

5-2013

# Social Workers Reflect on Engagement with Involuntary Clients

Courtney A. Jacobsen  
*St. Catherine University*

---

## Recommended Citation

Jacobsen, Courtney A.. (2013). Social Workers Reflect on Engagement with Involuntary Clients. Retrieved from Sophia, the St. Catherine University repository website: [https://sophia.stkate.edu/msw\\_papers/198](https://sophia.stkate.edu/msw_papers/198)

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact [amshaw@stkate.edu](mailto:amshaw@stkate.edu).

# Social Workers Reflect on Engagement with Involuntary Clients

By

Courtney A. Jacobsen, BSW, LSW

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial Fulfillment of the Requirements for the Degree of  
Master of Social Work

Committee Members

Carol F. Kuechler, MSW, Ph.D, LISW (Chair)

Roxanne Sanderson, MSW, LICSW

Dana Swayze, MSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publically present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## **Abstract**

For social workers, engagement refers to the process through which clients become active and involved in their treatment. Involuntary clients, or clients who are legally mandated or feel pressure to seek treatment, struggle with engagement and are often viewed as being resistant. This study examined the engagement process through interviews conducted with social workers who have experience in working with involuntary clients. Five social workers discussed the engagement process and strategies they use to encourage the engagement process with involuntary clients. They emphasized the importance of giving the clients choice and control over their treatment, and having the capacity to genuinely like the client. Motivational interviewing and relational approaches were cited as beneficial for fostering engagement with involuntary clients, a view that is consistent with previous research.

## **Acknowledgments**

First, I would like to thank my committee chair, Dr. Carol Kuechler, for her unwavering support, guidance and encouragement through this research process. Her high expectations for my work gave me the confidence and motivation to I needed to be successful in the completion of this work.

I am so grateful for my Clinical Research Committee members, Roxanne Sanderson and Dana Swayze, for assisting me in my research and carefully reviewing my work. They believed in my project from the beginning and offered their unique insights, playing a critical role in the execution of this project and paper.

A heartfelt thanks to my parents for putting up with the many ups and downs that my graduate education brought. They always believed I could accomplish my goals when even my faith was wavering. I am eternally grateful for my brothers for their continued love and support through this process.

Finally and most importantly, I would like to thank the St. Catherine University/University of St. Thomas School of Social Work for the graduate education that I received. The experiences that I have had and the things that I have learned in this program have made me a better human being and a more compassionate social worker.

**Table of Contents**

<b>Abstract</b>	<b>i</b>
<b>Acknowledgments</b>	<b>ii</b>
<b>Introduction</b>	<b>1-2</b>
<b>Literature Review</b>	<b>2-16</b>
<b>Conceptual Framework</b>	<b>16-17</b>
<b>Method</b>	<b>18-21</b>
<b>Findings</b>	<b>21-28</b>
<b>Discussion</b>	<b>28-32</b>
<b>References</b>	<b>33-36</b>
<b>Appendices</b>	
<b>Appendix A: Flyer</b>	<b>37</b>
<b>Appendix B: Consent Form</b>	<b>38-39</b>
<b>Appendix C: Interview Guide/Questions</b>	<b>40</b>

Engagement is defined as the process through which a client begins to actively participate in their treatment. It is also considered the stage of the therapeutic relationship that assists in having positive treatment outcomes (Friedlander, Escudero & Heatherington, 2006; Yatchmenoff, 2005; Tetley, Jinks, Huband & Howells, 2011; Simpson & Joe, 2004). The engagement process involves developing “agreement on the goals and tasks of treatment” through the collaboration of the therapist and client (Friedlander et al., 2006, p. 72). The therapeutic process of engagement is universal to all client and social worker interactions whether they are voluntary or involuntary clients.

Involuntary clients, or mandated clients are those who come to treatment under the coercion of a legal body or pressure from significant others, family members and institutions such as child protective services (Rooney, 2009; Regehr & Antle, 1997; Pope & Kang, 2011; Trotter, 2006). Rooney (2009) proposed definitions of involuntary clients that distinguish categories of motivation including both *legally mandated* clients as well as *nonvoluntary* clients. Examples of *legally mandated* clients include clients with sexual offenses, clients charged with assault or clients who are involved in a domestic violence situation. *Nonvoluntary* clients on the other hand, are likely to feel pressure to seek treatment from a significant other, workplace, family member or other source. People in both of these categories are included in the umbrella term “involuntary” (Rooney, 2009).

Based on the literature and practice experience, it is well documented that engagement for involuntary clients is often a different and more difficult process than engagement with voluntary clients due to the coercion of the legal system or significant others (Cingolani, 1984; Behroozi, 1992; De Jong & Berg, 2001). The purpose of this study was to explore the engagement process with involuntary clients by interviewing

practitioners who currently work with or have previously worked with involuntary clients in treatment settings.

### **Literature Review**

The focus of this literature review is the process of engagement, a fundamental component to every therapeutic relationship, with particular attention to the engagement process with involuntary clients. The process of engagement with all clients, aids to engagement and challenges to the engagement process are discussed first. Then, a description of the involuntary client population followed by the process of engagement with the involuntary client population, noting aids to engagement, is examined in further detail.

### **The Engagement Process**

Engagement within the context of a therapeutic relationship is defined as a point at which the client views treatment as a meaningful and important process (Friedlander, Escudero & Heatherington, 2006; Yatchmenoff, 2005; Tetley et al., 2011; Welsh & McGrain, 2008). It involves developing “agreement with the therapist on the goals and tasks of treatment” (Friedlander et al., 2006, p. 72). Engagement can also be described as the therapeutic relationship or therapeutic alliance that exists between the therapist and the client (Yatchmenoff, 2005; Tetley et al., 2011). The therapeutic relationship is structured by the goals of therapy that are created through collaboration between the therapist and client (Friedlander et al., 2006).

The engagement process is sometimes identified using other terms such as cooperation, collaboration, participation or *buy in* (Yachmenoff, 2005; Tetley et al., 2011). Yachmenoff (2005) defined a client’s *buy in* as expectancy plus involvement.

Expectancy is viewed as what the client expects to happen in therapy or treatment; the client's perceived benefit. Involvement on the other hand is defined as a client's active participation in treatment (Yachmenoff, 2005). During the engagement process, the client's worldview including values, core beliefs, and ways of conducting ones life are challenged in order to create substantive change (Chovanec, 2012; Tetley et al., 2011). Challenging the client's notions is the catalyst that facilitates the change process (Prochaska & Norcross, 2001; Tetley et al., 2011).

In order to describe the engagement process Yachmenoff (2005) asked practitioners questions about how they know whether a client is actually engaged or just going through the motions of their treatment. Practitioners were also asked what the term engagement meant in their treatment setting (Yachmenoff, 2005). Practitioners distinguished engagement as a concrete and measurable change in their client's behavior (Yachmenoff, 2005). Practitioners identified the clients' realization that they needed to make a change for themselves rather than for their family or the legal system as engagement in the therapeutic process (Yachmenoff, 2005). A measureable change in clients' behavior was one of the primary predictors of whether or not clients were engaged in treatment (Welsh & McGrain, 2008). Engagement behaviors included attending treatment regularly, full and open disclosure of thoughts, feelings and ideas, and completing any between-session tasks that were assigned (Tetley et al., 2011; Yachmenoff, 2005).

Four dimensions of engagement were identified in a study done by Yachmenoff (2005). These concepts are *receptivity*, *expectancy*, *investment* and *working relationship*. *Receptivity* describes how open clients are to receiving help in their life and also whether



or not the clients recognize a problem and a need for change (Yachmenoff, 2005).

*Expectancy* deals with the clients' perceptions of whether they will benefit from treatment (Yachmenoff, 2005). *Receptivity* and *expectancy* are closely related in the sense that if clients do not see the need for treatment and deny any problems, they are not likely to have high expectancy or be invested in their treatment.

*Investment* is characterized by clients' active contributions, participation and work in their treatment. The clients who demonstrate the concept of *investment* will take responsibility for their treatment goals (Yachmenoff, 2005). The *working relationship* is similar to the therapeutic alliance that exists between therapists and clients. A therapeutic alliance or *working relationship* is characterized by feelings of fair exchange and open communication between clients and therapists (Yachmenoff, 2005). In effective *working relationships* clients are able to like their therapist and respect the work that their therapist is helping them to accomplish (Tetley et al., 2011).

Motivation is described as one of the key predictors to clients' engagement in treatment (Hiller, Knight, Leukefeld & Simpson, 2002; Welsh & McGrain, 2008). Clients' desire to receive help and their recognition of the problem are both measures of their potential motivation for treatment (Welsh & McGrain, 2008). Clients who demonstrate a higher level of motivation demonstrate a higher level of personal commitment to treatment, a higher readiness for treatment and positive treatment outcomes (Hiller et al., 2002; Sia et al., 2000).

Clients' support networks, commonly significant others, families and friends, increase their motivation and aid in their continued treatment (Magill et al., 2010; Hiller et al., 2002). When a significant other is involved in treatment, clients have a natural

support system outside of the therapeutic environment (Magill et al., 2010). Family members, friends and significant others act as the clients' cheerleaders and support systems assisting in their treatment process (Hiller et al., 2002).

### **Aids in the Engagement Process**

The therapist can choose to employ certain strategies that encourage and assist in the engagement process with clients. These strategies allow the clients to develop a trusting relationship with the therapist, and the therapist to develop a stronger rapport with the clients. Strategies for assisting the therapist in the engagement process with clients include a "client-centered" approach, the stages of change, the stages of group development and relational approaches (Kurland & Salmon, 1998; Prochaska & Norcross, 2001; Chovanec, 2009; Welsh & McGrain, 2008; Jordan, 2001; Ford & Urban, 1963).

**Client-Centered Approach.** The client-centered approach is a framework for working with clients that places the primary responsibility for treatment on the client (Ford & Urban, 1963; Reevy, 2010). Carl Rogers identified four tenets of a client-centered approach. These tenets included: "viewing the client as choosing to grow and develop," "the emotional, feeling aspects of a client's experience," "the client's experience in the present," and "the therapeutic relationship... as a potential situation for growth, where the client learns to understand himself" (Reevy, 2010, pp. 158). The client-centered approach includes goals that encourage the congruence of the client's observations and thoughts about behavior as well as a focus on client's strengths (Ford & Urban, 1963; Braucht, 2009). Through this approach, clients identify their own areas that

need improvement and assume control over the direction of their treatment (Ford & Urban, 1963; Reevy, 2010).

**Stages of Change.** The stages of change model, introduced by Prochaska and DiClemente (1982), assists practitioners in identifying the stages a client in treatment will go through during the change process. The five stages a client in the change process will experience are *precontemplation*, *contemplation*, *preparation*, *action* and *maintenance*. In the *precontemplation* stage clients have little intention to make any changes in their life (Prochaska & DiClemente, 1982). Clients who are in the *contemplation* stage acknowledge that the problem exists but have not made a commitment to change (Prochaska & DiClemente, 1982). The *preparation* and *action* stages involve clients preparing to and actively working towards a change (Prochaska & DiClemente, 1982). Finally, in the *maintenance* stage, clients are working to maintain the change that they had made (Prochaska & DiClemente, 1982).

In recent years, the addition of another stage of change, *relapse*, was added in order to prepare clients and practitioners for the possibility of a relapse into the old, harmful behaviors (Prochaska & Norcross, 2001). *Relapse* is thought to be an expected part of the change process and by preparing for this ahead of time, clients can have a plan in place for when *relapse* does occur. If and when *relapse* occurs, practitioners guide clients back to the *maintenance* stage (Prochaska & Norcross, 2001).

The stages of change serve as indicators of where clients are in their change process. By identifying where the clients are in the change process, the practitioner is able to tailor treatment to where the client is and in turn further engage the client in the treatment process (Hiller, Knight Leukefeld & Simpson, 2002). Engagement in the

therapeutic process correlates directly to treatment retention as well as positive treatment outcomes (Hiller, Knight, Leukefeld & Simpson, 2002; Simpson & Joe, 2004).

**Stages of Group Development.** Much like the stages of change, the stages of group development serve as indicators for the progression of clients through the group therapy process. By using the stages of group development, the is able to identify at which stage their client group is operating and subsequently tailor interventions to meet the clients on their level (Behroozi, 1992; Rooney, 2009). Kurland and Salmon (1998) identified the stages of the group process as pre-group planning and preparation stage, the beginning stage, the work phase and the ending phase. Together, these stages identify the natural progression of a group. The pre-group planning and beginning stages of group work include activities such as setting rules and establishing norms within the groups (Kurland & Slamon, 1998). Next the group stages move into the work phase where the members apply themselves to achieve the primary goals of the group (Kurland & Salmon, 1998). Finally, the group process ends with a stage that includes termination not only with the therapist but also between any group members (Kurland & Salmon, 1998).

**Relational Approaches.** Similar to the involvement of family members and significant others in treatment, a relational and cultural approach between the client and the therapist also acts as an aid to engagement (Duffey & Somody, 2011; Jordan, 1995). Relational cultural theory is grounded in the work of Jean Baker Miller and her colleagues at the Stone Center at Wellesley College (Duffey & Somody, 2011). The primary therapeutic concepts of relational cultural theory indicate that as people develop and grow, the connections and relationships that are formed become the foundation of development (Jordan, 1995). This is in stark contrast to the westernized notion of the

“separate self” which identifies the person as an individual and connecting with peers through relationships isn’t necessary (Jordan, 1996).

The relational cultural model focuses on the concept of “we” rather than “I” (Jordan, 1996). A primary focus on relationships lends itself to working with women specifically because women view their world through the lens of relationships with others (Jordan, 2001; Gilligan, 1995). In terms of working with women in therapeutic relationships, the relational cultural theory emphasizes working with women on their terms, rather than “assimilating women’s voices to the existing theoretical framework” of the separate self (Gilligan, 1995, pp. 120).

Engagement through the relational cultural framework then consists of establishing mutual empathy between the therapist and the client (Jordan, 1996; Duffey & Somody, 2011, Jordan, 2001). Mutual empathy involves the therapist developing empathy for where clients are in their lives and also empathy for the whole person including clients’ social and emotional world (Jordan, 1996). Through mutual empathy and the development of the therapeutic relationship, a client can become engaged in his or her treatment (Jordan, 1996; Duffey & Somody, 2011).

### **Challenges to the Engagement Process**

Challenges to the process of engagement can stem from sources such as clients’ resistance and the pressures that coerce clients into treatment (De Jong & Berg, 2001; Yachmenoff, 2005; Ritchie, 1986). For example, Friedlander et al. (2006) outlined challenges working with groups such as adolescents, families with multiple stresses, and men such as challenges that are similar to those when working with people who are pressured and coerced into treatment.

*Resistance* and *reluctance* are two concepts seen as major challenges client engagement in treatment. As defined by Ritchie (1986) *reluctance* is associated with clients preferring to not be around a therapist or talk about their lives with a therapist. *Resistance* on the other hand is described as hostility towards change (Ritchie, 1986). *Reluctance* and *resistance* are highly associated with treatment non-compliance and non-completion (Smallbone, Crissman & Rayment-McHugh, 2009). *Reluctance* and *resistance* are common concepts when speaking about populations who are coerced into treatment (Clark, 1997; Sia et al., 2000). A study done by Chovanec (2012) focused on the engagement of men in domestic abuse programs and found that a large number of the men were not engaged from the beginning, having come to treatment only because of the fear of spending time in jail or other consequences. They did, however become more engaged as treatment progressed.

Yachmenoff (2005) also described the dimension of *mistrust* in the engagement process. This dimension was described specifically with engagement of coerced, mandated or involuntary clients and reflects clients' lack of trust regarding the treatment provided by the therapist (Oetzel & Scherer, 2003). *Mistrust* stems from clients who have faced consequences at the hands of any authority figures (Oetzel & Scherer, 2003). Clients who experience the dimension of *mistrust* demonstrated the presence of a persistent negative feeling about the agency (Yachmenoff, 2005).

### **Involuntary Status Clients**

Involuntary clients come to treatment or therapy because they face either legal consequences (mandatory) or personal consequences (nonvoluntary) if they choose not to attend (Regehr & Antle, 1997; Rooney, 2009). Facing either legal or personal

consequences for noncompliance with treatment creates an atmosphere of coercion, and an initial framework for understanding motivation (Rooney, 2009). Engagement typically does not come easily to clients who are coerced into treatment (Regehr & Antle, 1997; Rooney, 2009).

Rooney (2009) proposed definitions of involuntary clients that distinguish variations based on the source of motivation. Involuntary clients include both *legally mandated* clients as well as *nonvoluntary* clients. “Legally mandated clients must work with a helping practitioner as a result of a current or impending legal mandate or court order” (Rooney, 2009, p 5). Examples of *legally mandated* clients include clients with sexual offenses, clients charged with assault or clients who are involved in domestic violence. *Nonvoluntary* clients on the other hand, “have contact with helping professionals through nonlegal pressure from formal or informal sources” (Rooney, 2009, p 5). Nonvoluntary clients feel pressure from a significant other, workplace, family member or other source to seek treatment. People in both of these categories are included in the umbrella term, “involuntary.”

Other practitioners have characterized involuntary clients as “resistant,” “unmotivated” (Trotter, 2006; Behroozi, 1992). However, Rooney’s (2009) framework for defining involuntary clients distinguishes the primary source of their involuntary status and sets the stage for understanding the context for engagement in treatment. These sources are also discussed as their initial motivation for treatment (Rooney, 2009).

Involuntary clients are served in a variety of social work settings. These social work settings include but are not limited to: programs that provide services for offenders in corrections, chemical dependency programs, parents involved in child protective

services or clients involved in intensive case management (Clark, 1997; Yachmenoff, 2005; Thornton et al, 2003; Buck & Alexander, 2006). Social workers in these settings can include probation officers who work with clients on supervised release, child protection workers attempting to reunite a family or social workers providing outpatient treatment to sex offenders (Trotter, 2006; Rooney, 2009; Behroozi, 1992; Buck & Alexander, 2006; Pope & Kang, 2011). Whether it is a corrections setting or substance abuse treatment where a client is pressured by family to seek help, they all serve the involuntary client population (Rooney, 2006; Thornton et al., 2003).

### **The Engagement Process with Involuntary Status Clients**

Recent literature has focused on and identified strategies to aid in the engagement of involuntary clients. These strategies are grounded in a shift from a focus on the *resistance* among involuntary clients, (Ritchie, 1986) to a paradigm that addresses involuntary clients as a unique population that requires unique strategies and perspectives (Chovanec, 2008; De Jong & Berg, 2001; Rooney, 2009). *Resistance* and *reluctance* are viewed as being normal for both voluntary clients and involuntary clients during the engagement process (De Jong & Berg, 2001). Using the paradigm in which involuntary clients are viewed as a unique population, new pathways have been suggested for developing and fostering strong engagement with involuntary clients (Clark, 1997; Braucht, 2009; Buck & Alexander, 2006).

Cingolani (1984) noted that “the helping process with involuntary clients most frequently breaks down at the very beginning- at the stage of engagement” (p. 442). Engagement can be improved by utilizing multiple methods such as motivational interviewing, a strengths perspective and the group process combined with an



understanding of the stages of change (Chovanec, 2009; Boardman, Catley, Grove, Little & Ahluwalia, 2006). Motivational interviewing improves engagement through a client-centered approach that assists in motivation (Boardman et al., 2006).

### **Aids to the Engagement Process with Involuntary Clients**

The engagement process with involuntary and nonvoluntary clients is often viewed as a challenging process for practitioners, because these clients are often viewed as “resistant” or “unmotivated” (Trotter, 2006; Behroozi, 1992). Strategies were identified in the literature as being aids in the engagement process with involuntary clients. These aids for engagement with involuntary clients include a client-centered approach, Motivational Interviewing, stages of change, stages of group development and relational approaches.

**Client Centered Approach.** The strengths-based and client centered perspective is important in working with involuntary clients because this population is typically disenfranchised and oppressed (Rooney, G., 2009; Rooney, 2009). A strengths-based approach includes viewing the treatment process through a client-centered approach, where the client is the nucleus of the whole treatment process (Ford & Urban, 1963). Strengths-based practice focuses on healthy choices and behaviors and identifying clients’ particular strengths to aid in engagement in treatment (Clark, 1997). Behaviors and strengths such as this serve as protective factors for clients and assist in fostering cooperation, responsivity and engagement (Clark, 1997; De Jong & Berg, 2001; Braucht, 2009).

**Motivational Interviewing, Stages of Change and Group Development.** Using motivational interviewing strategies with involuntary clients can assist in the process of

overcoming resistance and unwillingness to make changes (Ritchie, 1986; Boardman et al., 2006). By facilitating “movement through the stages of change” involuntary clients and practitioners work in collaboration to set goals and discuss reasons for making a change (Kistenmacher & Weiss, 2008, p. 559). By highlighting the clients’ strengths, and highlighting their power to make arguments for their own change, clients take control of their treatment process (Kistenmacher & Weiss, 2008). Because clients actively take control of their treatment process and participate in their treatment, they are more likely to become engaged (Kistenmacher & Weiss, 2008; Yachmenoff, 2005). The stages of change and stages of group process begin with clients being unaware of the need for change and the purpose of the group. Both of these processes end with clients deciding to make a change with the support of group members (Chovanec, 2009; Prochaska & Norcross, 2001; Kurland & Salmon, 1998).

Chovanec (2009) created a framework that synthesized the stages and motivation for change with the stages of group development. These two frameworks align with specific characteristics and tasks in each section of development (Prochaska & Norcross, 2001; Kurland & Salmon, 1998). Chovanec noted ways that engagement takes place in the precontemplation, contemplation and preparation stages of change (Prochaska & Norcross, 2001; Kurland & Salmon, 1998; Chovanec, 2009).

The pre-group planning and beginning stages of group development align with the precontemplation, contemplation and preparation stages of change (Prochaska & Norcross, 2001; Kurland & Salmon, 1998; Chovanec, 2009). Most involuntary clients enter treatment in the precontemplation stage (Oetzel & Scherer, 2003). During the pre-group planning stage of group development there is an orientation to and forming of the

group where negotiable and non-negotiable aspects of the program are decided. (Kurland & Salmon, 1998; Chovanec 2009). During this time of precontemplation and pre-group planning, resistance should be anticipated and the roles of the therapist and group should be clarified (Chovanec, 2009). Important tasks for the therapist working with clients in precontemplation were identified as the ability to demonstrate support for non-threatening issues, use of inclusive group practices, provide information on potential group problems and continue to clarify roles, choices and non-negotiable aspects of the group.

The next stage of change for clients is the contemplation stage during which the clients are aware that there is a problem and begin to entertain thoughts of change (Prochaska & Norcross, 2001). A need for change is perceived during the contemplation stage, however there is no immediate plan for action or commitment from the client to make a change (Prochaska & Norcross, 2001; Sia, Dansereau & Czuchry, 2000). Contemplation takes place during the middle stage of the group process, which is characterized by the development of a clear focus and creating norms of the group (Kurland & Salmon, 1998; Chovanec, 2009).

The last stage of change that could be considered part of the engagement process is preparation. During the preparation stage of change clients are beginning to make small steps towards their bigger change (Sia et al., 2000). Problematic behaviors are reduced and clients are, in a sense, preparing to make a major life change (Prochaska & Norcross, 2001). This stage of change takes place while the group is still in the middle phase of development. The therapist and other group members provide support to each other in

planning and preparing for change, often role-playing the change among group members (Chovanec, 2009).

Utilizing the group format of therapy for involuntary clients helps to reduce the denial of a problem and increase the acceptance of the problem (Behroozi, 1992; Chovanec, 2009; Prochaska et. al., 1994). Involuntary groups are purposefully created to serve clients with similar treatment needs in order to create a greater accountability for the entire group (Thomas & Caplan, 1999). For example, men involved in domestic violence will be involved with other men who are involved in domestic violence to both challenge and support each other (Chovanec, 2012).

**Relational Approaches.** Relational approaches with involuntary status clients work primarily with involuntary women due to their tendency to gravitate towards the meaningfulness and importance of relationships (Jordan, 1995; Duffey & Somody, 2011). From the beginning, women seek out relationships with others so the work that needs to be done in therapy, is best done in the context of the relationship between the therapist and the client (Jordan, 2001; Gilligan, 1995; Simpson & Joe, 2004). “Core components of early engagement include participation and the forging of therapeutic relationships in the initial weeks following treatment entry” (Simpson & Joe, 2004, pp. 90). Because a relational framework consists of establishing mutual empathy, one of the primary tasks of a practitioner utilizing a relational approach is to develop empathy for the client regardless of their involuntary status (Jordan, 1996; Duffey & Somody, 2011; Jordan 2001).

The therapeutic process, viewed through the framework of relational cultural theory, focuses on resolving past relationships and forming healing connections, by

reconnecting (Jordan, 2001). By forming healing connections through mutual empathy clients are able to “explore and make meaning of the connections and disconnections” in their life (Jordan, 2001, pp 97; Jordan, 1996).

Women, who are in therapy or treatment as involuntary clients have significant disconnections in the relationships in their lives (Gilligan, 1995). Thus, using a therapy model that focuses on exploring, understanding and healing, women are engaged through receiving therapy that is grounded their worldview (Jordan, 1995). Through fostering positive relationships, a relational cultural perspective assists clients in moving away from isolation and finding meaning in their interactions, facilitating a healing environment (Duffey & Somody, 2011).

Social workers often work in settings with involuntary clients and clients who may have been coerced into seeking treatment. Regardless of the involuntary or voluntary status of clients that social workers serve, engagement is key to the therapeutic process. The purpose of this study was to explore the engagement process with involuntary clients by interviewing practitioners who currently work with or have previously worked with involuntary clients in treatment settings.

### **Conceptual Framework**

This research project was grounded in the frameworks of engagement theory and relational theory. Engagement theory describes the part of the therapeutic process in which clients become actively involved in their treatment or therapy and begin to view treatment as being meaningful (Friedlander et al., 2006; Tetley et al., 2011). The framework of engagement theory is focused on factors that aid in determining whether or not clients are engaged or have the potential to be engaged in treatment. These include

whether they are open to receiving help, their individual readiness for change and whether or not clients take an active participatory role in their treatment (Tetley et al., 2011; Hiller et al., 2002). When clients engage in their treatment they are able to identify benefits that they receive from treatment.

A relational framework views the whole treatment process from the lens of the relationship that forms between the therapist and client (Gilligan, 1995). A strong therapeutic relationship has been considered a potential indicator of positive treatment outcomes (Jordan, 1997).

The frameworks of engagement theory and relational theory guided the development of interview questions and were used to inform the discussion of the results. Interview questions were developed using an engagement framework (Chovanec, 2011) and relational aspects of the engagement process (Gilligan, 1995; Jordan, 1997). Questions inquired about the context of the work with involuntary clients, the strategies used to encourage engagement, how these strategies were helpful and how social workers identified clients' engagement (Chovanec, 2011; Chovanec, 2009; Yatchmenoff, 2005).

Additional questions were based on other aspects of engagement such as the primary motivations for clients to seek treatment. A relational approach was used when forming the question regarding the social workers' perceptions of clients' readiness for change and the behaviors that clients demonstrate when they become engaged (Tetley et al., 2011; Hiller et al., 2002; Simpson & Joe, 2004). The primary and latent themes identified in the interviews were compared to the findings identified by Chovanec (2011, 2009), Yatchmenoff (2005), Hiller et al. (2002), Simpson and Joe (2004) and Tetley et al. (2011).

## **Methods**

### **Research Design**

The purpose of this study was to obtain information from social workers about their perspectives on the process of engagement with involuntary clients. This information was gathered through interviews with participants identified through a snowball sample beginning with key informants who were social workers with experience in the engagement process with involuntary clients. Following Rooney's (2009) definition of involuntary clients, interviews took place with practitioners who work with mandated, or court ordered clients as well as non-voluntary clients, who may experience informal pressure to seek treatment. Information was collected through a single data collection strategy framed by the theory of engagement.

### **Sample**

The sample included five licensed social workers all of whom either currently work with or have worked with involuntary clients in the past. These contacts were made through a non-probability, purposive snowball sample, beginning with two key informants. The key informants for this study were a clinical supervisor with an LICSW and a research project committee member with an LICSW. Key informants distributed a flyer designed by the researcher to invite participants to the study (Appendix A). Social workers who were interested in participating in the study contacted the researcher directly through the contact information provided on the invitation flyer.

### **Protection of Human Subjects**

A research committee and the Saint Catherine University Institutional Review Board (IRB) reviewed this project prior to data collection to ensure the protection of

human subjects. The sampling process began with the key informants distributing the flyer (Appendix A) to coworkers, employees and other social workers they knew who met the criteria of working with involuntary clients. Included in the flyer was the researcher's contact information, interested participants contacted the researcher to clarify any questions and set up an interview time.

At the interview, the researcher administered the consent form (Appendix B). The consent form ensured the informed consent of all participants by providing a clear description of the research project, risks and benefits for participating, a description of the procedures and measures, an explanation of how to contact the researcher, and a description of confidentiality. The researcher then clarified that the participant understood the consent process by asking three questions to assure understanding of the purpose of the study and interview (Appendix C). The three questions that were asked to assure understanding were: "How would you describe the purpose of this study;" "What will I be asking you to do as a part of this study" and "What happens if you decide to withdraw from this study." Then the consent form was signed and the interview (Appendix C) began.

The interviews that took place were audio recorded using a locked personal recording device that was in possession of the researcher. The researcher completed both the transcription and coding of the interviews. Once non-identifying transcriptions were made, the original recordings of the interviews were destroyed. The consent form and the transcripts were kept in separate locked file cabinets in the researcher's home office to ensure confidentiality. All documents including but not limited to transcriptions and consent forms were destroyed April 30, 2013.



## **Data Collection**

The interviews were structured following the questions provided in Appendix C and allowed for follow up questions for further clarification. Interview questions were created by the researcher and grounded in the literature and engagement theory. The first few questions focused on the social worker's level of license and the settings in which the social worker interacted with involuntary clients followed by discussions of engagement techniques used. The latter questions were modeled after questions that were asked in a study by Chovanec (2011). The interviews ended with an open-ended opportunity for any additional information the social worker wanted to offer about the engagement process with involuntary clients.

Data was collected through digital recordings and took place in January and February 2013. The digital recorder was a program installed on the researcher's locked and password protected iPhone. The researcher used no outside transcribing resources and transcribed the interviews verbatim omitting names.

## **Data Analysis**

The data analysis consisted of a content analysis of the interviews as described by Berg (2009). By conducting a content analysis the researcher was able to assign codes to the content in the interview. These codes directly addressed the research question and were formulated using an interpretive approach (Berg, 2009). The interpretive approach allowed the researcher to view both what was said in the interview as well as any observational data collected during the interview as text to be considered. To create this text the researcher transcribed the interviews into a word document and collected all field notes regarding observations. The researcher also used summative content analysis; the

words that were used during the interview were a part of the codes along with latent themes that became apparent in analysis. The apparent themes were recorded and direct quotes from participants are presented in italics.

### **Strengths and Limitations**

A strength of this study is its exploratory and qualitative nature. Conducting a qualitative study consisting of interviews provided the opportunity for social workers to describe their own experiences with the engagement process in their own words. Because the researcher conducted face-to-face interviews, none of the questions had the possibility of going unanswered, as in a written survey. There was also consistency in the transcription process because the researcher completed the transcriptions herself. One identified limitation of this study stems from the small sample size; more participants would provide wider applicability. Also, in conducting face-to-face interviews, there was a potential for interview bias from either party that could impact the process or the results.

### **Findings**

This study sought to explore the engagement process with involuntary clients as discussed by the social workers who work with them. This section begins with a brief description of the participants in this study. Following this description, the primary themes identified from interviews with the participants are reviewed. Participants identified the theoretical frameworks they use, the strategies used to encourage engagement, their clients' key motivating factors, and indicators of their clients' engagement.

## **Description of Participants**

Recruitment efforts by the researcher resulted in a total of five interviews for this study: four women and one man. All participants were social workers who had either a Licensed Graduate Social Worker (LGSW) (n = 2) or Licensed Independent Clinical Social Worker (LICSW) (n = 3) level of licensure. The length of time that the participants who held their LGSW have been in practice was less than a year (5-7 months). In contrast, the length of time that participants who had their LICSW were in practice ranged from 10 to 27 years.

There was a variety of settings in which the participants worked, populations they worked with and types of therapy they provided. Settings included a day treatment facility (n = 1), in home therapy (n = 1), county probation (n = 1), and family crisis and support centers (n = 2). The populations that the participants worked with were all considered involuntary, including adults, children, families and couples. Two participants identified work with both groups and individual clients; one participant worked only with groups; one participant worked only with individuals and one participant worked only with families.

## **Identified Theoretical Frameworks**

All of the participants identified theoretical frameworks that they use in their work with involuntary clients. Because participants were able to list more than one theoretical framework that they use, more than five theoretical frameworks were identified. The most frequently identified theoretical frameworks included a relational and cultural approach (n = 5), Carl Roger's (1963) work with "Client-Centered" and strengths based approach (n = 3) and a Cognitive Behavioral Therapy approach (n = 3).

Other theoretical frameworks that were identified by participants include: Systems Theory (n = 1), Dialectical Behavioral Therapy (n = 2), the Developmental Model (n = 1). One participant identified *draw[ing] a lot from [Ronald] Rooney's stuff on group work with involuntary clients.*

### **Relational and Cultural Approach**

All participants identified utilizing relational and cultural approaches to guide their work with involuntary clients. One participant, with 28 years of experience in social work, had this to say: *I think to me the most important thing is being able to like your clients. If you can't like your clients you're not going to be able to work with them. You need to make it clear that you are there to work with them. You're not going to judge them, but you're there to help them reach their goals.*

The ability to have empathy for and identify with the client and the client's situation was identified as important. One therapist stated, *I guess I try to put myself in their shoes [considering] how hard it is to get up and come to treatment everyday.* Another participant stated that it is important to be able to *see the client as a person and that they are capable of change.* One social worker who had fifteen years experience in juvenile probation, echoed similar feelings. This participant stated, *I think you need to demonstrate that you're human; it's not you doing something to them... It's about developing a partnership and sharing... I think that's what makes the difference, having that relationship [with the client].*

Two participants identified using relational aspects in work with involuntary clients. These consist of ways in which their clients relationally refer to them and their treatment settings as an indicator of engagement. One participant who worked in the

juvenile justice system stated that *I think sometimes kids don't necessarily tell you that they like you but they might say something [positive about you] to someone else and it gets back to you.* Another participant identified the way in which clients refer to the treatment setting as part of peer socialization: *A lot of them say they don't want to be here... then will say to a new person "You're really going to like it here."*

### **Client Centered and Strengths-Based Work**

Three participants identified using a client centered and strengths-based approach when working with involuntary clients. Two of the three participants who identified this framework highlighted the importance of this approach. One participant discussed strengths-based by saying *I think underneath it all it's a person centered and strengths based approach.* Another participant identified the client-focused approach as being related to *the Rogers approach really about engaging the clients in the work you're doing.*

### **Cognitive Behavioral Therapy**

Three participants in this study identified an approach containing elements of Cognitive Behavioral Therapy in their work with involuntary clients. One participant stated *I work with cognitive behavioral theory... and try to incorporate CBT techniques.* Another participant stated in reference to all of her clinical practice *I am pretty much a cognitive behaviorist, so that's one of the primary approaches I work with.* A participant who works with a lot of groups stated that she uses structured frameworks such as *CBT based and CBT skill-based approaches.*

### **Other Theoretical Frameworks**

Other theoretical frameworks that were identified by less than three participants include Dialectal Behavioral Therapy (DBT) (n = 2), Systems Theory (n = 2), the Developmental Model (n = 1), and Ronald Rooney's approach to working with involuntary clients (n = 1). Two participants identified use of DBT approaches and Systems Theory approaches when working with involuntary clients. Participants stated *I recently began running a DBT skills group and I previously assisted in running a Dialectal Behavior Therapy group*. One participant noted that she worked with family systems and identified systems theory. Another participant stated that she was *a big believer in systems theory and systems work*.

One participant identified the Developmental Model and one participant identified Ronald Rooney's approach. The participant who identified working with the Developmental Model in relation to working with her juvenile clients stated that *developmental work and being able to at least look at where they are in terms of their development process and meeting them where they're at* is important to the engagement process. The other participant stated that he *took Ron Rooney's class about involuntary clients and his approach with them* and so he tried to *incorporate his approach* [into his work].

While discussing theoretical frameworks, one theme that was identified by the more experienced three of the five participants was the universality of the participant's approaches across all client groups. This included working with both involuntary and voluntary clients and also how they work with those clients whether they are working with individuals, groups, couples or families. One participant stated, *I think I would*

*engage involuntary clients and voluntary clients with the same approach; I wouldn't differentiate [between clients]. Echoing the same theme, another participant stated *I think I am pretty much who I am in my work, regardless of the client status.* A third participant stated that with group work she uses *really the same [engagement] strategies as with individual clients, just on a larger scale.**

### **Strategies to Encourage Engagement**

All five participants for this study identified strategies that they use to encourage engagement with their involuntary clients. Strategies most frequently identified by participants were incorporating the techniques of Motivational Interviewing and giving the client a sense of control over their therapy and treatment process.

#### **Motivational Interviewing**

The techniques involved in Motivational Interviewing were identified by all five of the participants as essential in engaging involuntary clients. One participant stated that *motivational interviewing techniques and motivational congruence* assisted in his work with involuntary clients. Another participant identified finding *a lot of motivational interviewing techniques* to be *helpful* [with engagement].

One specific motivational interviewing technique identified by all five of the participants, was using “change talk” with their clients. One participant did this by having them *look at the choices they have to carry out the court order and the potential outcomes of those choices.* Another participant used the motivational interviewing technique of change talk by doing *a temperature check about whether [the client] thinks that there is more work to do and setting new short term goals.*

### **Client Control**

The concept of giving clients control over their treatment was identified by four of the five participants in the study. One participant stated that *creating rules with the group so it feels like it's their group. [We also] try to create choice and control by having votes about things like how to organize the week and what food to have for celebrations.* Two participants stated that they engage the client in treatment through goal setting. One participant collaborates with the client when *setting short-term and long-term treatment goals.* Another participant described this collaboration by having the clients be responsible for *initiating what goals they have for treatment.* Finally, a participant who works in outpatient day treatment identified that *stating that these aren't our goals they're your goals and your responsibility and your choice* enables the clients to take control over their treatment.

### **Motivating Factors**

Each of the five participants identified some motivating factors for their clients. The main motivating factor identified by the participants was their clients' desire to accomplish their goals. Two distinct but very similar client goals were identified in this study. The first goal involved clients' desire to resolve their legal problems; the second goal was the desire to reunite with their loved ones and family.

One participant stated that the key motivating factor for her clients was *to resolve their legal issues whether that is getting probation off of their back or getting their kids back.* She went on to say that her clients involved in in-home therapy were *forced to stay somewhat involved to an extent* because of legal pressure. Another participant identified key motivating factor to be *getting the county off of their back and to taking control of*



*their life and their family.* Finally, one participant stated that the primary motivating factor for her client was *to reach their goals whether that is getting that is getting off of probation or getting their kids back.*

### **Identifying Engagement**

All of the participants in this study cited ways in which they identify that their clients are engaged in the treatment process. These indicators included the client showing up for appointments, completing homework between appointments, being awake and participating in their treatment, and showing a retention and application of concepts discussed in treatment. The most basic indicator of engagement in treatment identified by participants was the client showing up for appointments. One participant stated *just showing up to treatment is one step of engagement.*

Demonstrating a retention and application of treatment concepts between appointments was identified as a strong indicator of a client's engagement in treatment. One participant stated that she looks for an *integration of the material between sessions* to measure a client's engagement. Another participant stated that when her clients are *doing homework between appointments* they are likely to be engaged. Finally, one participant noticed a client's engagement when the client *is awake and paying attention, able to put time into their work and able to assist peers in their work.*

### **Discussion**

The purpose of this study was to explore the engagement process with involuntary clients by interviewing practitioners who currently work with or have previously worked with involuntary clients in treatment settings. This section will review how this study's findings compared to the literature regarding the theoretical frameworks used in work

with involuntary clients, strategies used by social workers to encourage engagement with clients, client motivating factors and identification of engagement with involuntary clients. Implications for practice, policy and future research will also be discussed.

### **Theoretical Frameworks**

All five participants in this study identified the theoretical frameworks and perspectives that they use when working with involuntary clients, some of the frameworks listed by participants were not identified in the literature. The theoretical frameworks that were identified were strengths-based, systems theory, CBT, DBT and Rooney's approach for working with involuntary clients. These findings are congruent with previous findings that suggest these theoretical perspectives will aid in clients engagement in work with involuntary clients (Chovanec, 2008; De Jong & Berg, 2001; Rooney, 2009; Clark 1997).

### **Strategies to Encourage Engagement**

All participants in the study discussed strategies they used to encourage engagement with involuntary clients both in individual and group treatment. The three most frequently identified strategies used by social workers in this study to encourage engagement with involuntary clients were relational strategies, motivational interviewing techniques, and a client-centered and client-controlled treatment. These strategies are comparable to the literature review findings that suggest relational strategies (Jordan, 1995; Gilligan, 1995), motivational interviewing techniques (Boardman, et al., 2006; Kistenmacher & Weiss, 2008), and client control (De Jong & Berg, 2001; Yachmenoff, 2009) contribute significantly to the engagement of a client.

### **Motivating Factors**

The motivating factors for involuntary clients to enter treatment were similar to those that were identified by the literature. All five of the participants identified that their involuntary clients' primary motivating factors are to achieve the goals of completing probation/parole and/or family restoration. Similarly, the previous literature identifies primary motivations for involuntary clients as legal pressure or coercive pressure from family members, friends and significant others (Regehr & Antle, 1997; Rooney, 2009; Trotter, 2006).

### **Identifying Engagement**

The ability to identify engagement was not a topic that was extensively covered in the literature review but carries importance when working with involuntary clients (Trotter, 2006; Behroozi, 1992; Yachmenoff, 2005). Rooney (2009) noted that if you are able to identify if/when involuntary or mandated clients are engaged you can try to recreate that experience to continue to encourage engagement. The majority of the participants identified simply showing up to treatment as a sign of engagement. Four of the participants also noted that when their clients demonstrate integration of material between sessions, they were likely to be engaged.

### **Implications for Practice**

This section will discuss implications for social work practice, addressing how social workers can work to engage their involuntary clients in practice and treatment. First, simply being human and finding ways to connect with the clients whether or not they are involuntary was identified as being important in encouraging the engagement process. Other implications for practice derived from this study include using strategies

to engage clients that support their own goals and motivation, encouraging the clients' sense of control, using theoretical frameworks to guide work, monitoring engagement through attendance, participation and encouragement of others.

Theoretical frameworks that were identified as being helpful in encouraging the engagement process include a relational and cultural approach, client centered and strengths-based work and cognitive behavioral therapy. These approaches place the emphasis of treatment on who the client is as a person. They also focus on working with the client and meeting the client where they are at, instead of having the client conform to the treatment.

Strategies that were identified by social workers as being helpful to encourage engagement with clients include incorporation of theoretically grounded perspectives such as motivational interviewing techniques and giving the client a sense of control over their treatment. Motivational interviewing techniques, which include facilitating clients through the stages of change, have been previously used with chemical dependency populations.

These techniques were also identified by the participants in this study as being helpful for working with involuntary clients as a way to assist the client in achieving a form of control in their treatment. By giving clients control, the participants reported that their clients are able to direct their treatment. One important finding of note was that as the level of experience and time spent in practice increased, so did the feeling of mastery in work with involuntary clients. Clinical social workers, as well as other mental health professionals can use the information from this study to better understand the importance of the engagement process and be intentional about their work with involuntary clients.

**Implications for Policy and Education**

Many involuntary clients are offenders and/or unable to advocate for themselves on a macro policy level. The responsibility for this advocacy falls on the mental health practitioners, social workers and other professionals who work with involuntary clients. Future implications for policy based on the findings from this study should be focused on providing education to all practitioners that introduces who involuntary clients are and how to work with them. At one point or another, most mental health practitioners, social workers and other professionals will work with a client labeled involuntary. For both social work and non-social work practitioners, being prepared in advance for involuntary clients would allow them to work more effectively with clients in this status.

**Implications for Research**

As it stands, limited research exists about the engagement process in general and in particular with involuntary clients. There has been a lack of research that allows social workers to express, in their own words, what works for their involuntary clients. This study demonstrates that practitioners are able to articulate their experiences with the factors of engagement. Further research on engagement should be incorporated into program evaluation designs related to effective service provision with involuntary clients.

## References

- Behroozi, C. S. (1992). A model for social work with involuntary applicants in groups. *Social Work with Groups, 15*(2-3), 223-238.
- Berg, B. L. (2009). *Qualitative research methods for the social sciences*. Boston, MA: Allyn and Bacon, 7<sup>th</sup> ed., (ISBN 0-205-62807-9).
- Boardman, T., Catley, D., Grobe, J. E., Little, T. D. & Ahluwalia, J. S. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment, 31*, 329-339.
- Bolton-Oetzel, K. & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 40*(3), 215-225.
- Braucht, G. (2009). The fundamental 'what works' principle: Responsivity. *Corrections Today, 7*(2), 108-109.
- Buck, P. W. & Alexander, L. B. (2006). Neglected voices: Consumers with Serious mental illness speak about intensive case management. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), 470-481.
- Chovanec, M. (2009). Facilitating change in group work with abusive men: Examining stages of change. *Social Work with Groups, 32*, 125-142.
- Chovanec, M. (2009). Work with Men in Domestic Abuse Treatment. In R. Rooney (Ed), *Strategies for work with involuntary clients*. New York: Columbia University Press.
- Chovanec, M. (2008). Innovations applied to the classroom for involuntary groups: Implications for social work education. *Journal of Teaching in Social Work, 28*, 209-225.
- Chovanec, M. (2012). Examining engagement of men in a domestic abuse program from three perspectives: An exploratory multimethod study. *Social Work with Groups, 35*, 362-378.
- Clark, M. D. (1997). Strength-based practice: The new paradigm. *Corrections Today, 59*(2), 200-202.
- Cingolani, J. (1984). Social conflict perspective on working with involuntary clients. *Social Work, 29*(5), 442-446.

- De Jong, P. & Berg, I. K. (2001). Co-constructing cooperation with mandated clients. *Social Work, 46*(4), 361-374.
- Duffy, T. & Somody, C. (2011). The role of relational-cultural theory in mental health counseling. *Journal of Mental Health Counseling, 33*(3), 223-242.
- Ford, D. H., & Urban, H. B. (1963). The "Client Centered" Psychotherapy of Carl Rogers. In *Systems of psychotherapy: A Comparative Study* (pp 396-444). Hoboken, NJ: John Wiley & Sons Inc.
- Friedlander, M. L., Escudero, V. & Heatherington, L. (2006). Engagement in the therapeutic process. In Friedlander, M. L., Escudero, V. & Heatherington, L. (Eds.), *Therapeutic alliances in couple and family therapy: An empirically informed guide to practice* (pp. 71-86). Washington, DC, US: American Psychological Association.
- Gilligan, C. (1995). Hearing the difference: Theorizing connection. *Hypatia, 10*(2), 120-127.
- Hiller, M. L., Knight, K., Leukefeld, C. & Simpson, D. D. (2002). Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment. *Criminal Justice and Behavior, 29*(1), 56-75.
- Jordan, J. (1995). A relational approach to psychotherapy. *Women and Therapy, 16*(4), 51-61.
- Jordan, J. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Meninger Clinic, 65*(1), 92-103.
- Jordan, J. (1996). Relational therapy in a non-relational world. *Work in Progress, 79*, 1-8.
- Kistenmacher, B. A. & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized control trial. *Violence and Victims, 23*(5), 558-570.
- Kurland, R. & Salmon, R. (1998). *Teaching a Methods Course in Social Work with Groups*. Alexandria, VA: Council on Social Work Education.
- Magill, M., Mastroleo, N. R., Apodaca, T. R., Barnett, N. P., Colby, S. M. & Monti, P. M. (2010). Motivational interviewing with significant other participation: Assessing therapeutic alliance and patient satisfaction and engagement. *Journal of Substance Abuse Treatment, 39*, 391-398.
- Pope, N. D. & Kang, B. (2011). Social work students' attitudes about working with involuntary clients. *Journal of Teaching in Social Work, 31*, 442-456.

- Prochaska, J. O., DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 276-288.
- Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., Fore, C., Harlow, L. L., Redding, C. A., Rosenblom, D., Rossi, S. R. (1994). Stages of change and decisional balance for 12 problem behaviors. *Health Psychology*, 13(1), 39-46.
- Prochaska, J. O. & Norcross, J. C. (2001). Stages of Change. *Psychotherapy*, 38(4), 443-448.
- Ritchie, M. H. (1986). Counseling the involuntary client. *Journal of Counseling and Development*, 64, 516-518.
- Reevy, G. M. (2010). Client Centered Therapy. In *Encyclopedia of Emotion*. (pp. 158-160). Santa Barbara, CA: Greenwood Press.
- Regehr, C. & Antle, B. (1997). Coercive influences: Informed consent in court-mandated social work practice. *Social Work*, 42(3), 300-306.
- Rooney, G. D. (2009). Oppression and Involuntary Status. In R. Rooney (Ed), *Strategies for work with involuntary clients*. New York: Columbia University Press.
- Rooney, R. H. (2009). *Strategies for work with involuntary clients*. New York: Columbia University Press.
- Sia, T. L., Dansereau, D. F. & Czuchry, M. L. (2000). Treatment readiness training and probationers' evaluation of substance abuse treatment in a criminal justice setting. *Journal of Substance Abuse Treatment*, 19, 459-467.
- Simpson, D. D. & Joe, G. W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, 27, 89-97.
- Smallbone, S., Crissman, B. & Rayment-McHugh, S. (2009). Improving therapeutic engagement with adolescent sexual offenders. *Behavioral Sciences and the Law*, 27, 862-877.
- Tetley, A., Jinks, M., Hubans, N. & Howells, K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment. *Journal of Clinical Psychology*, 67(9), 927-941.
- Thomas, H. & Caplan, T. (1999). Spinning the group process wheel: Effective facilitation techniques for motivating involuntary client groups. *Social Work with Groups*, 21(4), 3-21.



- Thornton, C. C., Patkar, A. A., Murray, H. W., Mannelli, P., Gottheil, E., Vergare, M. J. & Weinstein, S. P. (2003). High- and low- structure treatments for substance dependence: Role of learned helplessness. *The American Journal of Drug and Alcohol Abuse*, 29(3), 567-584.
- Trotter, C. (2006). *Working with involuntary clients: A guide to practice*. Crows Nest, Australia: Allen & Unwin Pty Ltd.
- Welsh, W. N. & McGrain, P. N. (2008). Predictors of therapeutic engagement in prison-based drug treatment. *Drug and Alcohol Dependence*, 96, 271-280.
- Werner-Wilson, R. J., Michaels, M. J., Gellhaus-Thomas, S. & Thiesen, A. M. (2003). Influence of therapist behaviors on therapeutic alliance. *Contemporary Family Therapy*, 25(4), 381-390.
- Yatchmenoff, D. K. (2005). Measuring client engagement from the client 's perspective in nonvoluntary child protective services. *Research on Social Work Practice*, 15(2), 84-96.

## Appendix A



THE ENGAGEMENT PROCESS WITH INVOLUNTARY CLIENTS

## Are you a social worker?

**Do you have experience working with involuntary clients?**

If so, I invite you to participate in my Masters of Social Work Graduate Research Project at the School of Social Work, St. Catherine University/University of St. Thomas

The purpose of this study is to explore the engagement process with involuntary clients by interviewing social workers who work with these clients in treatment settings.

Your perspective is important to inform future social workers about how the therapeutic process works with involuntary clients.

**Please call or email if you have questions or wish to participate!**

**Courtney Jacobsen**

## Appendix B

### THE ENGAGEMENT PROCESS WITH INVOLUNTARY CLIENTS INFORMATION AND CONSENT FORM

**Introduction:**

You are invited to participate in a research study investigating the engagement process with involuntary clients. This study is being conducted by Courtney Jacobsen, a graduate student at the St. Catherine University/University of St. Thomas School of Social Work under the supervision of Dr. Carol Kuechler, a faculty member at the school. You were selected as a possible participant in this research because you have experience working with the voluntary and involuntary client populations and responded to an invitation flyer. Please read this form and ask questions before you agree to be in the study.

**Background Information:**

One of the primary goals of treatment is to establish engagement with clients. Engagement is defined as the process through which the client begins to actively participate in their treatment and is the stage of the therapeutic relationships that assists in having positive treatment outcomes. Based on the literature and practice experience it is well documented that engagement for involuntary clients is often a different and more difficult process than engagement with voluntary clients due to the coercion of the legal system or significant others. The purpose of this study is to explore the engagement process by interviewing practitioners who currently work with or have previously worked with involuntary clients in treatment settings in order to further understand the engagement process with involuntary clients.

**Procedures:**

If you decide to participate, you will be asked to participate in an audio taped interview conducted by the researcher. Interview questions will include questions regarding the ways in which you see engagement in your clients, what you do in your practice that assists in the engagement process, the settings in which you have worked with involuntary clients and where new clients coming to treatment are in the change process. This interview will take 1 session lasting approximately 30 to 45 minutes and eight to ten social workers are expected to participate in this study.

**Risks and Benefits of being in the study:**

There are no known risks or direct benefits to you for participating in this research study.

**Confidentiality:**

Any information obtained in connection with this study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable. Transcriptions will not include any names or individually identifying information.

I will keep the consent forms and anonymous transcriptions in separate locked file cabinets in my home office and only my advisor and I will have access to the records while I work on this project. I will destroy all original reports and identifying information that can be linked back to you by June 1, 2013. I will be the only one that will have access to the audio recordings made and they will be destroyed immediately after the transcription is made.

**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations St. Catherine University or University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Courtney Jacobsen. You may ask questions now, or if you have any additional questions later, my faculty advisor, Dr. Carol Kuechler (651) 690- 6719 (cfkuechler@stkate.edu), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

---

I consent to participate in the study and I agree to be audio taped.

---

Signature of Participant

Date

---

Signature of Researcher

Date

## Appendix C

### Interview Questions

*The first few questions are to assure participant understanding of the study.*

How would you describe the purpose of this study?

What will I be asking you to do as part of this study?

What happens if you decide to withdraw from this study?

*The next few questions are about your practice as a social worker.*

What level of social work license do you hold?

How long have you had your social work license?

Where have you worked with involuntary clients?

*The next few questions are related to the ways you work with involuntary clients.*

Do you currently work with involuntary clients?

*If you do not currently work with involuntary clients, when answering these questions refer to the most recent time you worked with involuntary clients.*

In your work with involuntary clients what theoretical approaches to you use to guide your work?

What is the nature of your work with involuntary clients? (for example, individual intervention, groups, etc)

*Individual Interventions:*

What strategies do you use to encourage engagement?

How can you tell when client is engaged in the individual intervention process?

*Group Setting:*

What strategies do you use in a group setting to encourage engagement?

How can you tell when a client is engaged in the group setting intervention process?

What do you see as the key motivating factors for clients to stay involved in the intervention process?

How do you observe change in your clients over the course of the intervention process?

Is there anything else that you would like to add about the engagement process with involuntary clients?