific therapist behaviors that facilitate robust alliances in challenging SUD treatment contexts. By elucidating these interpersonal dynamics, this research contributes actionable guidance for training and practice, ultimately improving engagement, motivation, and long-term recovery outcomes for individuals with SUDs.

Evidence from recent meta-analyses (Wampold & Flückiger, 2023) underscores that a well-established alliance significantly correlates with positive treatment outcomes, accounting for approximately 8% of the variance in outcomes across diverse therapeutic modalities. The findings highlight that therapist factors, such as empathy, emotional expression, and the ability to repair alliance ruptures, play a vital role in alliance formation, often outweighing patient characteristics. Clinical applications extend to non-traditional formats like internet-based therapies, where the alliance, measured even in minimal clinician interactions, continues to impact outcomes, supporting the model's adaptability across various therapeutic approaches and settings.

The authors explore the TA in medical practice, emphasizing the importance of two main dimensions: the emotional component (warmth, caring, trust, and understanding) and the cognitive component (competence and information conveyance). Using a meta-analysis methodology, the study synthesizes data from existing research to assess the relationship between the TA and treatment outcomes. It examines correlations between alliance ratings and outcomes, considers how outcome ratings may vary depending on the rater, and identifies validity threats within the reviewed studies' designs. Key findings reveal a significant positive

correlation between a strong TA and enhanced treatment outcomes, with both emotional and cognitive alliance components contributing to patient satisfaction and treatment efficacy across various populations, including adults, children, and couples. However, several methodological limitations were identified: variability in study designs, challenges in measuring the alliance's emotional and cognitive aspects, the complexity of research design for comprehensive alliance studies, and potential rating biases based on the perspective of the rater (clinician or patient). These findings underscore the TA's critical role in effective treatment and highlight the need for future studies to clarify its dimensions and specific impacts on outcomes. (Wampold & Flückiger, 2023).

Establishing an impactful TA typically unfolds in two phases: initial rapport-building in the early sessions, followed by gentle challenges to maladaptive patterns, which may lead to temporary relational ruptures. Essential therapist qualities like genuineness, empathy, warmth, and non-judgmental regard, rooted in Rogerian principles, are pivotal for trust and connection (Rogers, 1951). A positive alliance is further marked by mutual respect, agreement on therapy goals, and collaborative decision-making, essential for navigating emotional challenges and deepening the therapeutic bond, thus enhancing treatment outcomes (Fjermestad et al., 2021). These qualities and processes directly relate to this study's aim of identifying the concrete therapist behaviors and interpersonal skills that foster and sustain strong alliances, especially within substance use disorder treatment contexts. By exploring therapists' perceptions of how they employ qualities such as active listening, adaptive communication, and responsive attunement, this research seeks to clarify which specific actions most effectively build trust and engagement early on and maintain the alliance through the often turbulent process of behavioral change. In doing so, the study addresses the research questions by detailing not just the

importance of the alliance, but precisely how it can be constructed and reinforced in practice to support long-term recovery.

Contemporary research on the TA emphasizes its critical impact on treatment outcomes across various therapeutic contexts. Studies have consistently demonstrated that TA characterized by trust, mutual respect, and alignment on treatment goals is associated with improved client engagement, retention, and overall effectiveness of treatment (Flückiger et al., 2018; Horvath et al., 2011; Norcross & Lambert, 2019; Wampold & Flückiger, 2023). A meta-analysis by Flückiger et al. (2018), which synthesized data from over 300 studies involving nearly 30,000 clients, revealed that TA accounts for about 8% of the variance in treatment outcomes, underscoring its stable and significant effect on therapeutic success. The predictive power of TA increases toward the end of therapy, suggesting that a well-maintained alliance supports enduring treatment benefits (Zilcha-Mano, 2017).

This research also highlights variability in TA's influence based on client diagnoses, with higher correlations observed in cases of borderline personality disorder than in SUD treatments. The TA has demonstrated specific challenges and importance within SUD contexts, where early-session alliance-building is essential due to frequent client ambivalence and resistance. Measurements like the Working Alliance Inventory (WAI) are instrumental in evaluating the TA's strength, and recent findings suggest that client-rated alliances often correlate more strongly with outcomes than therapist-rated or observer-rated alliances (Del Re et al., 2021; Horvath et al., 2011; Seebacher et al., 2024).

Divergence in the Studies on the Therapeutic Alliance

Significant divergences arise among studies regarding TA's impact, consistency across populations, and application in SUD treatment. These divergences highlight varying perspectives

on TA's strength as a predictor of positive outcomes, its applicability across diverse client populations, and its relative weight compared to other therapeutic factors. One primary area of divergence lies in the variability of TA's impact across different therapeutic modalities. For example, Flückiger et al. (2018) demonstrated a consistent, moderate correlation between TA and positive outcomes across a broad sample of psychotherapies, yet noted lower correlations within SUD treatment studies compared to treatments for personality disorders or mood disorders. This suggests that although TA is influential, its relative impact might be less pronounced for SUD clients. Certain studies, particularly those focused on SUD, propose that TA may be challenging to establish and maintain with clients experiencing high levels of resistance, ambivalence, or psychological comorbidities, which are more prevalent in SUD populations. By contrast, studies in other therapeutic domains often reported stronger TA-outcome correlations, especially where clients may be more readily engaged or less ambivalent (Del Re et al., 2021; Saraiya et al., 2023; Wampold & Flückiger, 2023).

Additionally, divergences exist in TA research due to methodological differences and varied assessment timing. Some studies assess TA at early stages of treatment, while others examine its impact across multiple sessions or after treatment concludes (Graves et al., 2017; Horvath et al., 2011). Early-stage assessments often show weaker predictive outcomes than assessments conducted later, which can complicate generalizations. Flückiger et al. (2018) highlight that later TA assessments yield a stronger impact on outcomes, as clients may require time to form and stabilize the alliance, especially in SUD settings where clients may initially struggle with trust and engagement. Studies that rely heavily on early TA assessments may thus diverge in their conclusions, potentially underestimating TA's importance in populations requiring more time to build therapeutic trust (Manjula & Antony, 2024).

Furthermore, there is disagreement in how different studies account for client characteristics, such as demographic variability and severity of co-occurring conditions. While certain meta-analyses include diverse samples and recognize that client demographics influence TA outcomes, others, particularly smaller-scale studies, may use homogeneous samples, limiting their generalizability across broader populations. In SUD contexts, studies frequently note that the TA may be hindered by co-occurring psychiatric conditions like anxiety and depression, which may create a different relational dynamic than in therapy settings without these additional complexities (Steuwe et al., 2023). Divergent results often stem from differing sample compositions and levels of psychological comorbidity, suggesting that TA findings might not transfer seamlessly across client populations.

These divergent results underscore the necessity of exploring therapist perspectives within the specific context of SUD treatment, where high rates of psychiatric comorbidity and diverse client backgrounds are common. By focusing on therapists' firsthand experiences, this study seeks to illuminate which concrete behaviors and strategies are most effective in fostering a strong therapeutic alliance despite these complexities. In doing so, it addresses the variability seen in prior research and strengthens the relevance and applicability of the findings to real-world SUD treatment settings.

Finally, departure arises around the underlying mechanisms driving TA's influence on outcomes. Some researchers argue that TA functions primarily as a relational framework that facilitates client engagement and motivates active participation (Norcross & Lambert, 2018). In contrast, others, particularly those in CBT contexts, suggest that TA's role is secondary to specific therapeutic techniques, especially in structured approaches like CBT, where TA may not be as actively fostered (Webb et al., 2010). This debate highlights contrasting views on TA's

function, whether it is the foundation of therapeutic effectiveness or simply one of many contributing factors.

The Therapeutic Alliance in SUD Treatment

The TA is essential in the treatment of SUD, where it has been shown to improve patient engagement, retention, and outcomes. Numerous studies indicate that TA's strength significantly impacts treatment efficacy, with a good alliance correlating with lower dropout rates and greater adherence to treatment (Dellazizzo et al., 2023; Hammarberg et al., 2023). Establishing a strong TA is especially crucial in the initial stages of treatment, as it lays the groundwork for sustained therapeutic engagement. For instance, clients who feel a strong bond with their therapist from the outset are more likely to commit to the often challenging journey of SUD recovery (Norcross & Lambert, 2018). Given the high rates of relapse and dropout in SUD treatment, a strong TA serves as a crucial foundation for promoting sustained engagement and long-term recovery. However, despite its recognized importance, there remains a lack of detailed understanding regarding the specific therapist behaviors and interpersonal skills necessary to build and maintain this alliance effectively with clients facing substance use challenges. By investigating therapists' perspectives on the concrete actions that strengthen the therapeutic alliance, this study aims to provide actionable insights that can guide clinicians in enhancing client motivation, adherence, and overall treatment outcomes in SUD contexts (Rübig et al., 2021).

In a study, von Grieff and Skogens (2019) examined TA in group settings for SUD treatment, emphasizing the cohesion among group members and between members and staff. Findings reveal that group cohesion, particularly when rooted in shared experiences, such as substance use, bolsters trust and engagement. Both clients and staff highlight the importance of a supportive environment for fostering positive change. While client recognition of shared

experiences strengthens bonds, staff often link cohesion to external factors like gender, potentially introducing challenges if this social homogeneity impedes broader therapeutic change. Trust, collaboration, and acceptance were vital for a positive alliance, supporting sustained engagement and fostering commitment in group-based interventions.

The von Greiff and Skogens (2019) study used a qualitative methodology centered on in-depth interviews with 81 clients and 18 treatment staff members to explore factors perceived as critical for initiating and sustaining change in treatment settings. Participant selection included male and female clients who had undergone treatment, with data collected between 2011 and 2014, focusing on aftercare experiences. Each interview lasted around 30 minutes and was guided by broad themes to capture insights on internal, social, and treatment-related factors. Qualitative analysis, supported by Nvivo software, involved categorizing and validating client responses, identifying common themes such as Treatment Group, Treatment Staff, Alcoholics Anonymous (AA), individual emotional factors, and aftercare, among others. Treatment staff interviews, unsegmented by client demographics, provided additional perspectives based on general professional experiences. Audio recordings were transcribed and cross-validated between two authors to maintain data integrity. However, several limitations could impact the study's findings. The small size of marginalized groups, particularly women, limited comparative analyses, and the homogeneity of certain groups complicated drawing broad conclusions. Relying on self-reported data introduced potential bias, as responses could be shaped by individual perceptions. Additionally, data collection over multiple years may have introduced variability in treatment practices and societal factors, affecting consistency in responses. The decision not to segment staff interviews by client demographics reduced insights specific to particular populations, potentially limiting the generalizability of findings. These constraints,

while not undermining the study's qualitative rigor, suggest caution in interpreting the results as universally applicable across diverse treatment settings and demographics (von Greiff & Skogens, 2019).

These insights highlight the pivotal role of trust, shared experiences, and group cohesion in supporting engagement and fostering sustained change within group SUD treatment contexts. However, translating these dynamics into individual therapeutic settings requires a more nuanced understanding of the specific therapist behaviors and interpersonal skills that cultivate similar levels of alliance and commitment. In one-on-one SUD treatment, the absence of peer-based cohesion demands that therapists intentionally create an environment of safety, authenticity, and mutual respect to replicate these benefits (Meier et al., 2020; Norcross & Lambert, 2018). Moreover, individual sessions require therapists to be highly adaptive, balancing directive interventions with an autonomy-supportive approach to address client ambivalence and resistance effectively (Dellazizzo et al., 2023; Deci & Ryan, 2017).

The complexity of working with clients who often present with co-occurring psychiatric conditions and histories of relational trauma further underscores the need for therapists to demonstrate advanced relational attunement and emotional flexibility (Flückiger et al., 2018; Stewart et al., 2022). Future research should explore how these relational qualities manifest in concrete, observable therapist behaviors that build and sustain the therapeutic alliance over time. By identifying these behaviors, clinicians can receive more targeted training to strengthen their capacity for alliance-building, ultimately improving client retention and treatment outcomes (Hammarberg et al., 2023; Horvath & Luborsky, 1993). This study seeks to address these gaps by examining therapists' lived experiences and perspectives on the strategies and skills that

foster robust alliances, particularly during the early stages of treatment when engagement is most fragile.

Rübig et al. (2021) explore the impact of attachment styles in therapeutic settings within a therapeutic community for SUD treatment. Berry et al. (2022) found that negative attachment styles were positively correlated with problematic substance abuse and fully mediated dysfunctional coping and the reasons for use. This finding promotes the premise that successful coping might prevent and reduce substance abuse-related problems in SUD patients. Both of these findings indicate that insecure attachment, common among SUD patients, often hinders alliance formation and engagement. Secure attachment is positively correlated with strong therapeutic bonds, and patients with this attachment style show better alliance and treatment outcomes.

The authors also reveal that a positive TA can counterbalance low motivation and potentially reduce dropout rates in SUD treatment (Berry et al., 2022; Rübig et al., 2021). The studies observe that SUD patients with comorbid mood and personality disorders, especially those with borderline traits, often face additional challenges in alliance-building due to interpersonal difficulties. Hence, the therapeutic community's role in fostering group support offers an alternative attachment figure that may aid in emotional regulation and promote alliance, underscoring the TC's potential as an effective setting for those with insecure attachment patterns.

These research studies focused on understanding the role of attachment styles, coping mechanisms, and motivations for substance use among individuals with psychosis and SUD patients. The primary findings indicate that insecure attachment styles are common in individuals with psychosis, linked to higher substance use and maladaptive coping strategies, which

exacerbate psychotic symptoms in a cyclical pattern of mental health deterioration. In SUD treatment settings, attachment security emerged as a key factor, with insecure attachment correlating with weaker therapeutic bonds, confirming that secure attachment strengthens the TA and motivation for change. The studies (Barry et al., 1995; Rübzig et al., 2021) used varied methodologies, including in-depth interviews and psychometric tools like the Adult Attachment Scale and Working Alliance Inventory-Short Revised, finding that SUD patients, compared to a healthy control group, had greater personality and mood pathology and less secure attachment, often turning to substance use for emotional regulation. The research further identified that patients in the “Action” stage of change developed stronger task alliances with therapists, suggesting that readiness for change enhances alliance building. Limitations, such as small sample sizes, cross-sectional designs, and self-report biases, hinder causal conclusions, underscoring a need for longitudinal research, gender-matched patient-therapist teams, and attachment-based therapies in SUD and psychosis treatment. The implications for clinical practice include tailoring therapeutic approaches to address attachment insecurities and maladaptive coping, with policy recommendations for preventive strategies that address the complex mental health needs of individuals with psychosis and SUD (Berry et al., 2022; Rübzig et al., 2021).

Diverging from broader psychotherapy literature, this section highlights specific difficulties unique to SUD treatment, such as client ambivalence, resistance, and stigma. While mainstream literature often focuses on general relational factors, SUD-specific studies indicate that co-occurring psychiatric conditions and societal stigma uniquely impact TA formation, necessitating tailored approaches. For instance, Dellazizzo et al. (2021) emphasize the

heightened importance of addressing trust and collaboration in SUD contexts, where clients frequently present with barriers like trauma histories and severe comorbidities.

Similarly, Finsrud et al. (2022) identify a distinct dimension of TA, confidence in the therapist versus confidence in the treatment, which SUD clients may experience as separate, diverging from traditional TA models that treat these as intertwined. This discrepancy is further reflected in measurement approaches; tools like the MPOQ Common Factor Scale (Finsrud et al., 2022) incorporate specific SUD-relevant variables such as task alignment and perceived credibility, contrasting with more general instruments like the Working Alliance Inventory (WAI), which focus on broader relational constructs. Additionally, while traditional TA research often posits that early-stage alliance strength predicts outcomes uniformly, SUD studies reveal fluctuating dynamics due to client-specific challenges such as ambivalence and fluctuating motivation levels.

In summary, the literature on TA in SUD contexts not only aligns with broader psychotherapy research in emphasizing the centrality of a strong alliance but also introduces divergences, particularly in understanding the interplay of therapist behaviors, tailored strategies, and client-specific factors. These insights advocate for a nuanced, adaptable framework in SUD treatment to address the complex interplay of relational and contextual elements unique to this population. This underscores the critical importance of moving beyond general alliance constructs to identify the concrete, moment-to-moment therapist behaviors and relational skills that foster trust, engagement, and sustained motivation in clients with SUD. By clarifying precisely what therapists need to do, and how, they can better tailor their approaches to meet the unique psychological and motivational needs of this population. Ultimately, these insights support the central aim of this study: to illuminate the specific interpersonal skills and strategies

that therapists employ to build and maintain a robust TA, thereby enhancing treatment adherence and long-term recovery outcomes.

Challenges to Establishing TA in SUD Treatment

Clients with SUD bring unique challenges, such as ambivalence and resistance to change, that complicate the formation of a strong TA. Many individuals with SUDs struggle with motivation and readiness for treatment, often due to complex factors, including fear of change and limited self-efficacy in recovery (Dellazizzo et al., 2021). This ambivalence can lead to resistance, making it difficult for therapists to establish a collaborative relationship at the onset of therapy, a critical period for engagement. Moreover, co-occurring mental health disorders, stigma, and prior negative experiences with treatment can further impair the development of trust, making clients more guarded and less receptive to therapeutic efforts (Meier et al., 2005). Therapists may also experience frustration or disengagement when met with persistent resistance, which can inadvertently weaken the alliance if not skillfully managed (Safran & Muran, 2000). These complexities highlight the need for nuanced, empathy-driven, and autonomy-supportive approaches rooted in theoretical models such as SDT. Understanding how therapists navigate these early relational obstacles is central to this study's aim of identifying effective strategies for initiating and maintaining strong alliances in SUD treatment (Dellazizzo et al., 2023; Fisher et al., 2024).

Establishing a strong TA in SUD treatment is often hindered by multiple complex challenges. Patients frequently present with co-occurring mental health conditions, such as anxiety, depression, or personality disorders, which can impede trust, foster defensiveness, and make it difficult for them to engage openly (Meier et al., 2020). Studies indicate that nearly 60% of patients with SUD also experience psychiatric comorbidities, making the establishment of a

collaborative therapeutic relationship more difficult (Finsrud et al., 2022). Socioeconomic disadvantages are associated with a nearly 35% dropout rate in the first three months, as individuals struggle with external pressures that therapists may overlook or misunderstand (Reyre et al., 2017). These intertwined clinical and socioeconomic challenges highlight the necessity for therapists to possess solid, evidence-based tools and interpersonal skills specifically designed to foster a strong TA. A robust alliance not only supports clients in engaging more deeply with treatment but also helps them navigate external pressures and internal resistance, ultimately increasing their chances of achieving and sustaining long-term sobriety. According to the Substance Abuse and Mental Health Services Administration (SAMSHA), understanding and implementing these alliance-promoting strategies is therefore critical for improving outcomes and empowering clients on their recovery journey (SAMSHA, 2013).

Finsrud et al. (2022) investigates the structure and impact of common therapeutic relationship factors, specifically examining how patients perceive and evaluate their relationships with therapists and the treatment in an intensive psychotherapy setting. Traditionally, therapeutic factors such as empathy, goal alignment, and client expectations have been studied in isolation, making it difficult to understand their combined influence on treatment outcomes. To address this, the researchers developed the MPOQ Common Factor Scale, a comprehensive instrument that integrates six relationship factors: task agreement, goal alignment, therapist empathy, client expectations, therapist expertise, and treatment credibility. These were administered to a sample of 332 patients receiving inpatient psychotherapy for issues including depression, anxiety, eating disorders, and trauma. Through exploratory factor analysis and exploratory structural equation modeling, the study identified two primary dimensions of therapeutic relationships from the patient's perspective: "Confidence in the Therapist," which reflects trust in the therapist's

empathy, expertise, and alignment on goals, and “Confidence in the Treatment,” encompassing treatment expectations and perceived credibility.

These findings align with the contextual model’s therapeutic change pathways, suggesting that both confidence in the therapist and the treatment itself play significant roles in therapy success. The study’s results also highlight substantial overlap among relationship factors, implying that patients may perceive these factors holistically rather than as separate constructs, which diverges from the traditional approach of studying these factors independently. However, limitations such as the inpatient sample’s generalizability to outpatient settings, the questionnaire’s restricted item number potentially narrowing the scope of constructs, and the lack of consideration for within-patient variability over time suggest areas for further research.

Moreover, Finsrud et al. (2022) also departs from SUD TA literature, in terms of measurement stability. The study’s emphasis on between-patient variability rather than tracking within-patient changes over time does not fully capture the potential fluctuations in SUD clients’ motivations and engagement levels, which are often significant. This design choice contrasts with approaches in SUD literature that emphasize the importance of tracking how relational factors evolve over time with individual clients. Finally, while confidence in the treatment process itself is a recognized element in SUD settings, Finsrud et al.’s study (2022) brings this concept forward as a separate critical component, distinct from relational confidence in the therapist. This perspective suggests that SUD practitioners might enhance treatment adherence by fostering both trust in the therapeutic relationship and confidence in the specific treatment modality, as Jones et al. (2023) observed with regard to clients struggling with stigma and internalized shame. Together, these findings both align with and expand upon SUD literature, highlighting that confidence in both the therapist and the treatment independently contribute to a

resilient TA and better treatment adherence. This expanded understanding encourages SUD practitioners to consider an integrated approach to TA that respects both relational and treatment-based dimensions as critical to fostering long-term engagement and recovery.

Therapist-related factors also pose substantial obstacles. High burnout rates, experienced by approximately 40 to 60% of SUD treatment providers, contribute to high turnover, which disrupts the consistency needed to build trust and rapport with clients (Landrum et al., 2012). Burnout impacts therapists' ability to sustain empathetic and focused engagement, essential components of a strong TA. Additionally, internalized stigma remained a significant barrier for clients, who often perceive judgment within healthcare settings. This perceived stigma discourages patients from being open, leading to early treatment termination for up to 50 to 70% of clients (Goldberg et al., 2020). Together, these factors illustrate the multifaceted challenges in SUD treatment that therapists must navigate to establish an effective TA. These entangled challenges highlight the critical importance of this study's focus: to uncover and clarify the specific therapist skills and behaviors necessary to build and maintain a strong TA, enabling providers to better engage clients, overcome barriers like burnout and stigma, and ultimately support long-term recovery in SUD treatment.

Research on common therapeutic relationship factors reveals a nuanced understanding of how patients evaluate their interactions with therapists and the treatment process, offering insights that both align with and expand upon established literature on the TA, particularly in SUD counseling (Goldberg et al., 2020; Landrum et al., 2012). A significant finding is the identification of two distinct dimensions within the TA: "Confidence in the Therapist" and "Confidence in the Treatment." This duality aligns with longstanding TA theories that highlight the importance of relational bonds, empathy, and trust in achieving treatment adherence.

Notably, in SUDs, the TA is often credited with motivating change and fostering commitment to recovery by helping clients feel valued and understood. While this study's "Confidence in the Therapist" factor mirrors these findings, its introduction of "Confidence in the Treatment" as a separate factor brings a new perspective to TA literature by suggesting that clients may distinguish between trust in the therapist and faith in the treatment itself. Traditional TA models often assume that these two elements are intertwined, but the separation of these dimensions here indicates that for some clients, particularly those with histories of negative treatment experiences or skepticism toward interventions, these components may function independently (Goldberg et al., 2020).

The researchers also found substantial overlap in therapeutic relationship factors, echoing theories like those of Wampold and Imel (2015), who propose that the therapeutic context's various components collectively create a healing environment. This integrated view aligns with existing SUD literature, where factors like empathy, goal alignment, and active listening are regarded as mutually reinforcing and essential for building a cohesive therapeutic environment. Yet, while SUD-specific research often isolates each factor to measure its individual impact, this study's findings imply that patients perceive these factors as a collective experience rather than as separate, isolated elements. This unified perception suggests that, from the client's perspective, empathy, expertise, and goal alignment may all contribute simultaneously to the experience of feeling confident in the therapist. As a result, it raises questions about the efficacy of overly rigid, segmented therapeutic techniques in SUD counseling and suggests that approaches that integrate cognitive, behavioral, and relational components may be more effective in fostering engagement. This insight underscores the importance of examining how therapists practically integrate these interconnected elements in their daily work, a central focus of this

study's exploration into the specific behaviors and strategies that strengthen the TA in SUD treatment.

Another unique aspect of the Wampold and Imel (2015) study is the focus on measurement stability across time, which has implications for the TA's role in SUD counseling. Stable relational quality, as highlighted in the literature, supports longer-term client engagement and adherence, critical factors in preventing relapse and sustaining recovery. Their study confirmed stability in TA factors but diverged in its design by assessing between-patient variability rather than tracking within-patient changes over time. In SUD contexts, where individual clients may experience significant fluctuations in motivation and engagement, capturing these dynamics over the course of treatment might yield important insights. Additionally, the study's finding that clients unify multiple therapist qualities under "Confidence in the Therapist" contrasts with SUD-specific research, where separate therapist behaviors (e.g., reflective listening, goal-setting) are often analyzed individually for their unique contributions to TA. This integrated approach reinforces the idea that clients may not differentiate among specific behaviors but instead perceive the therapist's presence and support holistically, underscoring the potential value of flexibility and adaptability over strictly defined techniques (Goldberg et al., 2020).

Finally, Goldberg (2020) focuses on expectations and treatment credibility, offering another layer of relevance for SUD settings, where client skepticism can pose significant obstacles. Research shows that clients who trust the treatment process, whether it is a 12-step program, CBT, or another modality, are more likely to engage actively (Campbell et al., 2015; Harada et al., 2018; Kan et al., 2014). This supports the concept of "Confidence in the Treatment" as a critical factor, which, although consistent with broader TA findings, provides a

new perspective by treating treatment-based confidence as distinct from the relational bond. Separating these two components implies that client beliefs in a particular therapeutic approach could significantly impact adherence, suggesting that SUD practitioners may benefit from exploring both relational and treatment-based factors to foster commitment and motivation. Altogether, this study's findings present a compelling view of the TA in SUD counseling, suggesting that the combined impact of relational confidence and faith in the treatment itself may yield a more resilient and engaged client.

It should be noted that this study diverges from typical alliance-outcome research in its emphasis on maximum alliance ratings rather than average ratings. Findings revealed that maximum alliance, not average alliance, predicted higher attendance at SUD visits, suggesting that a client's highest level of felt alliance at any point may be more indicative of their potential to remain engaged in treatment. This focus contrasts with much of the literature, which often treats average alliance ratings as the primary indicator of therapeutic success. Additionally, while typical measured-based care (MBC) efforts focus on symptom monitoring, this study's unique emphasis on alliance monitoring within an SUD setting offers new insights, particularly as it suggests that patients who fail to achieve a strong alliance at any point may be at higher risk for dropout. This approach signals the potential for MBC to incorporate alliance as a distinct metric alongside symptom measures to better support at-risk populations in treatment retention (Goldberg et al., 2020).

Additionally, trust issues often stem from clients' past experiences with authority figures, including healthcare providers, which can create a barrier to forming a TA. Sukla et al. (2025) show how mistrust, especially when compounded by histories of trauma or punitive treatment, affects client engagement and openness. Therapists in SUD treatment settings must often work

harder to overcome these initial trust barriers, requiring an empathic and nonjudgmental approach.

Comorbid psychiatric conditions are another hurdle, as they often interfere with clients' ability to engage fully in therapy. According to SAMSHA (2024), approximately 21.5 million adults in the United States have co-occurring disorders, meaning they experience both a mental illness and an SUD simultaneously. Anxiety, depression, and personality disorders are common among individuals with SUDs, and they can significantly hinder the therapeutic process (Smith et al., 2022). Therapists working in SUD treatment settings need to remain flexible and adapt their approaches, as clients with co-occurring disorders may require more structured and supportive techniques to foster engagement.

Societal stigma and internalized shame add further complexity. A recent analysis of clients in SUD treatment showed that internalized shame frequently contributes to self-isolation and low self-worth, complicating the client's willingness to engage with the therapist (Jones et al., 2023). Addressing this stigma and providing a nonjudgmental environment can help break down these barriers, allowing clients to experience therapy as a safe, supportive space. However, creating this environment requires more than general empathy; it demands specific, intentional therapist behaviors and interpersonal skills that actively reduce shame and build trust. By investigating therapists' firsthand experiences and strategies for overcoming stigma and fostering safety, this study aims to identify concrete approaches that strengthen the TA. In doing so, it directly addresses the study's goal of clarifying the precise skills needed to enhance engagement and promote long-term recovery among clients struggling with substance use disorders.

Therapist Behaviors and Their Impact on the Therapeutic Alliance

The TA, the collaborative relationship between therapist and client, is a cornerstone of effective psychotherapy. Therapist behaviors such as empathy, active listening, validation, and collaboration are pivotal in building and maintaining a strong TA. This dissertation explores recent research highlighting the significance of these behaviors in fostering a robust TA.

Empathy

Empathy, the ability to understand and share the feelings of another, is fundamental in psychotherapy. It involves therapists deeply attuning to clients' emotional experiences, thereby fostering trust and openness. A literature review by Kim (2018) on empathy within therapeutic contexts examined the neurobiological mechanisms of empathy to explain how empathic connections form and support TA. Kim (2018) highlights the role of mirror neurons, which create neural maps that help individuals understand and reflect the emotional states and intentions of others. These neurons facilitate an automatic process where a therapist's brain effectively "mirrors" a client's expressions and emotions, establishing an empathic link crucial for building trust and understanding in therapy (Kim, 2018).

Further, Kim (2018) emphasizes the involvement of the middle prefrontal cortex, particularly the anterior cingulate cortex and the ventrolateral prefrontal cortex, in empathy. These brain regions enable therapists not only to process the emotional experiences of others but also to experience similar emotions within themselves, creating a deeper relational attunement. This neurobiological connection allows therapists to feel another's emotions as if they were their own, making empathy an authentic and immediate response rather than a purely cognitive interpretation. The research suggests that these biological underpinnings of empathy significantly contribute to establishing a secure attachment, laying the groundwork for a strong TA by

creating an environment of safety and genuine emotional resonance between therapist and client (Kim, 2018).

Active Listening

Active listening entails fully concentrating, understanding, responding, and remembering what the client communicates, going beyond passive hearing and requiring therapists to engage with clients' narratives actively. Afshan (2024) highlights active listening's centrality in forming TAs, examining how empathic listening and involving full engagement with both the client's verbal and emotional expressions strengthen the therapeutic bond by fostering trust and validating client experiences. The study explores empathic listening's core components: atonement (aligning with client emotions), validation (acknowledging and confirming client feelings), and emotional regulation (helping clients manage emotions). Findings reveal that clients who perceive empathy from their therapist tend to form stronger alliances, as empathy encourages openness and self-disclosure, essential for therapeutic progress. This approach aligns with broader literature on empathy's significance but diverges in emphasizing specific feedback mechanisms, such as involving client opinions to fine-tune listening approaches. This divergence suggests a shift from solely therapist-led empathy to a more collaborative model that invites active client participation in shaping their therapy experience (Afshan, 2024).

Weinstein et al. (2022) explore how high-quality listening supports self-determination and enhances autonomy, relatedness, and openness during challenging conversations. The authors integrate SDT to analyze how listening can fulfill essential psychological needs, reducing defensiveness and encouraging motivation for change. The study emphasizes that "high-quality" listening, characterized by undivided attention, comprehension, and positive intention, satisfies speakers' autonomy and relatedness, promoting intimacy and mutual

understanding. Findings highlight that effective listening fosters non-judgmental, autonomy-supportive environments conducive to open, meaningful dialogue, even during controversial topics (Weinstein et al., 2022).

Diverging from mainstream literature, which often considers listening a component of general social support, this study positions high-quality listening as an independent, autonomy-supportive strategy. It suggests that listening alone, when genuinely focused on understanding and valuing the speaker, can drive motivational and relational outcomes typically attributed to broader social support mechanisms. This approach broadens the understanding of listening's specific impact on psychological well-being and change, distinguishing it from conventional constructs of support and challenging its passive interpretation in prior frameworks (Weinstein et al., 2022).

Validation

Validation involves acknowledging and accepting a client's feelings, thoughts, and experiences without judgment. It communicates respect and understanding, reinforcing the client's sense of self-worth. The *Psychiatry Podcast* (Puder, 2023) emphasizes that validation, combined with empathy and connection, is integral to building a TA. Puder's study, presented as an in-depth exploration of TA principles, emphasizes the foundational role of active listening and nonverbal cues in building a collaborative, trusting TA. It synthesizes core practices and evidence-based methods essential for establishing a therapeutic bond, including empathy, consistency, nonverbal communication, and maintaining a professional therapeutic frame. The study discusses various strategies therapists can employ, from mirroring patients' emotions to structuring sessions that minimize distractions, creating a setting that fosters open communication and patient comfort (Puder, 2023).

Findings from Puder's (2023) study highlight that techniques such as eye contact, leaning forward, mirroring patient emotions, and empathetic responses create a nonverbal connection, enhancing the therapeutic relationship. This emphasis on nonverbal dynamics diverges slightly from mainstream literature, which often centers more on verbal communication in TA. Here, the study underscores that TA depends equally on nonverbal elements, reinforcing the idea that therapists' physical engagement can profoundly impact patients' willingness to communicate openly (Puder, 2023).

Collaboration

Collaboration in therapy refers to the joint effort between therapist and client in setting goals and working towards them, empowering clients and fostering a sense of agency in their therapeutic journey. Bordin's (1979) model of the TA emphasizes that mutual agreement on goals and tasks, alongside the bond between therapist and client, is foundational to a strong alliance. Studies have shown that collaboration enhances engagement and adherence to therapy, particularly when clients are active participants in decision-making (Flückiger et al., 2018; Safran & Muran, 2000). The International Training Centre for Clinical Psychology (2024) notes that collaboration and transparency are key strategies to strengthen the TA, as therapy is inherently a joint process. Additionally, a collaborative approach has been linked to greater client satisfaction and motivation, which are essential for achieving positive therapeutic outcomes (Horvath et al., 2011; Pembroke, 2024; Wampold & Imel, 2015).

Integration of Therapist Behaviors

Integrating empathy, active listening, validation, and collaboration creates a synergistic effect that strengthens the TA, which is associated with better treatment outcomes across various modalities (Norcross & Lambert, 2019). Research underscores that empathy and validation are

core components of effective therapy, fostering trust and enhancing the client's openness to change (Rogers, 1957). The American Psychological Association (APA, 2023) highlights that the TA is a critical component of effective therapy, built on listening attentively and engaging clients as active participants in their treatment. Furthermore, combining these behaviors with collaboration ensures that clients feel understood and supported, promoting a sense of safety and empowerment within the therapeutic environment (Ackerman & Hilsenroth, 2003). Ortega and María (2023) argue that this integration fosters a therapeutic environment conducive to client growth and healing, ultimately leading to enhanced therapeutic outcomes. By exploring how therapists operationalize these integrated behaviors in real-world SUD treatment, this study seeks to identify the specific skills and strategies that most effectively strengthen the TA and support long-term recovery.

Initial Sessions

The initial therapy session is a critical component of the therapeutic process, setting the foundation for a successful TA. According to Woods (2023), the first session is not only about gathering essential clinical information but also about creating a safe and welcoming environment where trust and rapport can begin to develop. This session provides the opportunity for therapists to align on treatment goals and collaboratively establish a plan that reflects the client's unique needs and aspirations. The TA is built through mutual trust, clear communication, and the development of a personal bond, making the initial session pivotal in fostering these elements (Tustonja et al., 2024; Hubbert et al., 2001).

During the initial session, the therapist's ability to actively listen, show empathy, and avoid a purely interrogative approach is essential. As noted by Moses (2023), the first encounter allows therapists to learn about the client's history, goals, and presenting challenges, while also

beginning to build an understanding of the client's strengths and adaptive coping mechanisms. This creates a balanced view of the client and ensures that therapy begins on a collaborative and positive note. Moreover, Barlow et al. (2000) stress the importance of authenticity, attentiveness, and positivity during these early interactions, qualities that help clients feel comfortable discussing vulnerable and difficult topics, laying the groundwork for a relationship characterized by mutual respect and openness.

The initial session also sets the stage for managing potential ruptures in the alliance, and Barlow et al. (2000) explain that addressing discomfort or misalignment early on, through open communication, can transform such moments into opportunities for repair and growth. That research further suggest that a therapist's willingness to engage in real-time feedback with the client, by asking about their experience of the session or the therapist's approach, can deepen the alliance and foster a sense of safety and collaboration (Barlow et al., 2000).

An exploratory research study (Del Río Olvera et al., 2022) analyzed the relationship between the TA and patients' perceived improvement during the first five therapy sessions. Thirty-four university students, primarily women participated in the study, seeking help for conditions such as anxiety, mood disorders, and other psychological issues. The study utilized the Session Rating Scale (SRS) to measure the quality of the TA and the Outcome Rating Scale (ORS) to assess perceived personal well-being. Data were analyzed using STATIS-Dual, a statistical method designed to evaluate the stability and variability of the TA over time. Findings revealed that the TA was established during the first session and remained remarkably stable throughout the subsequent sessions. The first session had the highest statistical weight in contributing to the TA, emphasizing its foundational role in therapy. Patients' trust in the therapist and the therapeutic process was solidified early, which positively influenced their

perception of improvement. This stability in the TA aligns with literature identifying it as a key predictor of therapeutic outcomes, particularly when established early (Flückiger et al., 2020a).

However, Del Río Olvera et al. (2022) diverge from some traditional perspectives by suggesting that the TA, once formed, remained largely independent of subsequent fluctuations in patient well-being or symptom improvement. This challenges views emphasizing dynamic variations in the TA across therapy sessions. Additionally, the study highlights the first session's critical role in mitigating risks of therapy dropout and fostering engagement, contributing new insights into how early alliances set the trajectory for successful interventions. Ultimately, the first session is where the relational groundwork is laid, blending clinical structure with human connection. The therapist's ability to create a warm and professional environment, align on shared goals, and remain attentive to the client's emotional and psychological needs ensures that the alliance begins on a solid foundation, increasing the likelihood of successful therapeutic outcomes.

Summary

The literature review delves into the pivotal role of the TA in SUD treatment, emphasizing its profound impact on treatment engagement, adherence, and overall success. Drawing upon theoretical models, empirical research, and clinical observations, the review highlights the importance of tailoring therapeutic interventions to foster strong alliances, especially in the early stages of treatment.

The TA has its roots in foundational psychoanalytic theories, beginning with Freud's (1913) concept of transference and Rogers' (1951) client-centered approach. While Freud emphasized the therapist as an analytical observer, Rogers shifted the focus to empathy, congruence, and unconditional positive regard. These foundational ideas evolved into Bordin's

(1979) model, which conceptualized the alliance as comprising three core elements: agreement on goals, agreement on tasks, and an emotional bond. Bordin's model remains a cornerstone in understanding the alliance's role across diverse therapeutic modalities.

Empirical evidence underscores the TA as a robust predictor of treatment outcomes across various modalities and populations. Flückiger et al.'s (2018) meta-analysis synthesizing data from 306 studies revealed that the alliance accounts for approximately 8% of the variance in treatment outcomes. Client-rated alliances ($r = .25$) were found to be slightly stronger predictors than observer ratings ($r = .22$), highlighting the importance of clients' perceptions of the relationship. Furthermore, the alliance's strength in later sessions correlated more significantly with outcomes ($r = .30$) compared to early assessments ($r = .22$).

In SUD contexts, the TA plays a critical role in fostering motivation and reducing dropout rates. However, patients with SUDs often face unique challenges in forming alliances, including ambivalence, distrust, and comorbid psychiatric conditions. Studies have shown that a positive TA can mitigate low motivation, enhance engagement, and promote sustained recovery (Norcross & Lambert, 2018; Ryan & Deci, 2017). For clients with co-occurring borderline personality disorder, the alliance's impact is even more pronounced, as strong alliances can help navigate complex interpersonal dynamics (Flückiger et al., 2018).

Self-Determination Theory and its Relevance

SDT, as developed by Deci and Ryan (2017), provides a critical framework for understanding the motivational processes underlying successful therapeutic relationships. SDT emphasizes the fulfillment of three psychological needs, autonomy, competence, and relatedness, which are essential for intrinsic motivation and psychological well-being. When applied to SUD treatment, SDT posits that autonomy-supportive environments enhance client motivation, while

relatedness fosters trust and emotional connection, and competence builds clients' confidence in overcoming challenges.

Supporting SDT's applicability in SUD contexts, Chan et al. (2023) demonstrated that autonomy-supportive counseling enhances client engagement and reduces dropout rates. Similarly, Teixeira et al. (2022) found that positive feedback and empathetic therapeutic environments improve treatment adherence by fulfilling clients' psychological needs. These findings underscore SDT's role in aligning therapist behaviors with clients' readiness for change, thereby strengthening the alliance and improving outcomes.

Challenges in Therapeutic Alliance Formation. Despite its critical importance, forming a strong TA is often fraught with challenges, particularly in SUD treatment. Patients with insecure attachment styles or comorbid mood and personality disorders frequently experience difficulties in establishing trust and collaboration. Rübiger et al. (2021) noted that such clients often require more intensive relational support to engage meaningfully in therapy. Moreover, the initial sessions are pivotal, as they set the tone for future interactions and significantly predict long-term treatment success (Del Río Olvera et al., 2022). Therapists' behaviors also play a crucial role in alliance formation. Research highlights the importance of empathy, active listening, and collaboration in creating a supportive therapeutic environment (Hammarberg et al., 2023). However, missteps such as excessive rigidity, inappropriate self-disclosure, or overemphasis on technical interventions can hinder alliance development, particularly in clients with high resistance or ambivalence (Dellazizzo et al., 2023).

The review emphasizes the value of evidence-based therapeutic techniques in fostering strong alliances. MI, CBT, and trauma-informed approaches are particularly effective in SUD contexts. MI, for instance, aligns with SDT principles by supporting autonomy and fostering

intrinsic motivation, making it a valuable tool for clients in the precontemplation and contemplation stages of change (DiClemente, 2018). CBT, while effective in addressing maladaptive thought patterns, must be delivered in a relationally attuned manner to avoid undermining clients' autonomy (Ng et al., 2019). Trauma-informed care further enhances alliance building by acknowledging the pervasive impact of trauma on clients' behaviors and relationships. This approach emphasizes safety, empowerment, and collaboration, which are critical for engaging clients with histories of trauma or adverse childhood experiences (ACE) (Hatcher & Gillaspay, 2023).

The literature highlights the TA as a dynamic, relational process that requires ongoing attention and adaptation. Therapists must remain attuned to clients' evolving needs, employing strategies such as routine outcome monitoring and feedback-informed care to strengthen the alliance (Hatcher & Gillaspay, 2023). Additionally, training programs should focus on developing therapists' interpersonal skills, including empathy, active listening, and cultural competence, to better support diverse client populations. Future research should explore the intersection of attachment theory, SDT, and alliance formation in SUD treatment, particularly in clients with complex comorbidities. Longitudinal studies examining the alliance's role over the course of treatment could provide deeper insights into its impact on long-term recovery outcomes.

Search Strategy

A comprehensive literature search was conducted to identify relevant studies on TA in SUD. The following electronic databases were searched: The National University (NU) Library and NU Dissertation Databases. Google and Google Scholar were also used extensively.

When exploring the intersection of therapeutic alliance, substance use disorders, and therapist behaviors, it is helpful to use targeted search terms. The search was initially limited to

peer-reviewed articles published in English, although relevant non-academic articles in traditional media outlets were incorporated. Recent articles, dating from 2021, were preferred but research went back further to access relevant and important information.

Search terms included *therapeutic alliance*, *substance use disorder*, *addiction treatment*, *therapist-client relationship*, and *client engagement*, using Boolean operators such as AND and OR to combine terms (e.g., “therapeutic alliance” AND “substance use disorder”). Additional combined search terms included *counselor behaviors* and *alliance*, as well as *counselor behaviors* and *motivational interviewing*, which highlight specific therapeutic techniques relevant to the study. Searching for alliance formation strategies or examining frameworks in combination with *therapeutic alliance*, specifically *self-determination therapy* and the *Stages of Change Model*, were sought to obtain insights into how motivation and behavior change models integrate into therapeutic work. Additionally, keywords such as *psychiatric comorbidity* or *therapist empathy* or *active listening* combined with *alliance* were explored to explore evidence-based research on essential skills for building and maintaining alliances. Searches were conducted for alliance measurement tools such as *Working Alliance Inventory*, *California Psychotherapy Alliance Scale*, and *Vanderbilt Therapeutic Alliance Scale*, which provide metrics for evaluating relational quality between a therapist and client. Finally, terms like “counselor skills” and “therapeutic success”, “client motivation” and “adherence to treatment”, “therapeutic engagement in SUD contexts”, and “collaborative goal-setting in therapy” were searched to identify literature that reports on the behaviors and strategies that promote long-term recovery and positive outcomes in substance use treatment.

Chapter 3: Research Method

This chapter presents the research methodology and design employed in this qualitative phenomenological study, which explored the lived experiences of how addiction counselors in Israel make sense of their experiences establishing and maintaining TA with clients in SUD treatment. This study's methods and design relate directly to the research questions.

Research Questions

1. What therapist behaviors and strategies are most effective in establishing a strong TA during the initial sessions of SUD treatment?
2. What therapist behaviors and strategies are most effective in maintaining a strong TA throughout SUD treatment?

Research Approach

This study was guided by IPA, an approach that focuses on how individuals make sense of their personal and professional experiences within specific contexts. IPA was selected because it supports an in-depth, idiographic exploration of how therapists interpret their work and their meaning-making processes related to building and sustaining the TA. IPA is particularly well-suited to this research because it prioritizes the exploration of participants' subjective experiences and the meanings they attribute to their clinical actions and interpersonal interactions (Herchenroeder et al., 2024). This aligned with the purpose of this study by prioritizing rich, contextualized accounts of counselors' experiences in early therapeutic encounters and the alliance-building processes.

The primary goal of IPA is to investigate how individuals make sense of their experiences. It is assumed that people are actively engaged in interpreting events, objects, and people in their lives. To examine this process, IPA draws on the fundamental principles of

phenomenology, hermeneutics, and idography (Smith et al., 2022). The eidetic model, phenomenology, as developed by Edmund Husserl, is concerned with attending to the way things appear to individuals within their experiences (Williams, 2021). Using this model for this research study allows us to understand what it is like to “stand” in the shoes of the subject.

A qualitative design was essential because the relational, experiential, and interpersonal dynamics at the core of the TA cannot be meaningfully captured through quantitative methodologies alone. This approach allowed for a nuanced understanding of how therapists perceive, enact, and sustain behaviors that foster effective therapeutic relationships in SUD treatment contexts (DeAngelis, 2019; Norcross & Lambert, 2019). An important part of qualitative methodology is epistemological reflexivity, which refers to questions such as “How does the research define and limit what can be found?”, “How do the study design and methods of analysis affect the data and its interpretation?”, and “As the research is defined, how does this affect understanding of the phenomenon under investigation?” (Willig, 2008).

IPA was particularly aligned with the study’s aim to explore the subjective insights of counselors regarding the formation and maintenance of TA (Creswell & Creswell, 2018). The design was well-suited to addressing the research questions, which focused on identifying specific therapist behaviors and strategies effective in fostering TA. The design and methodology were appropriate as they align with the study problem, which centers on the lack of specificity in understanding the behaviors that effectively build therapeutic alliances (Levy, 2016). IPAs focus on personal experiences, and the meaning-making process is ideal for identifying and analyzing these behaviors as perceived by addiction counselors. It seamlessly connected to the study’s purpose in exploring how therapist actions foster client engagement and adherence to treatment. Moreover, IPA facilitates a deep investigation into counselors' perspectives and strategies,

providing actionable insights into the mechanisms underlying successful TA (Peat et al., 2019; Smith et al., 2022). IPA's ability to reveal intricate, context-specific experiences enables a comprehensive answer to the specific research questions by focusing on the lived experiences of counselors, their challenges, and their successes (Smith et al., 2022).

As an IPA study, this research was rooted in a strong commitment to idiography, which emphasizes a detailed, nuanced understanding of individual lived experiences before attempting to draw broader conclusions. This approach aligned with the idiographic principle that each participant's narrative was unique, shaped by their personal, social, and cultural context. In practical terms, this meant that each transcript was analyzed case by case, with careful attention paid to preserving the distinct voice, perspective, and meaning-making of each counselor. Only after thoroughly examining individual cases were patterns across cases considered, allowing for both convergence and divergence to emerge organically. This idiographic stance ensured that the findings remained grounded in the complexity of individual experience rather than prematurely abstracting to generalities (Peat et al., 2019).

Data analysis in this study followed the seven-step IPA approach articulated by Smith et al. (2022). This approach was particularly suited to capturing the lived experiences and meaning-making processes of addiction counselors working with clients in substance use disorder (SUD) treatment. Each transcript was treated as a single case before identifying patterns across cases, preserving IPA's idiographic commitment.

1. **Reading and Re-reading:** To begin, I immersed myself in the data by repeatedly reading the interview transcripts. This process involves active listening and engagement with the text, allowing the voices of the participants to emerge clearly. The aim is to enter the participant's world and gain a holistic sense of their experience.

2. **Initial Noting:** In this phase, I made detailed exploratory comments. These included descriptive comments (focused on the content of what was said), linguistic comments (how it was said, including tone and language use), and conceptual comments (interpretative insights and questions). This stage encourages openness to complexity and nuance in the data.
3. **Developing Emergent Themes:** Next, I synthesized the exploratory notes into emergent themes. This involved reducing the volume of data while preserving richness. Themes reflected the participant's original meaning but filtered through the researcher's interpretive lens, consistent with IPA's double hermeneutic stance.
4. **Searching for Connections Across Emergent Themes:** I then organized the themes to identify patterns and relationships, clustering them into superordinate themes. This includes processes such as abstraction (grouping similar themes), subsumption (elevating a theme to a superordinate status), polarization (highlighting oppositional themes), contextualization (considering temporal or narrative positioning), and function (examining the role a theme plays in the participant's account).
5. **Moving to the Next Case:** Each case was analyzed on its own terms before any cross-case analysis. This maintains IPA's idiographic emphasis and ensures that themes are not prematurely generalized. The goal is to honor the individuality of each participant's experience.
6. **Looking for Patterns Across Cases:** After analyzing all individual cases, I examined convergence and divergence across participants. This phase aims to identify shared experiences and unique perspectives, leading to higher-order interpretations while preserving individual nuance.

7. **Producing the Final Narrative:** Finally, I composed a coherent, interpretative narrative that presents each superordinate theme supported by verbatim participant quotes. These narratives were situated within existing literature on TA and addiction counseling, as well as framed by SDT. The analysis not only described the phenomena but also interpreted the underlying psychological mechanisms as conveyed by participants (Smith et al., 2022).

Throughout this process, reflexivity was maintained to monitor potential biases, and analytic rigor will be ensured through audit trails, peer debriefing, and transparent documentation of analytic decisions. This structured approach allowed the study to uncover deep insights into how addiction counselors construct and sustain therapeutic alliances within the Israeli addiction treatment context.

IPA was highly appropriate for exploring the complexities of TAs in SUD counseling due to the multifaceted nature of addiction and client-counselor relationships. SUDs often involve stigma, ambivalence, and co-occurring psychological conditions that significantly influence therapy dynamics, nuances not easily captured through quantitative methods (Hammarberg et al., 2023). IPA provides a lens for examining the lived experiences and subjective insights of counselors, enabling a deeper understanding of why and how specific behaviors are used to build rapport and foster alliances, particularly with resistant clients (Dellazizzo et al., 2023). This approach aligned with the study's objective to uncover effective strategies for enhancing TA, especially during initial sessions, where these relationships are most fragile (McInally & Gray-Brunton, 2021). By prioritizing the exploration of interpersonal and experiential factors, this qualitative methodology ensured actionable insights that did improve client engagement, motivation, and recovery outcomes in SUD treatment contexts.

IPA was particularly suited for exploring the complex and deeply personal experiences associated with SUDs, as it captured the nuanced social, psychological, and contextual factors shaping addiction and recovery. For example, Shinebourne and Smith (2011) used IPA to investigate narratives of addiction recovery, revealing the centrality of personal transformation and identity reconstruction in overcoming dependency. Similarly, McInally and Gray-Brunton (2021) applied IPA to examine the formation and evolution of TAs in SUD treatment, highlighting the role of empathy, mutual respect, and collaboration in fostering recovery.

IPA is invaluable in addressing qualitative research questions by delving into participants' lived experiences and uncovering underlying psychological processes that drive behaviors and decisions (McInally & Gray-Brunton, 2021). For instance, Klein et al. (2024) explored addiction therapists' experiences in supporting clients through relapse, uncovering the emotional toll on therapists and its implications for therapeutic relationships. Love et al. (2020) employed IPA to understand the influence of childhood experiences and significant life events on substance use and recovery among offenders, offering insights into personalized treatment strategies. By facilitating a deep and interpretative exploration of phenomena, IPA informs compassionate, tailored interventions that enhance treatment effectiveness and resonate with clients' realities (Peat et al., 2019).

Comparative case study and grounded theory were two commonly used qualitative methods in social sciences considered but deemed less suitable for this study than IPA. Comparative case study involves examining multiple cases to identify patterns, differences, and shared themes, with a focus on cross-case analysis and broader contextual understanding (Keronen, 2023; Yin, 2018). While useful for comparative insights, it risks diluting the depth of individual experiences, making it less appropriate for this research, which aims to explore the

lived experiences of counselors in establishing TAs in SUD treatment. Grounded theory, which generates theoretical frameworks grounded in participant data through iterative collection and analysis, was also found unsuitable as the study applies the established framework of SDT rather than seeking to construct new theories (Champ et al., 2024). Additionally, grounded theory prioritizes theoretical abstraction, whereas this dissertation study focuses on the rich, contextualized experiences of counselors, better aligning with phenomenological methods (Urquhart, 2023).

IPA, a specialized phenomenological approach, is the most appropriate choice for this study. It emphasizes exploring how individuals make sense of their lived experiences while incorporating the researcher's interpretative analysis (Smith et al., 2009). Unlike comparative case study or grounded theory, IPA allows for both idiographic (individual-level) and thematic analysis, offering an in-depth understanding of unique counselor experiences and broader insights into effective counseling practices. As highlighted by Smith and Osborn (2008), IPA is particularly suited for topics that are deeply personal or emotionally significant. Its focus on subjective experience and meaning aligns with the study's aim to uncover specific behaviors and strategies that foster strong TAs during the initial and ongoing stages of SUD treatment, making IPA the ideal methodological choice.

The sampling method was directly aligned with the research questions by ensuring that only therapists actively engaged in SUD treatment and with firsthand experience forming TAs were included. Conducting semi-structured interviews with these clinicians enabled an in-depth exploration of their behaviors, strategies, and reflections on the factors that contribute to developing a strong TA. By focusing on practitioners working within this specific clinical

context, the study ensured that the data collected were directly relevant, meaningful, and closely tied to the research questions (Delgadillo et al., 2022).

Theoretical Framework and Sampling Alignment

SDT served as the guiding theoretical framework for this study, emphasizing the fulfillment of psychological needs for autonomy, competence, and relatedness as key drivers of motivation and engagement in therapy. By selecting therapists who were experienced in fostering these needs through TA, the study ensured that the data collected will provide insights into how SDT principles can be operationalized in SUD treatment. The purposive and snowball sampling strategies thus reinforced the theoretical framework by selecting participants who were well-versed in applying these motivational principles in practice (Vansteenkiste et al., 2023).

In summary, the alignment between the problem statement, purpose, research questions, and sampling approach ensured that the study remained methodologically sound and focused. The use of purposive sampling allowed for the selection of therapists who have direct experience in forming and maintaining TAs in SUD treatment, while snowball sampling served as a strategic complement to mitigate potential recruitment challenges. This structured approach ensured that the study effectively addressed its research problem, fulfilled its purpose, and provided meaningful answers to its research questions, ultimately contributing to a deeper understanding of therapist behaviors that enhance TA and improve treatment outcomes in addiction counseling. Together, these strategies supported the study's goal of identifying effective therapist behaviors for building TAs, ultimately enhancing treatment practices and outcomes in the field of addiction counseling (Gierczyk et al., 2024; Moser & Korstjens, 2017; Sue et al., 2009).

Participants were recruited through direct contact via email and whatsapp chats through a few professional groups for therapists in Israel. Both have been used in the past by other therapists, and no permission is necessary to use these groups for recruitment purposes. Appendix A contains an invitation letter outlining the study's purpose and procedures and how each member will be contacted for the interview. These materials also specified ethical assurances, including confidentiality, voluntary participation, and the use of anonymized data (Hoeflich et al., 2022).

Population and Sample

The population for this study consisted of therapists actively working with clients undergoing substance use disorder (SUD) treatment in Israel. Participants included clinicians practicing in rehabilitation centers and private practice settings, with a specific focus on English-speaking professionals. Although the number of English-speaking addiction specialists in Israel is relatively small, this group represents a meaningful and relevant population because these therapists possess both the linguistic proficiency and clinical expertise required to treat English-speaking clients within a culturally distinct treatment environment. National data indicate that while many Israelis report some degree of English ability, functional proficiency varies considerably (Central Bureau of Statistics, 2024). As such, English-speaking SUD therapists constitute a specialized subgroup uniquely positioned to offer insight into therapeutic alliance (TA) development within this linguistic and cultural context.

This population was appropriate given the study's focus on examining therapist behaviors that foster a strong TA in SUD treatment. The inclusion of experienced counselors working directly with this population aligned with the study's problem, purpose, and research questions, which centered on improving therapeutic engagement and treatment outcomes through enhanced

alliance-building strategies (Creswell & Poth, 2021). These therapists practice within a unique cultural environment while serving a linguistically distinct client group, allowing them to provide rich, contextually grounded accounts of alliance formation shaped by interpersonal, cultural, and systemic factors (Krawczyk et al., 2023).

Research on TA across challenging clinical populations demonstrates that cultural, linguistic, and systemic conditions meaningfully influence the development and maintenance of therapeutic relationships. In a systematic review of 23 studies, Papalia et al. (2022) highlighted that alliance formation is particularly complex in contexts marked by stigma, trauma exposure, comorbid mental health conditions, and varying levels of intrinsic motivation. Although Papalia et al. (2023) focused on justice-involved youth, these findings are relevant to addiction counseling in Israel, where English-speaking clients may similarly experience cultural displacement, stigma, and psychological vulnerability. Therapists working in these contexts must navigate linguistic nuance, cultural dynamics, and systemic pressures while simultaneously fostering trust, safety, and engagement within the TA.

Purposive sampling was selected as the primary recruitment strategy for this qualitative phenomenological study, as it prioritizes the intentional selection of participants with direct, meaningful experience of the phenomenon under investigation (Moser & Korstjens, 2017). Given the study's focus on therapist behaviors that contribute to establishing and maintaining a strong TA in SUD treatment, purposive sampling ensured the inclusion of clinicians with substantial experience in alliance-building processes. This approach aligned with the study's central problem—namely, the lack of specificity regarding therapist actions that effectively establish alliances during early treatment—and its purpose of examining behaviors that support

engagement and meaningful therapeutic connection (DeAngelis, 2019; Norcross & Lambert, 2019).

Consistent with phenomenological research requirements, participants were selected based on their capacity to provide reflective, experience-based accounts grounded in professional practice (Creswell & Poth, 2018). Participants were English-speaking therapists practicing in Israel who provided treatment to clients with SUDs. This targeted sampling approach supported the collection of rich, detailed descriptions relevant to understanding how TAs are formed and sustained within this unique linguistic and cultural context.

Participant Inclusion Criteria

Participants were required to meet the following criteria:

- Provide treatment to individuals with substance use disorders
- Possess a minimum of two years of experience working with clients with SUDs
- Demonstrate experience in establishing therapeutic alliances, as evidenced by professional roles in rehabilitation centers or private practice
- Speak English fluently to participate in the interview process

This selection process ensured that participants possessed the clinical expertise and experiential knowledge necessary to meaningfully address the research questions.

Recognizing the specialized nature of the target population—English-speaking addiction counselors in Israel—a secondary recruitment strategy was incorporated to address potential access limitations. If initial purposive sampling did not yield a sufficient number of participants, snowball sampling was employed as a contingency strategy (Cherry, 2024; Gierczyk et al., 2024). Snowball sampling involves inviting participants to refer additional qualified professionals within their networks and is particularly effective when working with niche or

hard-to-reach professional groups (Etikan et al., 2020). Given the close professional networks within addiction counseling communities in Israel, this strategy supported both feasibility and credibility through professional referral (Gierczyk et al., 2024).

The sampling approach was also consistent with the study's theoretical grounding in self-determination theory (SDT), which emphasizes autonomy, competence, and relatedness as foundational to therapeutic engagement (Deci & Ryan, 2017). Inclusion criteria required participants to be English-speaking therapists practicing in Israel who currently or previously provided SUD treatment and who possessed formal training or professional certification in addiction counseling. These criteria ensured that participants had substantive experience fostering TAs and supporting client motivation within SUD contexts. The alignment between the study's problem, purpose, research questions, theoretical framework, and sampling strategy strengthened the methodological rigor of the study and ensured that participants were well positioned to provide insight into therapist behaviors that support the establishment and maintenance of a strong TA in SUD treatment.

Data Collection

Data collection involved semi-structured interviews conducted in a secure, private setting via Zoom, the a secure online platform to ensure confidentiality (Archibald et al., 2019). In qualitative research, data saturation occurs when no new themes or insights emerge from additional data collection. Given the specificity of the population and the focus on their lived experiences, the targeted sample size of 15 therapists is expected to achieve saturation, providing comprehensive insights into the phenomenon under investigation. All collected data was stored securely on password-protected Google cloud storage systems. Only the researcher had access to the data, and all identifiable information was removed during transcription to maintain

participant confidentiality (Squires, 2023). Zoom's transcription feature enabled the transcribing of all the sessions and created files that were analyzed by Nvivo. Nvivo software collected the themes or essences that captured the nature of the phenomenon under investigation; in our case, the behaviors that contribute to a more robust TA.

Instrumentation

Developing an effective interview protocol is crucial for exploring the behaviors that addiction therapists employ to establish a strong TA with clients undergoing SUD treatment. Given the specificity of the research questions and the unique context of English-speaking addiction counselors in Israel, a tailored interview protocol was recommended. A questionnaire and interview guide were developed for this study, with this dissertation's author acting as the interviewer, to gain insight from participants (see Appendix B). The interview questions were designed to align with the stated research questions.

The instrumentation section of this study articulated a rigorous methodology that integrates both quantitative and qualitative research traditions. This dual emphasis not only strengthened the measurement of key constructs but also captured the nuanced interpersonal strategies of addiction therapists, thereby informing the development of the research questions and the selection of interview guide items. Such an approach bridges the existing gap in the literature regarding specific therapist behaviors that enhance the TA in substance use disorder treatment (Wilmots et al., 2020).

Based on insights from the literature, open-ended questions were drafted to encourage detailed responses, such as:

1. "Can you describe specific techniques you use to establish trust with your clients?"

2. "How do you address challenges that arise in building a therapeutic alliance with clients who have a substance abuse disorder?"
3. "In your experience, what counselor behaviors have been most effective in maintaining a strong therapeutic alliance throughout treatment?" (Luborsky et al., 2022)

Study Procedures

The study followed a systematic and structured process to ensure that data collection was thorough, ethical, and replicable. The steps are detailed below:

Step 1: Institutional Review Board (IRB) Approval

Before commencing the study, the research proposal was submitted to the IRB for approval. This submission included all research materials, including the informed consent form, recruitment materials, interview protocol, and data management plan. Approval was granted, ensuring that the study complied with ethical guidelines for research involving human subjects (Creswell & Poth, 2021).

Step 2: Recruitment of Participants

Participants were recruited using purposive sampling, targeting licensed addiction therapists in Israel who work with clients with SUDs. Recruitment efforts included the following strategies:

- Direct outreach via email to professional colleagues, rehabilitation service providers, and private practices.
- Distribution of recruitment materials, including an invitation letter outlining the study's purpose, procedures, and confidentiality measures.
- Snowball sampling, whereby initial participants were invited to refer other eligible counselors within their professional networks, if necessary (Marshall et al., 2022).

- Provision of an informed consent document for participants' review and signature (see Appendix C).

Step 3: Screening and Consent

Potential participants were screened to ensure they met the inclusion criteria, including English proficiency, certification to work with SUD populations, and experience with comorbid psychiatric conditions (such as personality disorders, schizophrenia, schizotypal disorder, OCD, and bipolar disorder). Qualified participants received an informed consent stating they will have the right to leave the study at any point without providing a reason. This form detailed the study's purpose, procedures, potential risks, and benefits. Signed consent was obtained before participation (Clapp et al., 2023).

Step 4: Development and Field Testing of the Interview Protocol

To ensure clarity, content validity, and alignment with the research questions, the interview protocol went through field testing before formal data collection. Field testing was conducted with a small group of two to three addiction counselors who met the study's inclusion criteria but were not part of the main participant pool. These individuals served as expert reviewers to evaluate the interview guide's structure, language, and capacity to elicit in-depth, experience-rich responses related to the TA in SUD treatment (Flick, 2022).

Expert reviewers were selected based on three criteria: (a) licensure and clinical experience in addiction counseling for a minimum of three years; (b) familiarity with TA constructs through supervision, teaching, or publication; and (c) experience conducting or participating in qualitative research or structured clinical interviews. Each expert received a draft of the interview schedule, the informed consent form, and a summary of the research aims. After conducting a mock interview or reviewing the questions independently, they were invited to

provide written and/or verbal feedback on item relevance, wording clarity, logical flow, and comprehensiveness. Their feedback was analyzed thematically, and revisions were made to enhance question sensitivity, neutrality, and alignment with IPA principles (Brinkmann & Kvale, 2018).

Step 5: Data Collection

Interviews were conducted using a semi-structured format that allowed for in-depth exploration of each participant's lived experience while maintaining consistency across interviews. The process began with rapport building, including a warm greeting, review of the study's purpose, and a reminder of confidentiality and the voluntary nature of participation. Participants were encouraged to speak freely and informed that there are no "right" or "wrong" answers, a key strategy in creating psychological safety and openness (Smith et al., 2022). The interview flowed organically and was able to generally progress from broader contextual questions (e.g., professional background) to specific inquiries about alliance-building behaviors. Probes were used flexibly to elicit deeper reflection (e.g., "Can you tell me more about that?" or "How did you feel in that moment?"). The structure of the interview was intentionally open to allow the participant to guide parts of the discussion, reflecting the participant-led ethos of IPA and its idiographic focus.

Each interview lasted approximately 30 minutes and was conducted via Zoom. Interviews were audio-recorded and transcribed verbatim via the Zoom client. Participants were invited to review their transcripts for accuracy, if desired, and a few were contacted for brief follow-up if clarification was needed. A debriefing was held at the conclusion of the interview, during which participants were thanked, reminded of how their data would be used, and offered a summary of study findings upon completion. Interviews were scheduled at mutually agreed-upon times and

were expected to last 30 to 90 minutes. All interviews were audio-recorded with participants' consent and transcribed verbatim for analysis by the Zoom software (Tracy, 2020).

Step 6: Data Management and Security

To ensure confidentiality, all data was stored securely. Audio recordings and transcripts were stored on password-protected devices and encrypted cloud storage. Participant identifiers were replaced with pseudonyms during transcription to maintain anonymity. The researcher was the only one to know the names of the participants. Only the researcher had access to the data, with the exception of the auditor and the dissertation committee, as required.

Step 7: Data Analysis

The transcribed interviews were analyzed using IPA to explore the lived experiences of counselors. This method involved: Reading and re-reading transcripts to become fully immersed in each participant's account. Next, during initial noting, detailed annotations (descriptive, linguistic, and conceptual) were made to capture depth and nuance. In the third step, I developed emergent themes by synthesizing these notes into concise statements that reflected both participant meaning and interpretative insight. These themes were then organized by searching for connections within each case, clustering them into superordinate categories. I then moved to the next case, bracketing prior findings to preserve the idiographic focus. After completing individual analyses, I looked for patterns across cases, identifying shared themes as well as divergences. Finally, I produced a narrative account integrating thematic interpretations with illustrative participant quotes and linking the findings to existing literature and theory. This iterative and reflexive process ensured both rigor and sensitivity to the lived experiences of participants (Smith et al., 2022).

Step 8: Reporting Findings

Findings were documented in the dissertation manuscript, with a focus on addressing the research questions and contributing to the existing body of knowledge on TAs in SUD treatment. Participants were offered a summary of the study results upon completion.

Step 9: Ethical Considerations

Throughout the study, ethical principles were upheld, including respect for participant autonomy, confidentiality, and the right to withdraw at any time. Participants were informed of their rights and the measures taken to protect their information. Qualified participants received an informed consent stating they will have the right to leave the study at any point without providing a reason. By following these detailed procedures, this study aimed to collect robust, meaningful data that provided actionable insights into enhancing TAs in substance use disorder treatment. The outlined steps ensured transparency and replicability for future research (Whitney, 2021).

Data Analysis

Data analysis for this study was conducted using **Interpretative Phenomenological Analysis (IPA)**, a qualitative analytic approach designed to explore how individuals make sense of their lived experiences through an interpretive and idiographic lens (Smith et al., 2009; Smith & Osborn, 2008). IPA is grounded in phenomenology, hermeneutics, and idiography and is particularly suited to examining complex relational and professional experiences, such as therapists' efforts to establish and maintain a therapeutic alliance in substance use disorder (SUD) treatment. Central to IPA is the *double hermeneutic*, in which participants seek to make sense of their experiences while the researcher engages in an interpretive process to understand that meaning-making.

Analysis followed established IPA procedures and proceeded in a structured, sequential manner. Each interview transcript was analyzed individually before any cross-case comparison occurred, ensuring that each participant's account was examined in depth and on its own terms. This idiographic focus allowed for close engagement with the unique experiential world of each therapist and prevented premature generalization across cases.

The first stage of analysis involved repeated, line-by-line reading of each transcript to promote immersion in the data. During this stage, detailed exploratory notes were made, focusing on descriptive content, language use, emotional tone, and initial conceptual reflections. This close engagement supported sensitivity to nuance and allowed the researcher to remain grounded in participants' original words and meanings.

In the next stage, **emergent themes** were developed from the exploratory notes within each individual case. These themes represented concise expressions of psychologically meaningful aspects of the participant's experience related to therapeutic alliance development and maintenance. Emergent themes were then examined for conceptual connections and clustered to form higher-order thematic groupings within each case, while maintaining clear links to the underlying data.

After completing this within-case analysis for all participants, patterns were examined across cases to identify **convergences and divergences** in how therapists understood and experienced alliance-building in SUD treatment. This cross-case analysis resulted in the development of **superordinate themes** that reflected shared meaning across participants while preserving individual variation, consistent with IPA's balance between idiographic depth and interpretive synthesis.

Throughout the analytic process, reflexive engagement was maintained to acknowledge the researcher's interpretive role and to bracket pre-existing assumptions where possible (Smith et al., 2009). Analytic decisions, theme development, and interpretive insights were documented to create a transparent audit trail and to enhance the credibility and dependability of the findings. Qualitative data management strategies, including systematic coding and memoing, were used solely as organizational tools to support the IPA process. These procedures facilitated data organization, theme tracking, and analytic transparency but did not constitute a separate analytic method (Peat et al., 2019; McNally & Gray-Brunton, 2021). All analytic decisions were guided by IPA principles and remained grounded in participants' lived experiences.

This IPA-centered analytic approach was well aligned with the purpose of the study, which sought to explore therapist-identified behaviors that support the establishment and maintenance of a strong therapeutic alliance in SUD treatment. By privileging participants' meaning-making while engaging in careful interpretation, this method allowed for a clear, systematic, and nuanced understanding of how therapists experience alliance-building within complex clinical, relational, and cultural contexts (Ganesha & Aithal, 2022).

In keeping with Interpretative Phenomenological Analysis (IPA), the researcher was recognized as an active instrument in the analytic process. IPA is grounded in a double hermeneutic, whereby participants make sense of their lived experiences and the researcher engages in an interpretive process to understand that meaning-making (Smith et al., 2009). Accordingly, data analysis reflected a co-constructed understanding shaped by participants' accounts and the researcher's analytic engagement rather than an objective or value-neutral representation of experience.

The researcher's professional background in addiction counseling provided familiarity with the clinical context of substance use disorder (SUD) treatment and therapeutic alliance development, supporting sensitivity to participants' language, relational dynamics, and descriptions of therapeutic processes. To address potential bias, reflexive engagement was maintained throughout data collection and analysis. Reflexive notes and analytic memos were used to document interpretive decisions, emerging assumptions, and analytic rationale, thereby promoting transparency and trustworthiness. This approach supported intentional bracketing where possible while remaining consistent with IPA's epistemological position that interpretation is inherent to qualitative inquiry (Smith et al., 2009).

Assumptions

Assumptions were integral to shaping the foundation of this study, guiding its methodological approach, and contextualizing its findings. This research on the TA in SUD treatment operated under several key assumptions. A central assumption was that therapists participating in the study provided honest, comprehensive, and reflective responses during the qualitative interviews. This is crucial, as the study relied on the richness and authenticity of participants' narratives to explore their lived experiences, consistent with the IPA methodology (McInally et al., 2021; Smith et al., 2022). Additionally, it was assumed that participants shared a foundational understanding of key constructs, such as the TA and autonomy-supportive counseling, to ensure the reliability and coherence of their responses. This shared understanding aligned with existing research, which suggests that professionals within similar fields often operate within common conceptual frameworks, particularly when grounded in established theories like SDT (Deci & Ryan, 2017).

Another significant assumption was that the principles of SDT, specifically the psychological needs for autonomy, competence, and relatedness, were relevant and applicable to the context of SUD treatment. This was supported by extensive empirical evidence demonstrating the utility of SDT in healthcare settings, particularly in fostering motivation and improving engagement in addiction counseling (Chan et al., 2023; Deci & Ryan, 2017; Ng et al., 2012). Furthermore, it was assumed that therapists recruited for this study possessed the requisite professional competence and experience to provide valuable insights into perceived effective TAs. Given the advanced concepts being explored, including therapist-client dynamics and motivational processes, this assumption was supported by the purposive sampling strategy, which ensured that participants were qualified and experienced in SUD counseling (Dawood & Done, 2021; Smith et al., 2022).

A key focus of this study was the initial formation of the TA, it is assumed to be critical for fostering long-term treatment engagement and success in SUD contexts. Literature underscores the importance of early therapeutic sessions in establishing trust, setting mutual goals, and building collaborative bonds, all of which are foundational to effective therapy (Flückiger et al., 2018; Norcross & Lambert, 2018). While the study was conducted in Israel, it assumed that the findings regarding therapist behaviors and TA formation would be broadly applicable to diverse cultural contexts. The universality of SDT as a theoretical framework supports its cross-cultural relevance, although cultural nuances were acknowledged in the interpretation of findings (Deci & Ryan, 2017; Patel et al., 2024).

These assumptions collectively underpinned the study's design and execution, ensuring alignment between the theoretical framework, methodology, and research objectives. By explicitly acknowledging these assumptions and their rationale, the study maintained

transparency and rigor, enhancing the credibility of its findings and their potential contribution to the field of addiction counseling.

Limitations

Several limitations influenced the findings and interpretations of this study. One primary limitation was the reliance on qualitative data collected through interviews with therapists. While qualitative research methods, such as IPA, are effective for exploring lived experiences in depth, they are inherently subjective, and the interpretation of data can be influenced by researcher bias (Smith et al., 2009). To mitigate this limitation, bracketing techniques were employed, where the researcher systematically acknowledged and set aside personal beliefs and assumptions during data analysis to ensure a focus on participants' perspectives (McInally & Gray-Brunton, 2021).

Another limitation involved the potential lack of generalizability. The study's purposive sampling targeted English-speaking therapists working in Israel, which may not fully represent therapists in other cultural or linguistic contexts. Although SDT provides a universal framework applicable across cultures (Deci & Ryan, 2017), cultural nuances may still impact the TA's formation and development. To address this, findings were carefully contextualized, and the study's scope was clearly defined to acknowledge its cultural specificity while identifying transferable insights (Patel et al., 2024). Additionally, the sample size of 15 therapists may constrain the breadth of perspectives captured. While this sample size aligns with IPA methodology, which values depth over breadth, it inherently limits the diversity of experiences included (Smith et al., 2009). To address this, participants were selected based on their expertise in working with SUD populations, ensuring that the data was rich and relevant to the study's objectives.

Finally, the study relied on self-reported data from participants, which may introduce recall bias or social desirability bias, as participants may have tailored responses to align with perceived expectations (Chan et al., 2023). To mitigate this, interview questions were designed to be neutral and open-ended, encouraging participants to share their genuine experiences. Additionally, triangulation with existing literature on TAs and SDT ensured that findings were supported by broader evidence (Ng et al., 2012; Ryan & Deci, 2017). Despite these limitations, the measures taken to address them aim to enhance the study's credibility and rigor. By transparently acknowledging these challenges, this research contributed valuable insights into the role of therapist behaviors in forming effective TAs within SUD treatment.

Delimitations

Delimitations were the boundaries intentionally set by the researcher to define the scope of the study. This study on the TA in SUD treatment incorporated several key delimitations, grounded in the theoretical framework, research objectives, and methodological approach. One primary delimitation was the focus on English-speaking therapists practicing in Israel. This decision was made to ensure a common language for data collection and to explore therapeutic practices in a unique cultural and geographical context. While this focus may limit the generalizability of the findings to non-Israeli or non-English-speaking populations, it allows for an in-depth examination of the therapeutic alliance within a culturally specific framework. SDT provided a universal theoretical lens that supported the cross-cultural applicability of the study's findings while acknowledging potential nuances in local practices (Deci & Ryan, 2017; Patel et al., 2024).

The study also delimited its sample to therapists who have significant experience working with SUD populations, including individuals with comorbid psychiatric conditions. This ensured

that participants possessed the requisite expertise to provide meaningful insights into the formation and maintenance of TAs within SUDs counseling. By focusing on experienced professionals, the study aligns with existing literature emphasizing the importance of therapist competence in fostering strong therapeutic relationships (Flückiger et al., 2018; Deci & Ryan, 2017). However, this delimitation may exclude perspectives from novice therapists or those working in other mental health domains, potentially limiting the diversity of insights.

Another delimitation is the use of qualitative methodology, specifically IPA. This approach prioritized depth over breadth, focusing on the subjective experiences of a small, purposive sample of 10–15 participants. While this design did not aim for generalizability, it allowed for a detailed exploration of how therapist behaviors influence TA formation, which was particularly relevant given the study's phenomenological focus (Smith et al., 2009). The small sample size was consistent with IPA's emphasis on detailed, idiographic analysis, but it inherently limited the scope of findings to the specific population studied (McInally & Gray-Brunton, 2021).

Additionally, the study centered on the early stages of the therapeutic relationship, typically the first five sessions. Research has suggested that the initial formation of the TA is critical for long-term engagement and treatment success (Norcross & Lambert, 2018). By narrowing the focus to these early interactions, the study addressed a specific gap in the literature concerning how therapists establish trust and collaboration during initial sessions. However, this delimitation excluded later stages of therapy, potentially overlooking dynamics that evolve over time (Flückiger et al., 2018). The intentional selection of delimitations in this study ensured alignment with the problem statement, purpose, and research questions by narrowing the scope to address specific gaps in the literature.

The study focused on identifying therapist behaviors that enhanced the TA during SUD treatment, particularly in the initial sessions, where building trust and engagement is critical. By limiting the sample to English-speaking therapists in Israel and utilizing IPA, the research targeted a specific context, providing in-depth insights into therapist actions that foster strong alliances. These delimitations supported the problem statement, which highlighted the lack of specificity regarding effective therapist behaviors, and they maintain coherence with the study's purpose of improving treatment outcomes by strengthening the TA. Recent studies emphasize the importance of focused qualitative approaches in capturing the nuances of therapeutic processes, particularly when examining counselor-client dynamics (McInally & Gray-Brunton, 2021; Flückiger et al., 2018).

The intentional selection of delimitations in this study ensured alignment with the problem statement, purpose, and research questions by narrowing the scope to address specific gaps in the literature. The study focused on identifying therapist behaviors that enhanced the TA during SUD treatment, particularly in the initial sessions, where building trust and engagement was critical. By limiting the sample to English-speaking therapists in Israel and utilizing IPA, the research targeted a specific context, providing in-depth insights into therapist actions that fostered strong alliances. These delimitations supported the problem statement and maintained coherence with the study's purpose of improving treatment outcomes by strengthening TAs (Flückiger et al., 2018; McInally & Gray-Brunton, 2021).

Ethical Assurances

This study adhered to strict ethical standards to ensure the protection and well-being of participants, in compliance with the guidelines set forth by the IRB at National University. Approval from the IRB was obtained before the commencement of data collection to ensure that

the study's design, methodology, and procedures meet ethical requirements. The study posed minimal risk to participants, as it involved non-invasive interviews with professional therapists. However, potential ethical concerns included maintaining participant confidentiality and addressing researcher biases. To safeguard confidentiality, all identifying information was removed from the data, and pseudonyms were used in transcripts and reports. Participants were informed of these measures through an informed consent form, ensuring they understood their rights, including the ability to withdraw from the study at any time (Smith et al., 2009). Data was securely stored on encrypted digital devices, and access was restricted to the researcher. In compliance with IRB guidelines, all data were retained for a specified period and then securely destroyed.

The role of the researcher was central to the study, particularly in qualitative research where the researcher served as the primary instrument for data collection and analysis (McInally & Gray-Brunton, 2021). To address potential biases stemming from personal or professional experiences with the TA in SUD treatment, reflexivity was employed throughout the research process. Reflexivity involves ongoing self-reflection to identify and mitigate personal assumptions or preconceptions that could influence data interpretation (Smith et al., 2009). Bracketing techniques, consistent with IPA, were also used to separate the researcher's experiences from participants' perspectives, ensuring the analysis remained focused on the participants' lived experiences.

To further ensure ethical integrity, participants received detailed information about the study's purpose, procedures, and their rights before consenting to participate. They were given the opportunity to ask questions and provide informed consent voluntarily, in accordance with

ethical research practices (APA, 2020). By implementing these measures, the study upheld the highest standards of ethical research, prioritizing participant welfare and data integrity.

Summary

Using a qualitative approach grounded in IPA, the study explored the lived experiences of therapists in establishing TA with clients undergoing SUD treatment. This chapter provided a rationale for the chosen methodology and outlined the research methodology including the approach, assumptions, delimitations, and ethical considerations shaping this study. This chapter clarified the research design, including purposive sampling of English-speaking therapists in Israel and the data collection process, which involved semi-structured interviews to gain rich insights into the therapists' perspectives (Deci & Ryan, 2017; van Lier et al., 2018). The chapter also and discussed the alignment of this research with SDT, emphasizing the need to satisfy psychological needs for autonomy, competence, and relatedness in fostering a strong TA (Vansteenkiste et al., 2020).

Key assumptions were identified, such as the expectation that therapists will provide honest and reflective responses, that SDT is applicable in the context of SUD treatment, and that the early stages of therapy are critical for establishing trust and collaboration (Peat et al., 2019). Delimitations were also discussed, including the study's focus on experienced therapists and the emphasis on the initial phases of therapy.

Ethical considerations were rigorously detailed. Approval from the IRB will be secured before data collection, and measures to protect participant confidentiality were outlined, including the use of pseudonyms and secure data storage. The researcher's role was also addressed, with strategies such as reflexivity and bracketing employed to minimize bias and maintain objectivity during data analysis (McInally, W. & Gray-Brunton, 2021).

This chapter set the stage for Chapter 4, which presented the study's findings. The next chapter focuses on the themes emerging from the data, providing insights into the therapist behaviors and strategies that contribute to forming strong TAs. By building on the methodological foundation laid out in this chapter, Chapter 4 contributes evidence to the understanding and application of SDT in addiction counseling, and offers practical implications for enhancing therapeutic outcomes.

Chapter 4: Findings

The problem addressed in this study was the significant gap in existing research concerning the lack of specificity regarding the actions and behaviors of therapists that effectively established and maintained a TA during SUD treatment (Muran & Barber, 2010). While the importance of a strong TA had been well documented, particularly in fostering client engagement, adherence to treatment, and positive outcomes, there remained a paucity of detailed insights into the specific therapist behaviors that contributed to the development of this alliance, especially during the critical initial sessions (DeAngelis, 2019; Norcross & Lambert, 2019).

The purpose of this study was to examine the role of the TA as described by therapists working with clients with SUDs, using SDT as the guiding framework. Rather than measuring treatment outcomes directly, this study focused on how therapists perceived and described their own behaviors and strategies in building and sustaining the alliance.

This chapter presents the findings of a qualitative phenomenological study that explored addiction therapists' lived experiences of establishing and maintaining a strong TA in the treatment of clients with SUDs (Smith et al., 2022). The IPA approach allowed for a detailed, idiographic exploration of therapists' personal and professional reflections on the interpersonal dynamics involved in building and sustaining the TA in SUD treatment. The use of IPA was consistent with the study's theoretical grounding in SDT, as both prioritized the subjective experience of individuals navigating relationships that fostered autonomy, competence, and relatedness (Dece & Ryan, 2017).

The data analysis followed the seven-phase model of IPA delineated by Smith et al. (2022). First, I engaged in repeated reading of each transcript to develop familiarity with the participants' words, tone, and emotional expressions. This immersive step grounded the

subsequent analysis in the authentic voice of each participant. Second, I conducted initial noting, developing detailed descriptive, linguistic, and conceptual comments that captured not only what participants said but how they said it and what it might signify within the broader therapeutic context. Third, I identified emergent themes, condensing the exploratory notes into concise and meaningful units of analysis that reflected core psychological processes. These emergent themes were then clustered into superordinate themes (phase four), creating higher-order categories that captured patterns of meaning, such as “Authentic Presence,” “Validation,” and “Consistent Availability”, that recurred across the data. In the fifth phase, I bracketed previous findings and returned to the next case afresh, allowing for idiographic insight into each participant’s unique experience (Cutrer-Párraga et al., 2024; Smith et al., 2022). In phase six, I examined patterns across cases, synthesizing similarities and divergences into a final thematic structure that reflected shared phenomena while preserving individual nuance. Finally, in the seventh phase, I developed a comprehensive narrative that integrated participants’ voices with interpretative commentary. This double hermeneutic process—wherein the researcher sought to make sense of the participant making sense of their world—produced a layered understanding of the interpersonal strategies and therapeutic philosophies that informed the establishment and maintenance of the TA in SUD counseling (Smith et al., 2022).

The findings were presented thematically, organized around the four themes that emerged in response to Research Question 1 (RQ1, initial session alliance-building) and four additional themes addressing Research Question 2 (RQ2, maintenance of the TA over time). Each theme included illustrative quotations supported by the analytic process. The structure of the findings maintained a commitment to idiography, while also offering cross-case insights into the common

practices and values that therapists described as central to effective addiction counseling (Smith et al., 2022).

Trustworthiness of the Data

Ensuring trustworthiness was essential to the rigor and credibility of qualitative research, particularly in phenomenological inquiries where the goal was to illuminate participants' lived experience in depth and context. Trustworthiness refers to "the degree to which a study genuinely reflects participant perspectives and the context studied through the chosen qualitative study design and reporting of the findings" (Stahl & King, 2020, p. 32). Classic qualitative methodologists articulated complementary criteria, specifically credibility, transferability, dependability, and confirmability, as anchors for evaluating and enhancing the quality of interpretive work (Guba & Lincoln, 1985; Shenton, 2004). More recent scholars extended these ideas by emphasizing methodological transparency, reflexivity, analytic coherence, and the auditability of interpretive decisions across the research lifecycle (Moser & Korstjens, 2018; Nowell et al., 2017; Stahl & King, 2020).

In this IPA study, multiple, layered strategies were incorporated into the design, data collection, data management, and analytic processes to support trustworthiness. Data were generated through semi-structured, audiovisual interviews conducted via the Zoom platform, a format that facilitated geographic reach across Israel's addiction treatment community while preserving real-time relational cues (e.g., tone, facial affect) central to phenomenological meaning-making (Kvale & Brinkmann, 2014). This procedure aligned with recent phenomenological research employing video conferencing platforms, which demonstrated that such remote interviews effectively captured lived experience and embodiment through visible affect and synchrony in interaction. Other phenomenological investigations, including studies of

remote ethnography and Zoom classroom experiences, explicitly argued for the validity of preserving relational resonance and embodiment through video-based interviewing, supporting the method as a rigorous alternative to in-person interviews during geographically dispersed sampling (Hyde & Rouse, 2023).

Prior to beginning each interview, I read the approved informed consent script aloud (see Appendix C), confirmed participant understanding, answered questions, obtained verbal consent to proceed, and secured explicit permission to record audio and video. Participants were reminded that their involvement was voluntary; they could decline to answer any question, pause the recording, or withdraw from the study at any time without penalty. Recordings were downloaded immediately after each session, labeled only with a unique study ID, and stored in encrypted, password-protected folders accessible solely to the researcher, in accordance with IRB and National University data security requirements. Professional transcription was completed from the audio track via the Zoom software. All personally identifying information (names, locations, agencies, highly specific client anecdotes) was removed or altered during de-identification, and each participant was assigned a pseudonym used consistently in coding, memoing, and reporting to protect confidentiality. This process was supported via Nvivo software which facilitated running analysis queries and organizing codes in ways that enhanced reliability in theme development (Lozon & Bensimon, 2025). A de-identification log linking real names to pseudonyms was stored separately in an encrypted file. Participants were offered the opportunity to review their de-identified transcript excerpts used in the dissertation and could request redaction of any material they considered sensitive (Guba & Lincoln, 1985; Stahl & King, 2020).

Because IPA involves a double hermeneutic, with the researcher making sense of participants making sense of their clinical experience, demonstrating analytic transparency was especially important (Smith et al., 2022). To that end, a structured audit trail was maintained to document decisions at each analytic phase: initial noting conventions, theme development, clustering rules, revisions following peer debriefing, and movements from idiographic to cross-case interpretation. Reflexive memos captured my professional positioning as an addiction counselor and doctoral researcher, the assumptions I bracketed, and points where my insider knowledge of SUD treatment both illuminated and risked narrowing interpretation (Moser & Korstjens, 2018). Peer debriefing with my dissertation chair, and periodic consults with a qualitative analysis mentor, served as external checks on coding coherence and interpretive stretch, strengthening credibility and confirmability (Shenton, 2004). Thick, participant-centered description and the strategic use of illustrative quotations support readers in assessing the fit or transferability of these findings to comparable SUD treatment contexts (Guba & Lincoln, 1985; Nowell et al., 2017).

The sections that followed detail the specific procedures used to ensure credibility (authentic representation of participant meaning through prolonged engagement with transcripts, reflexive bracketing, and participant transcript opportunity); transferability (dense contextual description of therapist roles, treatment settings, and client populations to allow analytic generalization); dependability (systematic documentation of methodological decisions, versioned codebooks, and consistent analytic procedures across cases); and confirmability (audit trail, reflexive journaling, and evidence chains linking interpretations to raw data). Together, these strategies operationalized trustworthiness in this IPA investigation of therapist behaviors that

built and sustained the TA in SUD treatment (Guba & Lincoln, 1994; Smith et al., 2022; Stahl & King, 2020).

Credibility

Credibility in qualitative research refers to the degree to which the findings accurately represent the participants' meanings and lived experiences (Guba & Lincoln, 1985; Shenton, 2004). In this IPA study, credibility was established through several intentional strategies. First, prolonged engagement with the data was achieved through repeated reading and analytic immersion. Each transcript was read multiple times initially for familiarity, and then for meaning-making through detailed exploratory notes (Smith et al., 2022). This immersive process preserved the idiographic richness of each account while also surfacing psychological and contextual nuance.

Second, a verbatim transcription of each interview was performed using the Zoom software, and transcripts were then manually checked for accuracy by comparing them against the original recordings. Any necessary corrections were made to align with participants' exact words, tone, and pauses. Member checking was offered to participants through transcript sharing; while only three participants elected to review their transcripts, the option itself supported ethical transparency and allowed for clarification or redaction of sensitive content when requested (Birt et al., 2016; Morse, 2015).

Third, reflexive bracketing was incorporated throughout the analysis. I documented my assumptions and professional positioning as an addiction counselor and doctoral researcher in reflexive memos, which served to increase awareness of potential bias. This process minimized interpretive distortion and strengthened the authenticity of how participant perspectives were represented (Moser & Korstjens, 2018).

Finally, peer debriefing enhanced credibility by subjecting interpretations to external review. Regular discussions with my dissertation chair and periodic consultations with a qualitative research mentor provided additional perspectives on coding coherence, theme development, and the plausibility of interpretations. These checks reinforced analytic rigor and further anchored the findings in participants' lived experiences (Shenton, 2004).

Transferability

Transferability referred to the extent to which the findings of this study could be applied to other contexts, settings, or populations (Guba & Lincoln, 1985; Shenton, 2004). In qualitative research, the responsibility for judging transferability rests with the reader; however, the researcher facilitated this process by providing thick description that allowed others to assess the applicability of the findings to their own contexts (Nowell et al., 2017).

In this study, transferability was supported by detailed descriptions of participant demographics, professional backgrounds, and treatment settings. Each participant's years of clinical experience, type of therapeutic training, and work environment were documented to allow readers to evaluate similarities or differences with their own practice settings. Contextual descriptions of the Israeli addiction treatment landscape further grounded the data, clarifying the clinical environments in which the TA was established and maintained.

Additionally, verbatim quotations (see Appendix B) were integrated into the presentation of themes. These quotations offered a direct window into participants' voices, enabling readers to evaluate whether the interpretations aligned with the participants' lived experiences. By anchoring interpretations in thick description and participant narratives, the study provided sufficient contextual depth for others to consider the extent to which these findings may apply to

different clinical settings, populations, or cultural contexts (Nowell et al., 2017; Smith et al., 2022).

Dependability

Dependability in qualitative research referred to the stability and consistency of the research process across time and conditions (Guba & Lincoln, 1985; Shenton, 2004). To address dependability, I maintained systematic documentation of all methodological decisions and analytic procedures throughout the study. An audit trail was kept to record decisions regarding coding conventions, theme clustering, and revisions during the analytic process. This documentation provided transparency and allowed for the tracing of how interpretations developed over time (Nowell et al., 2017).

Versioned codebooks were created during the analysis to ensure that coding decisions were applied consistently across transcripts. As themes evolved, earlier coding frameworks were updated while preserving prior versions, enabling comparison and verification of analytic stability. This process demonstrated how themes were refined while maintaining continuity with participants' original meaning.

In addition, analytic procedures were applied consistently across cases. Each transcript was approached first idiographically and then compared across cases, ensuring that the idiographic richness of each participant's account was preserved before moving toward cross-case interpretation. This step-by-step procedure enhanced dependability by demonstrating methodological consistency while also aligning with the idiographic principles of IPA (Smith et al., 2022).

Confirmability

Confirmability in qualitative research referred to the degree to which the findings were shaped by the participants' accounts rather than researcher bias, motivation, or perspective (Guba & Lincoln, 1985; Shenton, 2004). In this study, confirmability was supported through multiple strategies designed to ensure transparency and minimize interpretive distortion. An audit trail was maintained to document decisions at each stage of the research process, from coding and theme development to clustering rules and analytic revisions. This record allowed for the verification of how findings emerged directly from the data. Reflexive journaling was also used to capture my assumptions, professional positioning, and analytic decisions. These memos provided a space to bracket insider knowledge as an addiction counselor and doctoral researcher, ensuring that interpretations remained grounded in participants' lived experiences (Moser & Korstjens, 2018).

Evidence chains were developed to link raw data with emergent themes and final interpretations. Each claim made in the findings could be traced back to verbatim quotations and coded material, reinforcing the transparency and rigor of the analytic process. In addition, peer debriefing with my dissertation chair and consultations with a qualitative mentor provided external checks on the plausibility and coherence of interpretations, further strengthening confirmability (Nowell et al., 2017; Shenton, 2004).

Results

The results of this study are presented in alignment with the two research questions and the themes that emerged from participant interviews. The findings are organized thematically, with four themes reflecting responses to RQ1 (therapist strategies for establishing a TA in initial

sessions) and four themes reflecting responses to RQ 2 (therapist strategies for maintaining a TA throughout treatment). Each theme is supported by illustrative participant quotations.

The presentation of results follows the analytic structure of IPA. This method emphasizes idiographic detail while also identifying cross-case patterns. The voices of participants are included through verbatim quotations to demonstrate how therapists described their approaches to alliance-building. Quotations are attributed to participants using pseudonyms, with identifying information removed to protect confidentiality.

Demographic Overview

The study included 14 licensed addiction counselors practicing in Israel. Participants represented therapeutic disciplines including clinical social work, addiction counseling, professional counseling, psychology, and psychiatry. The sample comprised 11 male and three female therapists, ranging in age from 32 to 72 years, with the majority between 40 and 60 years. All participants identified as Jewish, consistent with the cultural context and purposive sampling criteria. Years of professional experience ranged from 7 to 49. Educational backgrounds included master's degrees in social work or counseling, as well as advanced doctoral degrees in psychology and psychiatry. A demographic summary is provided in Table 1.

Table 1*Participant Demographic Information*

Pseudonym	Sex	Age	Religion	Therapist Type	Yrs. of Experience in Treating SUDs
Part. 1	Male	41	Jewish	MSW	14
Part. 2	Male	73	Jewish	MSW	35
Part. 3	Male	72	Jewish	MS in Addictions	17
Part. 4	Male	65	Jewish	PhD Psychology	25
Part. 5	Female	32	Jewish	MS in Counseling	7
Part. 6	Female	46	Jewish	MS in Counseling	7
Part. 7	Male	43	Jewish	MS in Counseling	14
Part. 8	Male	74	Jewish	Psychiatrist	45
Part. 9	Male	38	Jewish	MSW	9
Part. 10	Female	54	Jewish	MSW	14
Part. 11	Male	42	Jewish	MSW	14
Part. 12	Male	39	Jewish	MSW	9
Part. 13	Male	73	Jewish	Psychiatrist	49
Part. 14	Female	63	Jewish	MSW	38

Note. All participants were licensed in psychiatry, psychology, social work, and counseling, and were currently practicing in Israel. Age ranges are approximate to protect anonymity. All therapists identified as Jewish and were practicing in either outpatient (12) or residential substance use treatment settings (2). MSW is a master's in social work. All participants were engaged in work with SUD patients throughout their careers.

RQ1: What are therapists' perceptions of the behaviors and strategies that support the establishment of a strong therapeutic alliance in initial sessions?

Data Analysis Process Leading to Theme Development. The generation of themes in this study followed the seven-phase model of IPA described by Smith et al. (2022). Each step contributed directly to the identification of the superordinate and subordinate themes presented in the results.

1. **Reading and Re-Reading** – Each transcript was read multiple times to ensure familiarity with the words, tone, and pacing of the participants. During these readings, I began to notice recurring emphases on relational qualities such as presence, validation, and attunement.
2. **Initial Noting** – Exploratory notes were written in the margins of each transcript. These included descriptive notes on participant statements (e.g., “I need to show up consistently for my clients”), linguistic observations on word choice (e.g., frequent use of “trust,” “safety,” “authentic”), and conceptual notes about underlying meanings (e.g., sustained presence as a foundation for alliance). This process began to point toward the categories that later became the study’s themes.
3. **Developing Emergent Themes** – From the exploratory notes, I created concise statements that captured the psychological essence of what participants described. For example, comments about “showing up even when clients are resistant” were condensed into the emergent theme of *Consistent Availability*, while notes on “meeting the client where they are” led to the emergent theme of *Authentic Presence*.

4. **Searching for Connections Across Emergent Themes** – Within each transcript, emergent themes were clustered into broader superordinate categories. For example, *Validation* and *Empathic Attunement* were grouped together under the superordinate theme of *Establishing Alliance in Initial Sessions*. Similarly, themes such as *Adaptability* and *Boundary-Setting* were connected under the superordinate theme of *Maintaining the Alliance Over Time*.
5. **Moving to the Next Case** – Each transcript was then analyzed afresh, with prior themes bracketed to preserve idiographic focus. This ensured that the emergent categories from one participant did not overly shape the interpretations of another. For example, while *Validation* recurred in multiple transcripts, new themes such as *Transparent Communication* also emerged uniquely in subsequent cases.
6. **Looking for Patterns Across Cases** – After analyzing all 14 transcripts, I compared emergent themes across participants. Points of convergence were identified, such as the near-universal emphasis on *Authentic Presence* in the first sessions, while points of divergence, such as how *Boundary-Setting* was expressed differently across therapists, were also preserved. This cross-case analysis allowed me to refine eight final superordinate themes (four addressing initial alliance formation and four addressing alliance maintenance).
7. **Producing the Final Narrative** – The final superordinate themes and their related subthemes were organized into a coherent structure that directly addressed the two research questions. Verbatim quotations from participants were selected to illustrate each theme, demonstrating how the categories (e.g., *Authentic Presence*, *Validation*,

Consistent Availability, Adaptability) were grounded in the lived experiences of therapists.

Through this thematic analytic process, eight superordinate themes were identified. Four themes addressed RQ1, focusing on therapist behaviors and strategies that supported the establishment of a therapeutic alliance in initial sessions. Four additional themes addressed RQ2, focusing on therapist strategies that supported the maintenance of the alliance over time. The following sections present these themes, supported by verbatim participant quotations to illustrate how they emerged from the data.

Theme 1: Authentic Presence and Warmth. Thirteen of the fourteen participants described the importance of bringing a genuine, human presence into the therapeutic space from the outset. They emphasized showing up as themselves rather than adopting a professional façade. Participant 6 stated, “I want them to know I care about them, not just as clients, but as people... My goal is that they feel welcomed and safe.” Participant 5 commented, “I’m very real with the client... I’ll call them out, but it comes from a place of caring. I’m a straight shooter.” Participant 4 explained, “I am with them, not against them. I’m no different than they are—we’re both trying to make sense of things.” Participant 8 added, “I show up as myself. I don’t put on a show. That would be dishonest.”

Sub-theme 1.1: Being Real and Transparent. Thirteen of the fourteen participants emphasized the use of transparency and selective self-disclosure as a means of modeling honesty and vulnerability. Participant 4 stated, “I’ll often say, ‘I’m on the same journey, just a few steps ahead.’ That evens the playing field.” Participant 3 shared, “Sometimes I disclose things that are relevant—not to shift focus, but to humanize the moment and build trust.” Participant 14

reinforced this approach, explaining, “I work for you. You’ve hired me. I don’t know what you need yet, but I’m here to help you figure it out.”

Sub-theme 1.2: Inviting Feedback and Co-Creation. Seven out of fourteen therapists described the alliance as a dynamic, co-created process that begins with inviting the client into mutual shaping of the relationship. Participant 5 said, “I’m constantly checking in: ‘How is this going for you? Does this feel useful?’” Participant 3 reflected, “I now check in more than I used to. If I sense a disconnect, I bring it up directly.” Participant 7 added, “When a client is withdrawn early on, I’ll say, ‘I notice you seem distant. Can you tell me what that’s about?’ and that often opens things up.”

Theme 2: Non-Judgment and Unconditional Acceptance. The need to create an atmosphere of non-judgment was a recurring theme across 8 out of 14 therapists stated that this was essential for establishing trust with clients who often arrive carrying shame, ambivalence, or histories of stigma related to their substance use. Participant 14 asserted, “Non-judgment is number one... then comes compassion.” Participant 4 similarly explained, “My goal is that they come back. If they feel safe and not judged, we can begin.” Participant 11 described the importance of communicating, even without words, that “you will not be rejected for your truth here.” Participant 7 asserted, “Non-judgment is number one... then comes compassion.” Participant 4 similarly explained, “My goal is that they come back. If they feel safe and not judged, we can begin.” Participant 12 described the importance of communicating, even without words, that “you will not be rejected for your truth here.”

From these descriptions, the theme of creating an atmosphere of non-judgment was identified. Although participants did not always use the exact term “non-judgment,” their

reflections on acceptance, openness, and separating the client from the addictive behavior consistently pointed toward this shared strategy for establishing the therapeutic alliance.

Sub-theme 2.1: Emotional Safety. Participants (11 out of 14) mentioned the importance of fostering emotional safety so clients could take relational and emotional risks. Participant 5 said, “Safety and trust come first. Clients know they can back out anytime and I’ll still be here.” Participant 14 emphasized, “The safer they feel, the more likely they’ll say the thing that really matters—the part they’re scared to say.” Participant 2 stated, “During initial sessions, I think we need safety. I’m constantly checking in with the relationship. I’m giving them feedback and asking them for feedback... Safety and trust in knowing that this is a relationship they can back out of, and know that I’m aware of what’s happening in the relationship, is important” Participant 2 stated, “In the initial sessions, I think being very present and attuned to where the client is at is crucial. You must get a sense of their emotional world — are they depressed, overwhelmed, in crisis? You need to meet their intensity and reflect it... Being non-judgmental is critical” .

Sub-theme 2.2: Normalizing Client Experiences. Therapists (9 out of 14) used normalization to reduce shame and instill hope. One participant explained, “Normalization is key. I say, ‘What you’re feeling is a normal reaction to abnormal circumstances.’ That helps them exhale.” Another reinforced this by noting, “I often say, ‘You’re not broken. You’re surviving. Let’s figure out what’s not working anymore.’” Participants also described normalization as a process of deeply attuning to the client’s lived reality. As one explained, “I see it more as a process of being rather than doing. It’s about the client feeling that you’re truly with them in their process... Boundaries and the ‘being’ presence together build rapport—if you don’t have that, it’s much harder for clients to open up.” Another participant illustrated this through example: “I had a client on the brink of divorce with two young kids. She needed to feel

I understood the dilemma without providing solutions or answers right away. Reflecting or expanding on what they say shows you grasp the issue. Clients need to feel heard and that you have something to offer—even a small insight early on can help them feel they’re not just talking into the air.” Similarly, another emphasized the long-term impact of this safety, stating, “Ultimately, people want to feel safe enough to look at their deepest, darkest parts. The alliance enables this and is essential for recovery and growth.”

Theme 3: Early Clarity and Structure. Eight of the fourteen participants described the importance of setting clear expectations and boundaries at the outset of therapy. They explained that this structure reduced client anxiety and clarified the working agreement from the beginning. Participant 5 stated, “I lay it out right away—how we’ll work, what I expect, what they can expect. No surprises.” Participant 14 added, “I tell them, either we talk about everything, or we don’t talk at all. You’re here to change your life. That’s not a halfway job.”

Other participants reinforced this point by emphasizing directness and honesty about the therapeutic process. Participant 4 said, “I’m not here to fight them, but I’m not here to let them off either. I tell them we can laugh and cry—but we’re not going to bullshit each other.” Participant 13 echoed this stance: “Put it all on the table.” Six out of fourteen also highlighted the collaborative dimension of setting expectations. Participant 14 remarked, “You and I work on this together. I’m here to help you build your story, not to fix you.” Participant 6 stated, “I make it clear from the beginning: This is a partnership. I bring my tools—you bring your life.” Participant 9 framed it in similar terms: “Either we talk about everything, or we don’t talk at all.”

Sub-theme 3.1: Honesty about Process. Several participants emphasized the need to be direct and transparent with clients from the outset. Participant 4 stated, “I’m not here to fight them, but I’m not here to let them off either.” He added, “I tell them we can laugh and cry—but

we're not going to bullshit each other." Participant 13 expressed a similar approach, stating, "Put it all on the table." Participant 5 reinforced this stance: "Honesty and clarity. Meaning, you can lie to me and tell me anything, and I will believe everything you say—and that won't serve you, but that's how it's going to be here. So, just put it all on the table."

Other participants (5 out of 14) highlighted how setting this tone early created a shared understanding of the therapeutic relationship. Participant 4 explained, "When I don't know what's going on, I say it. When I'm confused, I ask. That's the model I want them to follow too." Participant 9 added, "Boundaries aren't walls—they're structure. I'm not your friend, but I care about you deeply. That balance is what helps them trust me."

Sub-theme 3.2: Shared Responsibility. Participants described the therapeutic alliance as a collaborative effort, emphasizing that clients and therapists shared responsibility for the work. Participant 14 stated, "You and I work on this together. I'm here to help you build your story, not to fix you." Participant 6 explained, "I make it clear from the beginning: This is a partnership. I bring my tools—you bring your life."

Other participants echoed this stance. Participant 9 said, "Either we talk about everything, or we don't talk at all." Participant 11 similarly emphasized, "We work on this together... I'm here to help you build your story."

Theme 4: Clarity and Transparency. All fourteen participants spoke about the importance of ongoing transparency—not just in expectations, but also in emotional honesty, relational dynamics, and therapeutic intent. They described this as helping to demystify therapy and reduce client anxiety in the early stages. Participant 5 explained, "We put it all out there and don't hold back. That's how it's going to be here." Participant 4 added, "When I don't know what's going on, I say it. When I'm confused, I ask. That's the model I want them to follow too."

Other participants reinforced this by emphasizing clarity around roles and process. Participant 14 said, “I explain what therapy is and isn’t, so they don’t feel lost.” The same participant added, “I always tell people, either overtly or covertly, from the very beginning: I work for you. You have hired me to do a service for you.” Participant 9 noted, “From the very beginning, I make it a point to follow the patient’s meanderings, knowing that path lubricates the alliance and also tells me a lot of things I don’t need to ask questions about.”

Four out of fourteen participants highlighted truth-telling as integral to this transparency. Participant 5 explained, “Honesty and clarity. Meaning, you can lie to me and tell me anything, and I will believe everything you say, and that won’t serve you, but that’s how it’s going to be here. So, just put it all on the table.” Participant 4 similarly emphasized the protective role of boundaries in supporting transparency: “Boundaries aren’t walls, they’re structure. I’m not your friend, but I care about you deeply. That balance is what helps them trust me.”

Sub-theme 4.1: Clear Expectations and Honesty. Seven out of fourteen therapists emphasized the need to set clear expectations and model honesty early in the therapeutic process. Several described how defining the nature of the relationship reduced client anxiety and established a foundation of trust. One participant explained, “I explain what therapy is and isn’t, so they don’t feel lost.” Another noted the importance of transparency in roles, stating, “I always tell people, either overtly or covertly, from the very beginning: I work for you. You have hired me to do a service for you.” Others reflected that honesty is demonstrated by following the client’s lead rather than imposing a rigid framework: “From the very beginning, I make it a point to follow the patient’s meanderings, knowing that path lubricates the alliance and also tells me a lot of things I don’t need to ask questions about.” Still another highlighted the importance of frankness in setting the tone: “Honesty and clarity. Meaning, you can lie to me and tell me

anything, and I will believe everything you say, and that won't serve you, but that's how it's going to be here. So, just put it all on the table.”

Sub-theme 4.2: Boundaries and Truth-Telling. Eight out of fourteen therapists highlighted the critical role of boundaries in strengthening the therapeutic alliance, describing them as structures that create safety rather than barriers that create distance. One participant explained, “Boundaries aren't walls—they're structure. I'm not your friend, but I care about you deeply. That balance is what helps them trust me.” Another added, “When they test the boundaries, I welcome it—but I hold the line. That's where safety comes from.” Others (5 out of 14) gave practical examples of how boundaries are set and reinforced: “Establishing boundaries is very important. For example, setting clear expectations about session times and availability, like whether to give your WhatsApp number or how much communication happens between sessions.” Another described the necessity of clarity in maintaining rapport: “The clearer we are with ourselves and our clients, the more they can have appropriate expectations. Boundaries and the ‘being’ presence together build rapport—if you don't have that, it's much harder for clients to open up.” For eight out of fourteen therapists, truth-telling went hand-in-hand with boundary-setting, ensuring that clients experienced the relationship as authentic, consistent, and safe.

RQ2: How do therapists perceive and describe the behaviors and strategies that support the maintenance of a strong therapeutic alliance throughout the course of SUD treatment?

Thematic analysis revealed four themes describing the strategies therapists used to sustain a strong alliance over time. These themes speak to the adaptive, relational, and developmental nature of the therapeutic process, particularly within the context of SUD treatment where motivation, resistance, and relapse are recurring clinical dynamics.

Theme 5: Flexibility and Meeting Clients Where They Are. A predominant theme across interviews (all fourteen participants) was the necessity of adapting therapeutic interventions to each client's readiness and pace. Therapists described working with ambivalence, regression, or stalled motivation not as clinical obstacles, but as part of the therapeutic rhythm that required attunement and patience. Participant 7 summarized this view: "First, I have to accept where they are; pushing won't help. If I try to force it, they disappear." Participant 6 explained, "If they're not ready, I can still be a supportive figure—but no real work is happening yet. That's okay. I can wait." Participant 3 reflected, "Sometimes you're just holding space. You're not pushing insight or action. You're showing up, waiting for readiness."

Sub-theme 5.1: Working with Stages of Change. Participant 4 offered a concrete example: "I'll find the smallest thing and ally with them on that—'You made it here today, that's progress.' That can be a doorway to bigger things." Participant 5 similarly described looking for slivers of engagement: "I try to name it when I see it. 'You're talking more today than last week.' That builds hope." These strategies demonstrated clinical agility, recognizing moments of movement and building momentum.

Sub-theme 5.2: Supporting Micro-goals. Rather than pushing for wholesale change, therapists emphasized (5 out of 14) setting small, achievable goals that met the client's current capacity. Participant 14 explained, "Sometimes the goal is just to come back next week. That's enough." Participant 6 added, "I'll ask, 'Can you try one thing between now and next time?' It could be a breath, a journal entry, a conversation. It builds their sense of agency."

Theme 6: Consistent Support and Reliability. Across participants (13 out of 14), consistency was identified as a powerful alliance-building force over time. Therapists spoke about the value of showing up, especially during periods when clients were not progressing, or

were actively relapsing. Participant 4 stated, “I am in their lives, not just once a week. I might text, call, send a check-in message. They need to know I haven’t forgotten them.” Participant 5 stressed, “Even if they ghost me, I leave the door open. I’ll send a message: ‘I’m still here if you want to talk.’ That matters.”

Sub-theme 6.1: Holding Steady During Relapse. Therapists (7 out of 14) described relapses not as alliance ruptures, but as opportunities to deepen the relationship. Participant 4 shared, “When they slip, I don’t dump them. I say, ‘Okay, what happened?’ That’s when we learn.” Participant 7 described working with one client who relapsed after months of sobriety: “He didn’t want to come back, felt too ashamed. I said, ‘That’s when you have to come back. That’s the work.’ He did. We were stronger after that.” These narratives reflect the therapist’s ability to maintain an alliance even through moments that threaten therapeutic continuity.

Sub-theme 6.2: Building Cumulative Trust. Thirteen out of fourteen therapists emphasized that trust was not forged in a single session but accumulated over repeated demonstrations of reliability, presence, and non-abandonment. Six participants noted that cumulative trust often emerged most clearly during times of rupture or silence, when the therapist’s willingness to remain available carried more weight than any specific intervention. Participant 9 reflected, “Clients test whether I’ll disappear when things get hard. Each time I show up again, it adds another layer of trust.” Participant 12 similarly shared, “Sometimes weeks go by without progress, but when I sit in the same chair ready for them, it speaks louder than words.”

For others, cumulative trust was tied to consistency across both in-session and between-session contact. Participant 8 explained, “They remember the text I sent after a relapse more than any brilliant interpretation I gave in session. It’s the steady presence that stays with them.”

Participant 14 added, “Trust isn’t built in the big breakthroughs. It’s built in the small, ordinary moments that prove I won’t walk away.”

Theme 7: Encouraging Autonomy and Self-Reliance. Another key strategy described by six out of fourteen therapists involved gradually stepping back to encourage the client’s self-direction. Rather than fostering dependency, the goal was to nurture internal resources and promote client-led recovery. Participant 5 described the arc: “In the beginning, they lean on me. Later, I want them standing on their own two feet.” Participant 2 echoed this: “Eventually they need to stop asking me what to do and start telling themselves what’s right.”

Sub-theme 7.1: Transitioning to Self-Leadership. Participant 14 noted, “When the alliance is strong, I can challenge them to take more responsibility for direction. I’ll ask, ‘What do you want to do with this session?’” Participant 6 shared, “Sometimes I’ll say, ‘You don’t need me to answer that, you already know.’ That kind of affirmation builds independence.” These moments marked a shift from therapist-directed work to client-led exploration, supporting internalization and personal growth.

Sub-theme 7.2: Empowering Narrative Agency. Six therapists spoke of helping clients construct meaningful narratives of their journey. Participant 3 stated, “They have to become the author. Not just tell the story they were given, but write their own.” Participant 4 emphasized, “We’re not just treating symptoms. We’re helping them find identity, values, purpose.” This narrative work was described as a turning point in recovery, as clients began to see themselves not only as struggling with addiction but as active agents shaping their future. Participant 11 explained, “When they begin telling the story differently, less as a victim, more as a survivor, you see the shift in how they carry themselves.” Participant 7 added, “I tell them, ‘You’re the editor now. You get to decide what parts stay in and what gets rewritten.’ That moment gives

them real power.” Together, these reflections highlight how narrative agency transforms the therapeutic alliance into a platform for identity reconstruction, where clients claim ownership of both their stories and their recovery.

Theme 8: Honest Challenge and Constructive Confrontation. Finally, seven therapists described the delicate art of challenging without rupturing, offering truth with compassion to promote insight and movement. This balance between empathy and confrontation was seen as essential in maintaining therapeutic vitality and momentum. Participant 6 explained, “I’ll say, ‘We’ve been here before... same story, different week. What do you want to do differently?’ It’s said with love, but it’s said.” Participant 14 described drawing on both supportive and directive roles: “Sometimes I’m the understanding mother. Other times I’m the stern father. Clients need both.”

Sub-theme 8.1: Reflecting Resistance. Rather than opposing resistance, therapists (7 out of 14) described engaging with it reflectively. Participant 14 shared, “When I see resistance, I don’t fight it. I reflect it. I say, ‘It seems like something’s getting in the way, what’s that about?’ That opens a door.” Participant 5 similarly noted, “I’ll name it: ‘I feel like you’re pulling back. What’s going on?’ That kind of honesty builds depth.”

Comparison of Results to the Literature Review

This study sought to explore therapists’ perceptions of the behaviors and strategies that support the development and maintenance of a strong TA in the context of SUD treatment, guided by the two central research questions.

Using IPA as the analytic framework, eight superordinate themes and their related subthemes were generated through the seven-phase process described earlier. Superordinate themes were designated when a pattern (a) recurred across a majority of cases (operationalized as

≥7 of 14 participants), (b) showed analytic richness (multiple coded excerpts within and across cases), and (c) directly addressed a research question. Subthemes captured more specific, nested, or lower-frequency patterns that were conceptually subordinate to the superordinate category and helped specify its range of expression. Theme formation proceeded idiographically case-by-case and then cross-case: emergent themes were clustered via abstraction, subsumption, polarization, contextualization, and function, refined in cross-case patterning, and finalized through evidence chains linking claims to verbatim quotations, a versioned codebook, and an audit trail with peer debrief checks. This process provided a transparent path from raw transcripts to the final thematic structure presented below. These findings addressed the two research questions and are organized below by superordinate theme with supporting quotations; implications for theory and practice are presented in Chapter 5.

Alignment with RQ1: Establishing the Alliance

The first four themes, *Authentic Presence and Warmth*, *Non-Judgment and Unconditional Acceptance*, *Early Clarity and Structure*, and *Transparency*, directly addressed how therapists described the behaviors they used to foster strong initial alliances. Participants reported showing up authentically, providing genuine human connection, and creating non-judgmental spaces where clients felt safe to begin therapeutic work.

Therapists also described intentional behaviors such as selective self-disclosure, inviting client feedback, outlining therapeutic expectations, and emphasizing client choice. For example, several participants explained that they clarified expectations early, encouraged collaboration, and reinforced that clients retained agency in the process. These accounts illustrated the specific strategies participants used in initial sessions to support the development of the therapeutic alliance. In sum, the findings indicated that therapist behaviors in the earliest sessions, when

characterized by presence, clarity, safety, and respect, were described by participants as central to fostering alliance formation with clients entering SUD treatment (Horvath & Luborsky, 1993; Flückiger et al., 2018).

Alignment with RQ2: Maintaining the Alliance

The second set of four themes, *Flexibility and Meeting Clients Where They Are*, *Consistent Support and Reliability*, *Encouraging Autonomy and Self-Reliance*, and *Honest Challenge and Constructive Confrontation*, answered RQ2 and illustrated how therapists perceived alliance maintenance as an ongoing, evolving process.

Rather than viewing the alliance as static or “established once and for all,” therapists described a dynamic relationship that required flexibility, responsiveness, and attunement to client change over time. Several participants (11 of 14) referenced relapse, resistance, or therapeutic rupture not as alliance failures, but as opportunities for deepening the relationship. This finding is echoed in the alliance rupture-repair literature, which positions conflict as potentially growth-enhancing when handled with transparency and care (Safran & Muran, 2000).

Participants’ emphasis on flexibility and meeting clients where they were strongly supported the transtheoretical model’s assertion that stage-matched interventions were more effective (Prochaska & DiClemente, 2018). Therapists described using micro-goals, small victories, and careful pacing as essential for maintaining client trust and momentum. Similarly, their emphasis on reliability—such as consistent outreach after a missed session—mirrored attachment-based theories of alliance that emphasized safety and predictability as critical for clients with histories of trauma or neglect (Mallinckrodt, 2010).

The transition from therapist-led to client-led work was also described as a key process, with participants explaining that they shifted from a directive to a reflective stance as clients

gained insight and confidence. This progression reflected the SDT concept of internalization, in which clients moved from externally motivated behavior to self-directed, value-driven choices (Deci & Ryan, 2017). In addition, therapists reported fostering narrative agency by helping clients re-author their stories, an approach supported in recovery literature as essential for identity reconstruction (McAdams, 2001).

Finally, the role of honest confrontation, delivered with warmth, was highlighted as a relational risk that, when used judiciously, could catalyze insight and change. This practice aligned with MI's emphasis on rolling with resistance while maintaining empathy (Miller & Rollnick, 2013), as well as the concept of the "corrective emotional experience" (Alexander & French, 1946), whereby a client experiences a difficult interaction without abandonment or rejection.

Integration with Theoretical Framework. SDT (Deci & Ryan, 2017) provided the central theoretical lens for this study, offering a motivational framework through which to understand how therapist behaviors support or hinder alliance development and maintenance. The findings demonstrated that therapist behaviors can serve to either frustrate or fulfill the client's psychological needs for autonomy, competence, and relatedness—and that fulfillment of these needs is integral to both therapeutic engagement and sustained change.

For example:

1. Autonomy was supported through mutual feedback, collaborative goal-setting, and a de-emphasis on therapist authority in favor of shared power.
2. Competence was fostered by therapists breaking down goals into manageable micro-tasks, validating small successes, and providing clear, transparent feedback.

3. Relatedness emerged through authentic presence, non-judgmental acceptance, and the therapist's reliable presence over time—even during relapse or resistance.

Thus, this study contributed to a growing body of literature that positions SDT not only as a theory of motivation but also as a relational framework for therapeutic engagement, particularly in SUD contexts where autonomy has often been historically overlooked (Ryan et al., 2011).

Contribution to the Field. These findings directly reflected participants' descriptions of how the therapeutic alliance was established and maintained in addiction counseling. The results identified several contributions to the understanding of the therapeutic alliance in this context, as expressed across participant accounts.

1. **Nuanced Understanding of Therapist Behavior:** The study highlighted specific, actionable behaviors that clinicians can employ to foster and maintain alliance over time—moving beyond abstract constructs to observable practices.
2. **Validation of SDT in Clinical Practice:** The alignment between therapist behaviors and SDT's motivational needs supported the clinical applicability of this theory in addiction treatment and offers a humanistic alternative to more directive or compliance-based models.
3. **Expansion of Alliance Literature in SUD Contexts:** Much of the alliance literature has focused on general psychotherapy. This study narrowed the lens specifically to addiction counseling, a setting often marked by complexity, resistance, and high dropout rates.

4. **Therapist Voice:** By privileging the voices of clinicians, the study contributed to practice-informed research and centers the lived expertise of those working with addiction treatment.

In sum, the findings of this study not only answered the stated research questions but also reinforced the importance of relationship-centered, autonomy-supportive, and flexible therapeutic approaches in fostering durable engagement and recovery in clients with substance use disorders. These findings also strongly aligned with SDT, highlighting how meeting clients' needs for autonomy, competence, and relatedness is foundational in SUD treatment (Deci & Ryan, 2017; Vansteenkiste et al., 2020). Authentic presence, non-judgment, and clarity supported relatedness and competence. Flexibility and gradual autonomy promotion aligned with MI principles (Miller & Rollnick, 2013) and have been shown to improve engagement and reduce dropout rates (Norcross & Lambert, 2019; Flückiger et al., 2018).

Summary

This chapter presented the results of an IPA of fourteen in-depth interviews with experienced therapists working with clients navigating SUDs. The research sought to illuminate the lived experiences and clinical wisdom of therapists regarding the development and maintenance of a strong therapeutic alliance—a construct widely acknowledged as a critical factor in treatment engagement and client outcomes (Flückiger et al., 2018; Norcross & Wampold, 2018). The analysis generated eight overarching themes with corresponding sub-themes, each capturing therapist-identified strategies that foster connection, trust, and collaboration with clients in early and ongoing phases of treatment.

Each theme that emerged through the analytic process is grounded in rich, nuanced accounts from participants and anchored in the theoretical framework of SDT (Deci & Ryan,

2017). The results revealed that the therapeutic alliance was not a static or procedural component of treatment but rather a dynamic, relational phenomenon that required intentional, ongoing investment. These findings confirmed and extended existing research on alliance development in clinical contexts and offer unique insight into its expression within the distinct landscape of addiction counseling. These findings also confirmed prior research by demonstrating that alliance-building behaviors commonly identified in general psychotherapy literature—such as warmth, empathy, and clarity of expectations—were also emphasized by addiction counselors (Bordin, 1979; Horvath & Luborsky, 1993; Norcross & Wampold, 2018). At the same time, the results extended this literature by showing how these behaviors were enacted in the unique context of SUD treatment. For example, participants described the importance of reliability after missed sessions, direct confrontation delivered with warmth, and transparency regarding the therapeutic process—practices highlighted as especially critical with clients who often presented with ambivalence, stigma, or prior negative treatment experiences. These accounts provided unique insight into the therapeutic alliance in addiction counseling by illustrating how alliance-building required both the adoption of common relational strategies and their adaptation to the specific challenges of working with substance-using populations.

Summary of Findings for RQ1

The first research question focused on how therapists initiate a strong alliance during the early stages of therapy. The data coalesced around four major themes: *Authentic Presence and Warmth, Non-Judgment and Unconditional Acceptance, Early Clarity and Structure, and Transparency*. Across participants, there was a need for realness and human connection as the foundation for all clinical work. Therapists described being fully present, emotionally accessible, and transparent about their intentions. These behaviors fostered an atmosphere of trust, safety,

and shared humanity—essential prerequisites for engaging clients often burdened by shame, ambivalence, and stigma (Miller & Rollnick, 2013; Yalom, 2002).

Importantly, participants rejected the notion of clinical detachment or stoic professionalism and instead described valuing relational authenticity. They reported that self-disclosure, when used judiciously, was a means of enhancing trust. Participants also described that directly inviting client feedback reinforced autonomy and voice, aligning with SDT's emphasis on agency and mutuality in growth-promoting relationships (Deci & Ryan, 2017). In this way, the findings showed that alliance development was not described as dependent solely on therapist warmth but as involving attunement, congruence, and the active co-creation of a relational space where early engagement could develop.

Summary of Findings for RQ2

The second research question examined how therapists sustain the therapeutic alliance throughout the course of SUD treatment. This phase revealed an additional four themes: *Flexibility and Meeting Clients Where They Are*, *Consistent Support and Reliability*, *Encouraging Autonomy and Self-Reliance*, and *Honest Challenge and Constructive Confrontation*. These themes illustrate the long arc of therapeutic engagement—one that is non-linear, often interrupted by relapse, resistance, or client withdrawal, yet sustained through the therapist's capacity to remain present, adaptive, and grounded.

Flexibility was identified as a central clinical issue because participants consistently emphasized the need to adapt to client readiness, circumstances, and pacing. Eleven of the fourteen therapists specifically described flexibility as essential for sustaining the therapeutic alliance. For example, Participant 2 stated, "In the initial sessions, I think being very present and attuned to where the client is at is crucial. You must get a sense of their emotional world—are

they depressed, overwhelmed, in crisis? You need to meet their intensity and reflect it.”

Participant 7 explained, “If I push too fast, I lose them. I have to match where they are and move at their pace.” Participant 10 added, “Sometimes you have to go slower, sometimes you can go quicker. The key is not forcing it but reading where they are.” Simultaneously, participants emphasized the importance of reliability and consistency in their work with clients. Several described making outreach after missed sessions or maintaining contact during difficult periods as central to sustaining trust. Participant 5 stated, “Safety and trust come first. Clients know they can back out anytime and I’ll still be here.” Participant 12 explained, “If they disappear for a week, I call or text. I want them to know I haven’t forgotten them.” Participant 9 added, “I don’t give up on them. Even when they relapse, I keep showing up.”

As therapy progressed, participants described a gradual shift in roles—from directive to reflective—as they encouraged clients to take increasing ownership over their process. Empowering clients to make their own choices, reflect on their story, and find meaning in their recovery was identified as essential for long-term change. These behaviors resonate with SDT’s notion of fostering intrinsic motivation and supporting narrative agency (Ryan & Deci, 2017; McAdams, 2001). Therapists also described the judicious use of confrontation—delivered with compassion—as a mechanism for deepening insight and surfacing stuck points. In doing so, they maintained the alliance not through avoidance of tension, but through engaging rupture with honesty and care (Safran & Muran, 2000).

Theoretical Integration. SDT provided a meaningful and organizing lens through which to understand these results. The therapists’ emphasis on attunement, transparency, collaboration, and flexibility can all be conceptualized as behaviors that support the client’s psychological needs for autonomy, competence, and relatedness, the very nutrients of motivation, engagement,

and healing (Deci & Ryan, 2017). Rather than controlling or prescribing change, therapists in this study sought to cultivate the conditions under which change could emerge from within the client. This is a significant paradigm shift from traditional, compliance-based models of addiction treatment and offers strong support for SDT as a framework for both conceptualizing and delivering care in this domain.

In particular:

1. **Autonomy-support** was evident in therapists' collaborative stance, openness to feedback, and respect for pacing.
2. **Competence** was fostered through goal setting, affirming progress, and scaffolding skills.
3. **Relatedness** emerged through emotional availability, reliability, and ongoing presence—even during moments of rupture or regression.

These findings contribute to the literature by specifying *how* therapists operationalize SDT principles in real-world SUD treatment and by highlighting the interpersonal mechanics that sustain the alliance over time.

Contribution to Knowledge and Practice

This study expanded understanding of the therapeutic alliance in addiction counseling by offering a therapist-centered perspective rooted in direct clinical experience. Much of the existing literature emphasized client perceptions or quantitative alliance measurements. By contrast, this study provided a practice-informed account of how therapists constructed, preserved, and at times repaired the alliance in SUD treatment, a context consistently identified in the literature as clinically complex due to high relapse vulnerability, treatment ambivalence, and co-occurring conditions (Kelly et al., 2017; Magill et al., 2021; Volkow et al., 2016).

Moreover, the study's findings underscored the critical importance of humility, consistency, and human connection in therapeutic work. In settings where relapse is common, progress is non-linear, and shame runs deep, it is the strength and durability of the therapeutic alliance, shaped moment by moment by the therapist, that allows clients to return, reengage, and ultimately, move toward recovery. These findings also offered practical implications for training, supervision, and clinical practice. Rather than emphasizing rigid technique or manualized interventions, they suggested that cultivating therapeutic presence, relational flexibility, and narrative co-construction may be the most powerful tools in a clinician's repertoire.

Chapter 5 provides a detailed discussion of these findings in relation to existing literature, elaborating on points of convergence and divergence. It also addresses the limitations of the current study, implications for clinical practice and counselor training, and offer recommendations for future research in therapeutic alliance development within addiction counseling. Finally, the chapter explores how these findings may inform broader systemic and theoretical considerations in the field of addiction psychology.

Chapter 5: Discussion, Recommendations, and Study Summary

The problem addressed in this study is the significant gap in existing research concerning the lack of specificity regarding the actions and behaviors of therapists that effectively establish and maintain a TA during SUD treatment. While the importance of a strong TA is well-documented, particularly in fostering client engagement, adherence to treatment, and positive outcomes, there remained a paucity of detailed insights into the specific therapist behaviors that contribute to the development of this alliance, especially during the critical initial sessions (Finsrud et al., 2022; Flückiger et al., 2018). The purpose of this dissertation was to examine the role of the TA in enhancing treatment outcomes for patients with SUDs, underpinned by the principles of SDT (Deci & Ryan, 1985). By exploring how the TA can fulfill the basic psychological needs of clients, the objective of this study was to understand the insights into improving engagement, motivation, and long-term recovery in SUD treatment.

A qualitative research methodology, using IPA, was used to explore the lived experiences of licensed addiction counselors regarding how they establish and maintain the TA with clients in SUD treatment. IPA was selected because it emphasizes the meaning individuals assign to their lived experiences, aligning well with this study's aim of understanding the subjective perceptions of therapists within their clinical contexts. The design enabled in-depth exploration of how counselors interpret their relational processes, techniques, and emotional engagement with clients struggling with addiction. Semi-structured interviews were conducted via Zoom, transcribed verbatim, and analyzed through a seven-phase process that included descriptive, linguistic, and conceptual coding. This iterative method allowed for the identification of emergent and superordinate themes that reflected both shared and unique experiences among participants.

The study's findings showed that addiction counselors rely on a clear set of relational behaviors to build and sustain the therapeutic alliance in SUD treatment. Participants described that the alliance is established during the earliest contacts when therapists demonstrate authentic presence, communicate emotional steadiness, and create an atmosphere of safety that encourages disclosure and engagement. Counselors reported that clients responded positively when they felt genuinely seen and emotionally supported, which they viewed as the foundation of early trust. The findings also showed that maintaining the alliance over time depended on consistent follow-through, validating client effort, adjusting interventions to match client readiness, and supporting client autonomy in decisions about treatment direction. These behaviors were described as essential to keeping clients engaged, reducing resistance, and strengthening motivation, particularly for individuals who enter treatment ambivalent, guarded, or struggling with shame.

At the same time, several limitations must be acknowledged when interpreting these findings. The study drew from a small, purposive sample of fifteen English-speaking addiction counselors practicing in Israel, which restricts the breadth of cultural and clinical contexts to which the results may be generalized. As with all qualitative research, the co-constructed nature of the data introduces the potential for subjectivity, even with the use of reflexive journaling, audit trails, and member-checking to enhance credibility and confirmability. The exclusive focus on therapist perspectives also limits the study, as the client viewpoint, an essential component of the dyadic nature of the TA, was not captured. Further, reliance on self-reported interviews raises the possibility of recall bias and social desirability effects, as participants may unintentionally portray their clinical behaviors in an idealized manner.

Despite these constraints, the study offers substantive contributions by clearly identifying how specific counselor behaviors operationalize the psychological needs of autonomy,

competence, and relatedness within real-world SUD treatment. These insights extend the existing literature and point to important avenues for future research, while also underscoring the need for training and supervision models that more intentionally cultivate these relational competencies in clinical practice. Ultimately, these findings reaffirm that the quality of the therapeutic relationship remains one of the most powerful and enduring determinants of successful addiction treatment, and that strengthening this alliance must remain a central priority in both clinical practice and professional training.

Discussion

Research Question 1 (RQ1)

The results of this study demonstrate that therapists consistently rely on a set of relational behaviors supporting the rapid development and ongoing maintenance of the TA in SUD treatment. Across interviews, participants repeatedly emphasized that the alliance is initiated through authentic interpersonal engagement and marked by emotional presence, empathic attunement, transparency, and the establishment of safety. These behaviors were described not as formal techniques but as foundational interpersonal conditions that enabled clients to feel understood and willing to engage. This aligns with longstanding research identifying early relational factors as essential to TA formation, particularly in addiction treatment, where ambivalence, shame, and distrust are common barriers to engagement (Flückiger et al., 2018; Hammarberg et al., 2023). The present study supports these conclusions; participants consistently reported that when demonstrating openness, groundedness, and emotional availability in the first sessions, clients became more willing to disclose, collaborate, and participate meaningfully in treatment. Thus, RQ1 is supported by clear practitioner testimony

that the alliance is initially built through these core relational behaviors rather than through the application of any specific modality or intervention.

The findings further demonstrate that therapists maintain the TA through ongoing relational consistency, validation of client effort, and autonomy-supportive practices that honor client pacing and self-determination. Participants described the alliance not as a static achievement but as a responsive, continuously negotiated process that deepens through dependability, respect for client agency, and reinforcement of progress. These descriptions mirror the broader literature emphasizing that sustained therapeutic engagement in SUD treatment depends on meeting clients' psychological needs for relatedness, competence, and autonomy, as articulated by SDT (Ryan & Deci, 2017; Vansteenkiste et al., 2023).

Participant narratives repeatedly highlighted these same needs: clients engaged more fully when they felt connected to the therapist, capable of making meaningful changes, and respected as partners in decision-making. This provides direct empirical support for RQ2 by showing that the long-term maintenance of the alliance is tied to these motivational dynamics and reinforced through relational behaviors that operationalize the principles of SDT in clinical practice. Collectively, the findings affirm that the TA functions both as a relational foundation and as an active mechanism of change, demonstrating strong alignment with the theoretical and empirical literature included in this study.

The narratives shared by participants reveal that effective alliance-building in SUD treatment is based on a consistent set of relational practices that unfold across the course of therapy. Counselors described how early engagement depended on a genuine interpersonal presence that communicated safety, respect, and attunement, conditions that made ambivalent or guarded clients more willing to enter the therapeutic process. As therapy progressed, the alliance

was strengthened through predictable and reliable interactions, consistent emotional availability, and the therapist's ability to validate incremental progress. Participants also emphasized the importance of honoring client autonomy by jointly setting goals, pacing interventions according to the client's readiness, and collaborating around decisions rather than imposing them. These accounts reflect a shared belief that clients remain engaged when they feel connected, capable, and in control of their recovery trajectory, which mirrors the core psychological needs outlined in SDT.

The study's findings validate the broader literature: alliance-building is not technique-driven but relationally driven, and counselors deepen engagement by responding flexibly to the client's emotional state, motivation, and developmental stage of change. This integrated understanding supports the conclusions drawn for both research questions by showing that the same relational qualities that initiate the alliance also sustain it, and that these counselor behaviors directly parallel the motivational and relational mechanisms identified in the literature review. These findings align closely with both Rogerian principles of unconditional positive regard and congruence (Rogers, 1957), as well as Yalom and Leszcz's (2005) emphasis on the therapist's authentic use of self as a healing instrument. The focus on presence, mutuality, and hope also reflects SDT's construct of relatedness as a core motivational driver for engagement.

Building on these insights, the second major finding emphasizes the importance of maintaining the TA over time in SUD treatment. It addresses RQ2, which sought the most effective therapist behaviors and strategies to sustain a strong alliance throughout treatment, while considering both client characteristics and therapist insights. Maintaining a strong TA throughout treatment requires consistent attunement, flexibility, and reinforcement of autonomy-supportive behaviors. Therapists describe the ongoing work of "reading the room", adjusting

their approach based on shifts in client emotional states, motivation levels, and therapeutic ruptures. Several therapists highlight the importance of navigating pushback and resistance without reactivity, noting that relational consistency, "being steady, not shaken", is often what builds long-term trust with clients who have chaotic interpersonal histories.

Validation emerges as a central mechanism for sustaining engagement. Therapists speak about "naming the good" in client effort, highlighting strengths, and reflecting growth over time. This is especially potent when clients are struggling with setbacks or ambivalence. Many therapists describe the need to hold a "both/and" perspective, recognizing client pain and progress simultaneously. Other key strategies also emerge from participants' accounts, reflecting the nuanced ways in which therapists sustain the therapeutic alliance over time. One central theme was the respect for client autonomy. Therapists emphasized the importance of avoiding coercion or prescriptive advice, instead fostering collaboration and client-led insight. This approach allows clients to maintain a sense of ownership over their treatment process, a principle consistent with SDT's emphasis on autonomy as a core psychological need (Deci & Ryan, 2017). By inviting clients to identify personal goals, make choices about session focus, and determine the pace, therapists promote intrinsic motivation and long-term engagement rather than compliance based on external pressure. This respect for autonomy not only strengthens the therapeutic bond but also reinforces clients' sense of competence and agency, both of which are critical for sustained recovery.

Establishing clear and compassionate boundaries also surfaced as a vital alliance-maintenance behavior. Participants described boundaries not as rigid constraints but as relational anchors that communicate stability, consistency, and safety. In the unpredictable landscape of addiction recovery, where ambivalence, relapse, and emotional volatility are common, these

boundaries provided a secure therapeutic frame. Maintaining this balance between empathy and structure aligns with the literature emphasizing that clients in SUD treatment often require both emotional containment and clear relational parameters to feel secure enough to engage in deeper therapeutic work (Horvath & Symonds, 1991; Flückiger et al., 2018).

Another recurrent theme involves the therapist's consistent emotional regulation. Participants describe intentionally modeling emotional steadiness and containment when clients were distressed or dysregulated. This regulated presence served as a corrective emotional experience for clients whose interpersonal histories often involved volatility, mistrust, or neglect. Such consistency mirrors findings from trauma-informed care models, which highlight the importance of therapist affect regulation in fostering safety and co-regulation (Courtois & Ford, 2020). By demonstrating calm responsiveness, therapists reinforced the alliance as a reliable space, reducing reactivity and supporting clients' capacity to tolerate difficult emotions without disengagement or relapse.

Finally, participants emphasized the value of periodic recalibration of goals, a process of intentionally "checking in" not only on treatment plans but also on the state of the relational dynamic itself. These reflective conversations allowed both therapist and client to address ruptures, clarify expectations, and reaffirm shared purpose. Such ongoing recalibration reflects Safran and Muran's (2000) conceptualization of alliance repair as an integral, growth-enhancing process rather than a sign of failure. Participants described this process as an opportunity to restore collaboration, deepen mutual understanding, and realign therapeutic direction. Regular attention to the relational process thus served as both a preventative and restorative strategy, strengthening the durability of the alliance over time.

Taken together, these findings illuminate how the sustained strength of the therapeutic alliance in SUD treatment depends not only on initial rapport but also on the therapist's ongoing commitment to autonomy support, emotional regulation, compassionate structure, and relational reflection. These behaviors operationalize the alliance as a living, adaptive process—one that evolves in tandem with client growth and challenges—ultimately reinforcing motivation, resilience, and treatment continuity. This dynamic process reflects SDT's emphasis on supporting all three basic psychological needs—autonomy, competence, and relatedness—throughout the course of treatment. Therapists who could flexibly balance nurturance with firmness and empowerment with structure report stronger, more enduring alliances. This observation also resonates with the broader literature suggesting that the therapeutic alliance must be co-constructed and continually reaffirmed as treatment progresses (Ackerman & Hilsenroth, 2003; Flückiger et al., 2018).

All these findings reinforce the centrality of the therapeutic alliance in SUD treatment and illustrate the interpersonal and relational skills therapists perceive as critical in establishing and sustaining this alliance. In addition, the data align closely with the core tenets of SDT, suggesting that therapist behaviors that promote autonomy, competence, and relatedness play a key motivational role in client engagement and retention.

However, this study is not without limitations. The participant sample, while rich and information-dense, was limited to English-speaking therapists working in Israel, which may limit generalizability to broader or non-English speaking contexts. Additionally, the study relied on self-reported data, which may be subject to social desirability bias. Finally, as is typical in IPA, findings reflect subjective meaning-making and thus prioritize depth of understanding over generalizability.

Interpretation and Contextualization of Findings

In RQ1, I asked what therapists perceive as the behaviors and strategies from the therapist's perspective that support the establishment of a strong therapeutic alliance in the initial sessions. Therapists in this study identify authentic presence, transparent communication, empathic attunement, and the provision of grounded hope as primary mechanisms for establishing a therapeutic alliance during the initial sessions. These findings support and extend the foundational literature on the alliance, particularly in addiction treatment settings. They align with Bordin's (1979) tripartite model, tasks, goals, and bond, by showing that the bond component is often established first and serves as the emotional scaffold upon which collaboration and shared purpose are later built.

The behaviors highlighted by participants mirror core Rogerian constructs such as congruence and unconditional positive regard (Rogers, 1957), yet they go further by emphasizing interpersonal transparency and humility—qualities particularly salient in working with clients who present with high shame, trauma histories, and ambivalence toward treatment. This emphasis is consistent with findings by Moyers and Miller (2013) and Meier et al. (2005), who emphasized that the therapist's interpersonal style in early sessions is a primary predictor of engagement and retention in SUD treatment.

From the standpoint of SDT, these behaviors fulfill the psychological need for relatedness, which is essential for fostering internalized motivation and voluntary participation in change efforts (Ryan & Deci, 2000). When clients perceive their therapist as genuine, accepting, and emotionally available, they are more likely to feel safe and valued, which can facilitate trust and disclosure, key prerequisites for the internalization of treatment goals (Zuroff et al., 2007).

Factors Influencing Interpretation

The results should be interpreted within the cultural and clinical context of the study: licensed English-speaking addiction counselors practicing in Israel. This unique population often serves clients who navigate cultural hybridity, religious identity, and social stigma around addiction. The participants' emphasis on humility and mutuality may be partially shaped by the cultural expectations of the Israeli therapeutic environment, where relational authenticity is often privileged over formality. These cultural dynamics may not generalize to more hierarchically structured clinical settings or populations with different norms regarding authority and disclosure.

Moreover, participant self-reporting may introduce social desirability bias. Therapists may be inclined to present themselves in idealized terms, emphasizing relational skills considered clinically desirable. However, the depth and consistency of the themes across diverse clinical settings suggest a strong convergence around core relational values.

Contribution to Literature and Theory

The findings from this study extend existing literature on the early establishment of the TA in SUD treatment by offering granular detail about how therapists translate theoretical constructs into observable behaviors. Consistent with prior studies emphasizing that the initial phase of therapy is critical for engagement and retention (Flückiger et al., 2018; Hammarberg et al., 2023), participants in this study described the deliberate use of authentic presence, warmth, and transparency as mechanisms for cultivating safety and trust. These findings empirically reinforce Bordin's (1979) tripartite model, goals, tasks, and bond, by demonstrating how SUD counselors explicitly prioritize the *bond* dimension through relational consistency and genuine attunement from the very first session.

Research has long suggested that empathy, non-judgment, and authenticity predict early alliance strength (Horvath & Luborsky, 1993; Rogers, 1951). However, few studies have illuminated *how* these qualities are enacted in real-world SUD contexts. This study bridges that gap by identifying micro-behaviors such as selective self-disclosure, inviting client feedback, and clarifying expectations, which mirror recommendations from MI (Miller & Rollnick, 2013) and enhance client autonomy and engagement. These actions resonate with Deci and Ryan's (1985, 2017) SDT, demonstrating that autonomy-supportive interactions—those that affirm client choice and agency—are foundational to internal motivation and early alliance development.

Moreover, the present findings corroborate Dellazizzo et al. (2023) and Meier et al. (2005), who emphasized that early therapist behaviors promoting collaboration and emotional safety predict lower dropout rates in addiction treatment. The participants' focus on "being with the client, not above them" directly exemplifies the relatedness component of SDT, wherein motivation flourishes in relationships characterized by mutual respect and empathy. Similarly, Finsrud et al. (2022) identified distinct dimensions of confidence in both the therapist and the treatment modality; the current results support and extend that framework by showing that therapist authenticity and emotional availability strengthen both dimensions simultaneously.

From a theoretical standpoint, this study advances the integration of SDT and therapeutic-alliance theory by showing that relational constructs such as presence and transparency are not merely affective but motivational mechanisms that satisfy clients' needs for relatedness and autonomy. This aligns with Teixeira et al. (2022) and Chan et al. (2023), who found that competence- and autonomy-supportive climates enhance sustained engagement in health behavior change. Participants' practices, such as affirming client pace, validating struggle,

and co-creating goals, embody these SDT principles, translating them into applied relational techniques that operationalize motivation within the therapeutic exchange.

Additionally, the study substantiates findings from Horvath and Symonds (1991) and Norcross and Lambert (2018), which demonstrated that the therapist's relational stance often outweighs technical intervention in predicting client outcomes. By emphasizing relational safety, these therapists positioned the alliance as an active treatment *mechanism* rather than a mere precondition for change, echoing Safran and Muran's (2000) conceptualization of the alliance as a dynamic process shaped through ongoing mutual regulation.

These results align closely with and extend the existing literature by identifying the specific therapist behaviors, authentic presence, emotional validation, early structure, and transparent communication that embody SDT's psychological-needs framework and operationalize alliance theory in early SUD treatment. They affirm that when therapists approach initial sessions as opportunities to establish autonomy-supportive, competence-building, and related relationships, clients experience heightened trust, intrinsic motivation, and willingness to engage, setting the trajectory for sustained therapeutic work and recovery.

Societal and Clinical Implications

These findings carry significant implications for clinical practice, counselor training, and system-level policies. The results underscore the need for therapist training programs to prioritize the development of relational competencies, such as authentic presence, deep listening, and transparent communication, as core therapeutic skills rather than peripheral "soft skills." These competencies form the foundation for building trust and engagement in the early stages of treatment and should be explicitly integrated into professional development curricula, practicum supervision, and continuing education for addiction counselors.

Supervision models, in particular, should emphasize the first session as a high-stakes relational opportunity. Supervisors can help early-career therapists develop reflective awareness of their “use of self” during initial interactions, encouraging mindful attention to tone, pacing, and emotional attunement. This reflective supervision process not only enhances relational confidence but also supports professional growth in therapists learning to navigate the complex interpersonal terrain of SUD treatment.

Treatment retention efforts may also benefit from formalizing early-session relational interventions as structured components of clinical protocols. By recognizing the therapeutic alliance as an active mechanism rather than a secondary factor, treatment programs can incorporate standardized relational check-ins, client feedback loops, and collaborative goal-setting during initial sessions. Systematizing these interventions may reduce early dropouts, which remain stubbornly high in SUD treatment (Ball et al., 2006), and promote stronger long-term engagement.

At a policy level, these findings suggest that relational competence should be recognized as a critical element of effective care. Policy initiatives could incentivize the development of these competencies through continuing education requirements, accreditation standards, or reimbursement models that reward alliance-focused practices. Integrating alliance measures into quality assurance and outcome evaluation systems would signal to providers and funding bodies alike that relational quality is not ancillary to treatment success, but rather central to it.

On a broader societal level, emphasizing relational safety and mutuality during the earliest stages of treatment may improve access to care for individuals who have historically mistrusted or avoided services due to stigma, discrimination, or previous negative treatment experiences. When therapists create environments grounded in transparency, empathy, and

respect, they communicate to clients, particularly those from marginalized or traumatized populations, that therapy can be a safe space for healing rather than judgment. This shift in relational tone has the potential to expand the reach of treatment services, strengthen community trust in behavioral health systems, and ultimately contribute to more equitable outcomes in addiction recovery.

Research Question 2 (RQ2):

What therapist behaviors and strategies are most effective in maintaining a strong TA throughout SUD treatment, considering client characteristics and therapist insights?

Interpretation and Contextualization of Findings

Therapists described the maintenance of TA as a dynamic, ongoing process requiring relational consistency, emotional attunement, boundary clarity, and autonomy-supportive interactions. They emphasized that trust, once established, must be regularly reinforced, particularly in response to client ambivalence, relapse, or interpersonal ruptures. The ability to remain emotionally steady and attuned while adjusting strategies in real-time emerged as a defining feature of effective long-term alliance work.

Validation, of effort, struggle, and small victories, was a recurring theme. Therapists emphasized “naming the good” to remind clients of their agency and progress, particularly during challenging moments. This mirrors Flückiger et al.’s (2018) assertion that the TA is not static but must be actively nourished over time. It also aligns with the trauma-informed principle of recognizing resilience rather than solely focusing on pathology.

These behaviors closely parallel the motivational constructs of SDT. Therapists’ emphasis on respecting client autonomy, adjusting to the client’s pace, and co-creating treatment plans supports SDT’s assertion that autonomy and competence, along with relatedness, are

essential to sustaining intrinsic motivation over time (Deci & Ryan, 2017). When clients experience themselves as capable and in control of their therapeutic process, they are more likely to remain engaged even during periods of distress or relapse.

Factors Influencing Interpretation

The high consistency of this theme across participants may be partially shaped by the professional culture of addiction counseling in Israel, where many clinicians work in multidisciplinary settings that value holistic and trauma-informed care. Additionally, the participant pool included many therapists with extensive experience and post-master's certifications in MI, CBT, and trauma therapy, which may influence their commitment to autonomy-supportive practices. Another consideration is that participants may have described ideal behaviors they *aspire* to, rather than what they are consistently able to implement. Nonetheless, the thick, nuanced accounts provided suggest lived experience rather than theoretical idealism.

Contribution to Literature and Theory

These findings offer a practical contribution to the literature by detailing the micro-behaviors therapists use to preserve alliance in the face of common SUD challenges—resistance, relapse, and distrust. Whereas much of the alliance literature (e.g., Horvath et al., 2011) has emphasized early-session formation, this study emphasizes sustained relational engagement, a relatively underexplored area in addiction therapy research. The data also refined SDT by illustrating how the ongoing fulfillment of psychological needs must be adapted throughout the treatment journey. Therapists emphasized that what motivates a client in week one may differ from what motivates them in month six, reinforcing the need for relational flexibility and responsiveness as essential therapeutic skills (Thai et al., 2024).

The results of this study carry significant implications for clinical practice, supervision, organizational culture, and the broader systems that shape addiction treatment delivery. The results suggest that clinical practice should evolve from viewing alliance-building as a front-loaded or introductory task to conceptualizing it as an ongoing, relational process that requires continuous investment, recalibration, and mutual attentiveness. Therapists who approach the alliance as dynamic rather than fixed are better equipped to navigate fluctuations in client motivation, relapse, and resistance, factors that are inherent to the long-term treatment of SUDs.

Supervision and continuing education programs should emphasize advanced relational skills beyond the basics of empathy and active listening. Training that focuses on rupture repair, motivational recalibration, and the integration of client feedback can enhance therapists' capacity to sustain the alliance through the inevitable challenges of addiction work. Supervisors play a pivotal role in helping clinicians develop these competencies by modeling reflective dialogue, exploring emotional countertransference, and encouraging flexibility in therapeutic stance. Such relational supervision not only supports professional growth but also mirrors the attunement and responsiveness expected in therapy itself.

At the organizational level, treatment programs and agencies must recognize the considerable emotional labor, time, and attunement required to maintain strong therapeutic relationships. Institutional cultures that privilege productivity metrics, such as client quotas or rapid turnover expectations, risk undermining the very conditions that allow the therapeutic alliance to flourish. Administrators and policymakers should therefore embed relational quality into performance evaluation frameworks, staff training initiatives, and workload management policies. This shift acknowledges that the alliance is not a "soft" dimension of care but a measurable determinant of retention and recovery outcomes.

In today's increasingly digital therapeutic landscape, technology-mediated interventions, such as telehealth sessions or app-based counseling platforms, must also account for the unique challenges of maintaining relational warmth, trust, and continuity across distance and time. Clinicians working in these modalities should be trained in strategies that humanize the digital interface, such as intentional eye contact through the camera, explicit empathy statements, and consistent follow-up communication. Program designers should integrate user feedback mechanisms and ensure that digital tools support, rather than dilute, the alliance's relational essence.

At a societal level, promoting sustained therapeutic relationships has the potential to improve long-term outcomes for individuals with SUD by reducing dropout and relapse rates and fostering sustained engagement in care. Beyond individual recovery, these findings contribute to broader public health goals by reframing recovery as a relational process rather than a solely behavioral or compliance-based one. Recognizing recovery as relational emphasizes that healing occurs within secure, consistent, and empathic human connections—conditions that extend far beyond symptom reduction and toward the restoration of trust, agency, and social belonging.

Recommendations for Practice

The findings of this study offer several actionable recommendations for clinical practice, supervision, and counselor training in the field of SUD treatment. These recommendations are grounded in participant narratives, supported by relevant literature, and framed within the SDT framework.

1. Prioritize Relational Skills in Training and Supervision

Counselor education programs and clinical supervision models should give explicit attention to developing therapists' relational competencies, including authentic presence,

empathic attunement, and transparent communication. These skills were identified by participants as foundational to establishing a therapeutic alliance in initial sessions and sustaining it over time. Traditional training often prioritizes manualized treatment models or evidence-based interventions; however, this study reinforces existing literature that relational factors are often more predictive of positive outcomes than technique alone (Elliott et al., 2011; Norcross & Lambert, 2019). Integrating structured reflection on “use of self,” including experiential exercises and feedback on relational stance, would better prepare clinicians for work with SUD populations, who often present with high ambivalence, shame, and trauma-related defenses.

2. Implement Relational Calibration as a Clinical Practice

Therapists should be encouraged to engage in ongoing relational calibration, or checking in on the strength, stability, and quality of the therapeutic alliance across the course of treatment. Participants in this study described the alliance not as a one-time achievement but as a dynamic relationship requiring constant maintenance. As Flückiger et al. (2018) argue, therapists who actively tend to the alliance and repair ruptures are more likely to foster durable engagement. Practical tools may include formal alliance measures (e.g., Session Rating Scale), client feedback protocols, and supervisor-supported debriefs that reflect on moments of relational disconnection or client disengagement (Duncan et al., 2003).

3. Cultivate Autonomy-Supportive Clinical Environments

Given the strong alignment between participant behaviors and SDT’s psychological needs framework, clinical settings should cultivate autonomy-supportive environments. Therapists should be trained to avoid directive or prescriptive interventions that risk client disengagement. Instead, encouraging client-led goal-setting, collaborative decision-making, and

spacing aligned with client readiness may enhance internal motivation and treatment adherence (Ryan et al., 2011).

This recommendation mirrors the MI literature (Miller & Rollnick, 2013), which emphasizes the power of partnership, evocation, and acceptance as mechanisms of change, particularly for individuals with SUD.

4. Institutionalize Early Engagement Protocols

Treatment organizations may benefit from designing specific protocols or guidelines for the first three sessions of therapy, based on strategies validated in this study: authentic welcoming, offering hope, creating a judgment-free zone, and establishing mutual expectations. Embedding these behaviors systemically can reduce premature dropout, a common barrier in addiction treatment (Ball et al., 2006; Meier et al., 2005). This should not be overly standardized but rather flexible enough to allow therapists to express their unique presence while holding fidelity to principles that promote early engagement and relational safety.

Recommendations for Future Research

A logical next step in advancing this line of inquiry is the development of a quantitative instrument that operationalizes the specific therapist behaviors identified in this study. Because the current IPA design provided rich phenomenological insight into how counselors cultivate and sustain the therapeutic alliance, translating these behaviors into measurable constructs represents the most coherent continuation of this work. Developing such an instrument would allow researchers to examine whether behaviors such as authentic presence, transparency, empathic attunement, ongoing relational calibration, and autonomy-supportive practices reliably predict engagement, retention, or treatment outcomes across larger and more diverse samples. This recommendation aligns with prior methodological scholarship emphasizing the importance of

converting qualitative constructs into psychometric tools to test generalizability (Fishman & Galguera, 2003). By building directly upon the framework and findings of this study, future quantitative validation would strengthen empirical understanding of alliance mechanisms within SUD treatment.

Future researchers may also expand on these findings by incorporating client perspectives to complement and contrast the therapist viewpoint. The therapeutic alliance is fundamentally co-constructed, and while this study captured the therapist's lived experience, client narratives remain essential for understanding how relational behaviors are received, interpreted, and experienced. Prior work has underscored that mutuality, reciprocity, and collaborative negotiation are central to alliance formation (Bedics & McKinley, 2020). Therefore, future studies, potentially structured as dyadic IPA designs, should include therapist–client pairs to explore areas of attunement, misattunement, alliance rupture, and repair. Integrating client accounts would also illuminate how relational strategies interact with motivation, readiness, and emotional vulnerability, supporting a more comprehensive and theoretically grounded application of SDT.

Generalizability also represents a key direction for future research. Because all participants in this study were English-speaking therapists practicing in Israel, expanding to different cultural and linguistic contexts would allow researchers to examine how culturally held values shape alliance expectations and relational behavior. Constructs such as “authentic presence,” “relational transparency,” and “non-judgmental space” may carry different meanings across cultures, particularly when comparing egalitarian, self-disclosing therapeutic norms with more hierarchical or collectivist models of care. Emerging cross-cultural research suggests that alliance behaviors are interpreted through culturally embedded relational (Mutegi & Ngunjiri,

2025), and culturally adapted alliance-building strategies may differ significantly from those emphasized by participants in this study (Masuda et al., 2023). Conducting research in non-Western, multilingual, or resource-limited environments would address a clear limitation of this study while advancing culturally informed clinical practice.

Another promising research direction involves examining the longitudinal effects of the relational strategies identified in this study. While the present findings clarify how therapists establish and maintain the alliance within treatment, they do not address whether these relational behaviors predict lasting recovery outcomes. Future longitudinal designs, incorporating follow-up interviews, sober-living indicators, quality of life metrics, or relapse data, could clarify whether early alliance formation predicts longer-term stability in addiction recovery. Prior scholarship has emphasized the importance of relational continuity for durable treatment outcomes (Benish et al., 2011), and investigating whether specific therapist behaviors provide protective or sustaining effects would have meaningful implications for program design, funding models, and clinical priorities.

Finally, future research should explore supervision practices and training environments that support the development of relationally skilled therapists. Participants in this study emphasized that effective alliance-building arises not from technique alone but from the therapist's relational stance, emotional availability, and capacity for attuned, moment-to-moment responsiveness. Understanding how supervisors mentor these skills, and how educational programs structure relational training, would address an important implication of this study: relational competence must be deliberately taught and supported. Investigating how clinical supervisors foster or hinder the cultivation of alliance-focused skills would provide insight into workforce development across SUD settings, a need already recognized in the addiction

counseling literature (Choy-Brown et al., 2025). Such research could clarify how relationally attuned practice is sustained, reinforced, and institutionalized within treatment organizations.

Table 2

Summary of Recommendations for Practice and Future Research

Category	Recommendation	Supporting Finding	Theoretical Alignment / Source
Practice	Prioritize relational skills (authenticity, empathy, transparency) in training and supervision	Alliance built through therapist presence, transparency, and nonjudgmental stance	Rogers (1957); Meier et al. (2005); Ryan & Deci (2000)
	Implement relational calibration practices (ongoing alliance check-ins and feedback mechanisms)	Alliance is dynamic; requires maintenance, not a one-time formation	Flückiger et al. (2018); Ackerman & Hilsenroth (2003)
	Cultivate autonomy-supportive clinical environments and interventions	Maintaining alliance through respecting client agency and collaboration	Deci & Ryan (1985); Miller & Rollnick (2013)
Future Research	Institutionalize early engagement protocols to support client retention	Early sessions are critical for trust, especially in clients with trauma and shame	Ball et al. (2006); Finsrud et al. (2022)
	Develop quantitative or mixed-method tools to validate identified therapist behaviors	IPA themes rich but based on therapist perceptions only	Expand measurement and generalizability
	Include client voices or dyadic designs to explore mutual perceptions of alliance	Alliance is co-constructed; current study only examined therapist perspective	Horvath et al. (2011); Zuroff et al. (2007)

Category	Recommendation	Supporting Finding	Theoretical Alignment / Source
	Replicate study in diverse cultural and linguistic contexts	Participants limited to English-speaking therapists in Israel	Cultural generalizability and relevance
	Examine long-term outcomes associated with alliance-building strategies	Study focused on formation/maintenance but not downstream impacts	Flückiger et al. (2018); Ryan et al. (2011)
	Investigate supervision practices that cultivate relational skills	Need for institutional support in relational competence development	Norcross & Lambert (2019); Elliott et al. (2011)

Table 2 summarizes recommendations based on the findings of a qualitative IPA study of licensed SUD counselors, aligned with SDT and the broader TA literature.

Study Summary

This dissertation set out to explore a deeply interpersonal but often underdefined element of SUD treatment: the therapist behaviors that build and sustain a strong TA. While the alliance has long been recognized as a predictor of treatment success, dropout reduction, and recovery outcomes, the mechanisms by which it is created and maintained, particularly from the therapist's perspective, remain underarticulated in the literature. This study addressed that gap through a qualitative investigation grounded in IPA, offering nuanced insight into how therapists understand and enact the therapeutic alliance across the arc of SUD treatment.

The research was guided by two questions:

1. What are therapists' perceptions of the behaviors and strategies that support the establishment of a strong therapeutic alliance in initial sessions?

2. What therapist behaviors and strategies are most effective in maintaining a strong therapeutic alliance throughout SUD treatment, considering client characteristics and therapist insights?

Fifteen experienced addiction counselors working in Israel were interviewed to explore their lived experiences and clinical insights. The data revealed two interrelated, yet distinct, sets of findings: (1) establishing the alliance requires authentic presence, transparency, empathic attunement, and offering hope; (2) maintaining the alliance over time demands emotional consistency, validation, respect for client autonomy, and a willingness to recalibrate the relationship as treatment progresses.

Reframing the Therapeutic Alliance in SUD Treatment

One of the key contributions of this study was its reframing of the TA not as a static agreement or phase of treatment, but as a relational process requiring continual investment, attunement, and repair. Participants emphasized that the alliance begins with a human connection, a “realness” and emotional accessibility that allows clients to feel seen and safe. In early sessions, these behaviors disarm shame, reduce mistrust, and set the tone for collaborative engagement. Over time, therapists must sustain the alliance by being flexible, emotionally steady, and validating of client effort, particularly when clients struggle or relapse. The alliance, in this sense, is not built once, it is built again and again in the micro-moments of the therapeutic relationship.

This study also contributed to the operationalization of abstract therapeutic principles. Concepts like “empathy,” “presence,” or “support” are often invoked but rarely specified in clinical training or literature. The findings of this study offer concrete descriptions of these behaviors in action—from self-disclosure used judiciously to communicating belief in the

client's potential, even in the face of ambivalence or resistance. These narrative details have immediate practical value for therapists, supervisors, and educators.

Self-Determination Theory: A Powerful Framework

SDT provided a powerful framework for understanding the motivational implications of the TA. Across both research questions, therapist behaviors were consistently aligned with SDT's three core psychological needs: relatedness, autonomy, and competence. When therapists created relational safety (relatedness), honored client pacing (autonomy), and reflected back effort and growth (competence), clients were more likely to remain engaged and to take ownership of their recovery.

The study reinforced prior findings that autonomy-supportive environments promote internalized motivation and enhance outcomes in SUD treatment (Ryan et al., 2011). It also extends the literature by showing how therapists, often intuitively, structure their interactions in ways that fulfill these basic psychological needs, even if they are not explicitly drawing on SDT in their clinical thinking. In doing so, it supports the integration of SDT-informed approaches into addiction counseling theory, training, and supervision.

Clinical and Societal Significance

At the clinical level, this study underscored the need to elevate relational competence to a central pillar of evidence-based practice. In an era where outcome measures and manualized interventions often dominate discourse, this research reaffirmed that the way therapy is conducted, how a therapist shows up, relates, listens, and adjusts, is often as important as what techniques are used. For clients with SUD, many of whom have histories of interpersonal trauma, loss, or marginalization, the therapist's relational stance may serve as the most powerful intervention.

At a broader level, this study holds significance by highlighting relational factors that may influence engagement and retention in substance use disorder treatment, areas of ongoing concern within public health systems. If therapists can be trained and supported in building early and enduring alliances, the likelihood increases that clients will remain in treatment long enough to benefit from it. This has implications for reducing relapse, criminal recidivism, overdose, and the intergenerational impacts of addiction. Additionally, clients who feel seen, understood, and empowered are more likely to experience recovery not as an external demand but as an internal process of healing and growth.

Limitations and Integrity

The study's findings must be interpreted with attention to its limitations. The sample included only English-speaking therapists practicing in Israel. While rich in diversity of background and orientation, the cultural and linguistic homogeneity of the group may affect generalizability. Moreover, as a qualitative study relying on therapist self-report, the findings reflect personal perceptions rather than objective measures of behavior. Nevertheless, the thematic saturation and coherence across participants provide confidence in the study's trustworthiness, and the IPA methodology allowed for a depth of meaning-making often unavailable in quantitative research.

Final Reflections and Takeaway Message

This dissertation underscores the essential role of the therapeutic alliance as a central mechanism of change in addiction counseling and advances the field by clearly articulating the specific relational behaviors that support its formation and maintenance. By grounding these behaviors within SDT, the study expands theoretical understanding of how autonomy, competence, and relatedness are operationalized in real clinical interactions. It also contributes

practical knowledge to the profession by identifying ways in which training, supervision, and organizational culture can better support clinicians in cultivating meaningful therapeutic relationships with clients navigating the complex terrain of substance use disorders.

At its core, the takeaway message is both simple and profound: in SUD treatment, the relationship is not merely the container for therapy, it is the therapy. When counselors approach clients with authenticity, emotional steadiness, transparency, and respect for autonomy, they create the psychological conditions in which motivation can emerge, shame can soften, and change can take root. These findings serve as a reminder that even in an era increasingly shaped by protocols, digital tools, and outcome metrics, the most powerful catalyst for recovery is still the human connection between therapist and client.

Ultimately, this study affirms that meaningful therapeutic work happens in the space where two people meet, where the client's vulnerability is met with compassion, where ambivalence is met with patience, and where agency is nurtured rather than imposed. As the field continues to evolve, clinicians, educators, and policymakers must remain attentive to this enduring truth. The future of effective addiction treatment will depend not only on advances in science, but on our ongoing commitment to the relational heart of the work.

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Appendix A

Invitation Letter for Potential Study Participants

HaChozeh MiLublin 9a
Beit Shemesh, Israel 99623

May 30, 2025

Dear [Potential Participant's Name],

I am conducting a study as part of my doctoral dissertation at National University, focusing on the role of therapeutic alliances in enhancing treatment outcomes for clients with substance use disorders (SUDs). This research seeks to explore the experiences of therapists in establishing and maintaining strong therapeutic alliances with their clients.

You have been identified as a potential participant based on your professional experience and expertise in the field of counseling and addiction counseling. Your insights and perspectives would provide valuable contributions to understanding how specific therapist behaviors and strategies impact the therapeutic alliance. Participation in this study will involve a single interview lasting approximately 60–90 minutes, which will take place at a mutually convenient time and location or virtually via Zoom. The interview will be recorded, with your consent, for transcription and analysis. All information you provide will remain confidential and will be used solely for research purposes.

Your participation is entirely voluntary, and you may withdraw at any time without any consequences. To ensure anonymity, any identifying information will be removed from the final report. If you are interested in participating or have any questions, please feel free to contact me at yaacovmr@gmail.com or +972-528084406. I would be happy to provide additional details or address any concerns you might have.

Thank you for considering this opportunity to contribute to research that aims to improve therapeutic practices in the field of addiction counseling.

Sincerely,
Yaacov Rosedale
Doctoral Candidate, National University

Appendix B

Interview Guide for Study Participants

Introduction

- Thank the participant for their time and introduce the study purpose.
- Explain the structure of the interview and expected duration.
- Reiterate confidentiality and consent to record the interview.
- Personal Information: Age_____, Sex_____, Race_____, Religion_____, Number of years in the profession_____, Discipline area in the profession_____.

Purpose of Study

This phenomenological study, utilizing Interpretative Phenomenological Analysis (IPA), will explore and understand the lived experiences of counselors in establishing therapeutic alliances with clients undergoing substance use disorder (SUD) treatment (McInally, W. & Gray-Brunton, 2021; Peat et al., 2019). The focus of this research is understanding from the perspective of the therapist the actions taken that help establish a strong therapeutic alliance. If the identified actions are taken by the therapist we predict that there will be a higher TA and we will be able to identify the specific variables that contribute to forming a strong therapeutic relationship (Sutton, 2021).

The therapeutic alliance is the collaborative relationship between a therapist and a client characterized by mutual trust, respect, and understanding. Research indicates that a strong therapeutic alliance is associated with better treatment outcomes across various therapeutic modalities and client populations. This can be measured by looking at the bond between client and therapist; the collaborative approach and agreement on treatment goals; and the collaborative approach and agreement on treatment tasks (Stubbe, 2018). It is crucial in promoting client

engagement, motivation for change, and adherence to therapeutic (Flückiger et al., 2018; Norcross & Lambert, 2019).

Question: Do you have experience with the therapeutic alliance in your practice?

Interview Questions

Section 1: Background

1. Provide details on your professional background and experience in addiction counseling.

Section 2: Establishing the Therapeutic Alliance

2. In your experience, what are the most important factors in building a strong therapeutic alliance during initial sessions?
3. Describe specific actions or behaviors that you believe are effective in establishing trust and rapport with clients?
4. How do you tailor your approach to clients with different levels of readiness for change?

Section 3: Maintaining the Therapeutic Alliance

5. What indicators are you using to inform your therapeutic alliance?
6. How do you address challenges such as client resistance or lack of engagement?
7. Provide an example of a time when you successfully rebuilt a strained therapeutic alliance?

Section 4: Impact of the Therapeutic Alliance

8. In your opinion, how does the strength of the therapeutic alliance influence treatment outcomes?
9. Have you noticed any patterns or trends in how therapeutic alliances evolve over time with different clients?

Section 5: Reflections and Insights

10. What advice would you offer to new therapists about building and maintaining therapeutic

alliances?

11. Is there anything else you would like to share about your experiences with therapeutic alliances in SUD treatment?

Conclusion

- Thank the participant for their time and valuable insights.
- Reiterate how the information will be used and the next steps.
- Offer to provide a summary of the study results if they are interested.

Appendix C

Informed Consent

My name is Yaacov Rosedale, and I am a doctoral student at National University (NU).

I'm asking you to take part in a research study about therapeutic alliance from a therapist's perspective. The name of this research study is "The Therapeutic Alliance in Substance Abuse Counseling from a Therapist's Perspective: A Qualitative Phenomenological Study".

You may participate in this research if you meet all the following criteria:

- You are age 18 or older.
- You are or have been a mental health professional.
- You are or have worked with people who identify as having a substance use disorder or process addiction.
- Live and reside in Israel

I hope to include 5 – 15 people in this research.

Please read this form carefully and ask any questions you may have before agreeing to take part in this study.

What you will be asked to do: If you agree to participate in this study, you will be asked to do the following activities:

1. Participate in an online interview via Zoom for 30 – 60 minutes.
2. Agree to have the interview transcribed so that it can be used to process the responses from the surveys.

During these activities, you will be asked questions about:

- Background
- Establishing the Therapeutic Alliance

- Maintaining the Therapeutic Alliance
- Impact of the Therapeutic Alliance
- Reflections and Insights

Risks: There are no foreseeable risks or discomforts associated with this study. You can still skip any question you do not wish to answer, skip any activity, or stop participation at any time.

Benefits: If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this study.

Recording: I will be audio/visual recording the session during your Zoom interview. You can disable the video function of the online meeting platform at any time.

Confidentiality: I will keep records of this study private and take reasonable measures to protect the security of all your personal information. In any report I make public, I will not include any information that will make it possible to identify you. I will securely store your data for 3 years. Then, I will delete electronic data and destroy paper data.

Taking part is voluntary: Participation in this study is completely voluntary. You may quit at any time.

If you have questions: Please ask any questions you have now. If you have questions later, you may contact me at yaacovmr@gmail.com or at (052) 808-4406.

Appendix D

Non-Disclosure/Confidentiality Agreement

I, Yaacov Rosedale, will be running the research study titled “The Therapeutic Alliance in Substance Abuse Counseling from a Therapist’s Perspective: A Qualitative Phenomenological Study”.

My role will be to run the study and conduct the interview which will be transcribed via Zoom’s transcription feature.

In this role:

1. I will not disclose the names of any participants in the study.
2. I will not disclose personal information collected from any participants in the study.
3. I will not disclose any participant responses.
4. I will not disclose any data.
5. I will not discuss the research with anyone other than the researcher(s).
6. I will keep all paper information secure while it is in my possession.
7. I will keep all electronic information secure while it is in my possession.
8. I will return all information to the researcher when I am finished with my work.
9. I will destroy any extra copies that were made during my work.

Signature Date

Researcher Signature Date

Full contact information of researcher:

Name: Yaacov Rosedale, LPC

Phone: 052-8084406

Email: yaacovmr@gmail.com

Appendix E

Recruitment Materials

Email/Letter Recruitment Guidelines

My name is Yaacov Rosedale, and I am a doctoral student at National University. I am conducting a research study to understand the specifics of the therapeutic alliance between therapists and substance abuse and other addicted clients. The study is titled *The Therapeutic Alliance in Substance Abuse Counseling from a Therapist's Perspective: A Qualitative Phenomenological Study*.

I am recruiting individuals who meet all of these criteria:

- You are aged 18 or older.
- Current mental health professional that treats people with process or substance abuse addictions.
- Live and reside in Israel.

If you decide to participate in this study, you will be asked to do the following activities:

1. Participate in an online interview via Zoom for 30 - 60 minutes
2. Agree to have the interview transcribed so that it can be used to process the responses from the surveys.

During the interview, you will be asked questions about:

- Background
- Establishing the Therapeutic Alliance
- Maintaining the Therapeutic Alliance
- Impact of the Therapeutic Alliance

- Reflections and Insights

If you are interested in participating in this study, please contact me at yaacovmr@gmail.com or

052-808-4406. As a reminder, the interview will take place on Zoom.

Yaacov Rosedale
Licensed Professional Counselor
NCAC II

Appendix F

Pre-Screening Guide for Participant Eligibility

Study Title:

The Therapeutic Alliance in Substance Abuse Counseling From a Therapist's Perspective: A Qualitative Phenomenological Study

Researcher: Yaacov Rosedale, Doctoral Candidate, National University

Section 1: Introduction Script

Hello, and thank you for your interest in participating in this research study. Before we move forward, I'd like to ask a few brief questions to ensure you meet the inclusion criteria. This will only take a few minutes and your responses will be kept confidential.

Section 2: Inclusion Criteria Checklist

Please answer the following questions:

1. Age Verification

- a. Are you 21 years of age or older?

Yes

No → If No, the individual is not eligible to participate.

2. Professional Qualifications

- a. Are you currently a licensed mental health professional (e.g., counselor, psychologist, clinical social worker)?

Yes

No → *If No, the individual is not eligible to participate.*

b. Please specify your licensure and credentialing (e.g., LPC, LCSW, psychologist):

3. Work Experience with SUD Clients

a. Do you currently work with clients diagnosed with substance use disorders (SUDs)?

Yes

No → *If No, the individual is not eligible to participate.*

b. Please indicate your practice setting (check all that apply):

Private Practice

Rehabilitation Center

Community Mental Health

Hospital or Inpatient Setting

Other: _____

4. Language and Location

a. Are you an English-speaking therapist currently practicing in Israel?

Yes

No → *If No, the individual is not eligible to participate.*

Section 3: Summary of Eligibility

- This participant **meets** all inclusion criteria and is eligible for the study.
- This participant **does not meet** all inclusion criteria and is **not eligible** for the study.

Initials of Screener: _____ **Date:** _____

Appendix G

Social Media Post

My name is Yaacov Rosedale, and I am a doctoral student at National University. I am conducting a research study to better understand the therapeutic alliance in substance abuse counseling from a therapist's perspective.

I am recruiting individuals who meet all these criteria:

1. Are age 18 and older
2. Live in Israel
3. A therapist treating patients that are suffering from substance abuse or other process addictions.
4. Can speak English

This study consists of an interview over Zoom. You are invited to participate in this study. If you have any questions, please contact me at 052-808-4406 or yaacovmr@gmail.com.

Thank you for considering participating in this voluntary research!

Yaacov Rosedale