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The Relationships between Perceived Therapeutic Alliance, Therapist Self-Disclosure, and Dropout Expectancy among Male Substance Abuse Treatment Participants

Harriett Elizabeth Reeh
Walden University

Walden University

COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCES

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Harriett Reeh

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Review Committee
Dr. Rodney Ford, Committee Chairperson, Psychology Faculty
Dr. C. Tom Diebold, Committee Member, Psychology Faculty
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David Clinefelter, Ph.D.

Walden University
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Abstract

There are contrasting views from Freudian, humanistic, and feminist theorists regarding whether therapist self-disclosure (TSD) affects the relationship between the therapeutic alliance (TA) and dropout of substance abuse treatment by males. However, there is a paucity of research regarding these topics yet therapists need clear empirical support for the use of TSD in enhancing the TA such that dropout can be averted. This study investigated whether or not TSD moderated the relationship between perceived TA and dropout expectancy. The research participants were 132 men attending residential substance abuse treatment. Four groups of men were randomly assigned to 1 of 4 experimental conditions. One of 2 statements was read to the participants that described the TA as weak or strong. After reading 1 of these statements, participants watched 1 of 2 DVDs (7 minutes each). The DVDs depicted 2 males role-playing an intake session. One DVD included TSD and the TSD was edited out of the other DVD. After watching the DVD, participants responded to the question of whether or not they would continue treatment with the depicted therapist. Results from hierarchical logistic regression indicated that weak TA was a good predictor of dropout expectancy. TSD did not significantly affect research participants' opinions regarding whether or not they would continue treatment with the depicted therapist. Therefore, results from the present study do not support views that TSD should be used or avoided. This study can contribute to positive social change by reinforcing an important process (building a strong therapeutic alliance) that contributes to treatment completion. People who complete substance abuse treatment are more likely to manage or abstain from their addictions and to become fully functioning and positively contributing members of society than those that dropout.

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ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Dedication

This dissertation is dedicated to the staff and the anonymous research participants at the residential substance abuse treatment centers who were involved in this study. Without you, this project would not have been possible.

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I am very grateful to a number of people who made this dissertation possible. First, I'd like to thank my chair, Dr. Ford. I became inspired to research the topic of therapist self-disclosure (TSD) after seeing his presentation during a Walden residency. Although his knowledge of the topic was truly impressive, it was his passion for TSD that inspired me to pursue the topic too. I had several conversations with Dr. Ford, especially at the beginning of this whole process. Each time the conversation ended, I walked away with that fresh sense of inspiration I had after the first time I heard him speak about TSD.

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I also appreciated Dr. Ragsdale's timely guidance. He offered suggestions that other committee members and I did not think of, thus enriching the overall quality of this dissertation and inspiring me to think in ways I had not before.

I thank the staff and the research participants who allowed me to conduct my research in their facilities. I appreciated their time, enthusiasm, and support. I appreciated that they felt that this project was worthwhile and important enough to involve themselves.

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My husband deserves special mention also because of the things he did to make this degree and this dissertation possible. He spent many hours editing for me when I needed a pair of fresh eyes. His contribution in this way was invaluable. He also spent weeks memorizing his lines for the stimulus DVD that I used for this project. On the night we filmed the DVD, he had no problems saying the lines and making it look natural. Also during the past five years, many times he went grocery shopping by himself and did my half of the household chores without complaint so that I had enough time to complete my homework.

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I thank all my previous work supervisors since September of 2005 for the allowances made to make this degree and this dissertation possible. I want to express my gratitude to one of my work supervisors in particular, Dr. Mawson. She was a wonderful cheerleader for getting my dissertation done by exaggerating my strengths and denying my weaknesses. As can be seen, it takes a whole village of supporters to write a dissertation.

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Chapter 1: Introduction to the Dissertation

Introduction to the Study

People who drop out of substance abuse treatment often continue to suffer from substance abuse disorders (Troller, Csiernik, & Didham, 2006). Left untreated, people with chronic and severe substance abuse disorders are at risk for becoming jobless and homeless (Stein, Dixon, & Nyamthi, 2008). They are also at risk for developing more severe disorders such as Korsakoff's syndrome, which is a form of severe amnesia (Brocate et al., 2003). Long-term abuse of drugs and alcohol can lead to significant and lasting brain chemistry and brain function changes (McLellan, Lewis, O'Brien, & Kleber, 2000). Some people who drop out of treatment programs, who were previously criminally entrenched, continue to engage in criminal activities in order to financially sustain their addictions (Huebner & Cobbina, 2007). As a result, innocent members of society suffer in monetary and in other ways. Therefore, it is important to determine which factors affect treatment dropout in order to prevent further suffering within both the addict population and society in general.

Background of the Study

Dropout from substance abuse treatment centers varies from around 13% (Daughters et al., 2008) to 69% (Siqueland et al., 2002) with an average of approximately 55% (Sayre et al., 2002). Therefore, up to 69% of people with severe addiction problems who attempted treatment will most likely continue to suffer the effects of long-term alcohol and/or drug abuse (Siqueland et al., 2002). Clearly, research is needed to determine which client and therapist factors affect dropout.

Client Variables

Literature on client variables that affect dropout from substance abuse treatment is mixed. Some researchers found that younger clients are more likely to drop out of treatment than older clients (Saarnio & Knuutila, 2003; Siqueland et al., 2002) whereas other researchers found that client age made no significant difference (Daughters et al., 2008; King & Canada, 2004). King and Canada (2004) found that people with greater pretreatment severity of substance abuse were more likely to drop out whereas other researchers (Meier et al., 2006; Sayre et al., 2002; Siqueland et al., 2002) did not find that pretreatment severity affected dropout.

One client factor that has some consensus in the substance abuse dropout literature is the effect of Antisocial Personality Disorder (ASPD) when examined with other variables. Daughters et al. (2008) found that males with ASPD who voluntarily took treatment were more likely to drop out than those who were court-mandated with or without ASPD. Other researchers have also found that ASPD was a predictor of dropout (Meier & Barrowclough 2009; Siqueland et al., 2002). However, when demographic factors (e.g., race, employment, age, and education) were entered into Siqueland et al.'s (2002) regression model, presence of ASPD became nonsignificant.

Another client factor that appears to have some consensus in the substance abuse dropout literature is legal coercion. Legal coercion refers to mandatory attendance to substance abuse treatment imposed by the court or imposed as a term of conditional release (e.g., parole or statutory release). Clients who were court-mandated to attend

substance abuse treatment dropped out at rates significantly lower than clients attending treatment voluntarily (Daughters et al., 2008; Perron & Bright, 2008).

A general consensus can also be found in the substance abuse dropout literature concerning a client factor that does not appear to affect dropout. Most researchers agree that previous attempts to complete substance abuse treatment is not a significant predictor of dropout (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Daughters et al., 2008; Meier et al., 2006; Pulford et al., 2006).

Therapist Variables

Little is known about the related therapist variables that affect client dropout from substance abuse treatment. Two therapist variables that have been found to affect dropout were staff-client conflict (Ball et al., 2006) and clients' perceptions of their therapists as being controlling and as having poor ability to convey empathy (McKellar et al., 2006).

One specific therapist variable that several researchers have examined (regarding its effect on dropout from substance abuse treatment) is therapeutic alliance. Therapeutic alliance refers to the quality and strength of the therapist-client relationship (Horvath, 2001). Meier et al. (2005) concluded in their literature review that the majority of researchers found that a strong early therapeutic alliance was a consistent predictor of retention. Other researchers studying dropout from mental health treatment (Horvath, 2001; Johansson & Eklund, 2006; Saatsi, Hardy, & Cahill, 2007) also found that people who dropped out of therapy rated the therapeutic alliance lower than people who completed therapy. Horvath (2001) reported that two groups of researchers (Florsheim et al., 2000; Joyce & Piper, 1998) found that a high initial therapeutic alliance was related to

dropout. Horvath speculated that the clients who dropped out in these studies may have had unrealistic expectations.

Another specific therapist variable that has not been examined regarding treatment dropout is therapist self-disclosure (TSD), which refers to the sharing of personal information by a therapist (Hill & Knox, 2002). Literature in the general area of TSD was mixed in that many researchers (e.g., Barrett & Berman, 2001; Hanson, 2005; Myers, 2004; Thomasen, 2005) found that TSD promoted client change. Some researchers (Unis & Lunnen, 2008) thought TSD had little impact and others suggested that it could be harmful under certain circumstances (Knox, Hess, Petersen, & Hill, 2002; Peterson, 2002; Wandschneider, 2007).

Research results may be mixed partly because previous researchers have not precisely defined and measured TSD. For example, little is known regarding which types of TSD affect clients. For instance, telling clients how their behavior affects the therapist versus revealing personal information may affect clients differently.

In addition, little is known regarding the level of TSD that could be harmful or beneficial (e.g., superficial, moderate, and very personal). Also, there is little research available regarding which quantities and in which stages of therapy that TSD may be helpful or harmful. Furthermore, there is no available research that specifically addresses whether TSD moderates relationships with other variables, such as the therapeutic alliance or attachment for example, to affect dropout.

Moreover, there were no available studies to date that specifically addressed whether people who dropped out of substance abuse treatment and experienced TSD

differed from those who completed treatment and experienced TSD with regard to how they rated the therapeutic alliance. The few studies that addressed TSD and the therapeutic alliance have produced mixed results. Most researchers (e.g., Audet, 2004; Bedi, Davis, & Arvay, 2005; Burkard, Knox, Groen, & Perez, 2006; Hanson, 2004, 2005) found that TSD enhanced the therapeutic alliance. One pair of researchers found that TSD and the therapeutic alliance were not related (Kelly & Rodriguez, 2007). Myers (2004) found an interaction between TSD and the therapeutic alliance. When Myers's research participants rated a session in which a mock therapist disclosed personal information in the context of a weak alliance, they rated the therapist less favorably. The converse also occurred: When the therapist disclosed personal information with a client in which there was a strong alliance depicted, clients rated the therapist more favorably (Myers, 2004).

There was no research to date that specifically addressed whether or not addictions therapists' disclosures that they struggled with addiction affected their clients' decisions to drop out of treatment. On the one hand, clients may believe that therapists who experienced addiction were better able to understand them and were better able to convey empathy. Therefore, clients may be more likely to complete treatment with such a therapist because they may belief that the treatment provider understands them and can provide effective therapy. On the other hand, clients may believe that a therapist who has experienced addiction is less able to help them because clients may believe that these counselors have issues of their own to resolve. In this case, clients may be more likely to drop out of therapy with this type of therapist.

One of the factors that potentially affect how TSD is received by the client is therapeutic alliance (Bedi et al., 2005; Burkhard et al., 2006). Based on results from Klein and Friedlander's (1987) study, it could be hypothesized that if a therapist discloses very personal and negative information to a client, and the therapist and client have established a strong therapeutic alliance, TSD may enhance the probability that the client will complete treatment because this disclosure may enhance the bond. Conversely, it could also be hypothesized (from Klein & Friedlander's results) that if a therapist disclosed something personal and negative to a client with whom the therapist has a weak therapeutic alliance it may raise the probability that the client discontinues treatment because they may feel uncomfortable with the therapist or the client may generate misperceptions about the therapist's competence or mental health. There is no available research to date that specifically supports or contends these possibilities. Given the lack of research in some specific areas and the inconsistencies in other areas, the current study examined whether or not a specific TSD (that a therapist struggled with addiction and that he sought treatment) moderated the relationship between the therapeutic alliance and dropout expectancy from residential substance abuse treatment.

A moderator variable changes the strength and/or direction of a relationship (Baron & Kenny, 1986). It is reasonable to believe that if a therapist disclosed personal and negative information to a client that this disclosure could strengthen, weaken, or change the direction of the relationship between the therapeutic alliance and dropout based on Klein and Friedlander's (1987) results.

Alternatively, mediator variables are those that account for the relationship between the predictor and criterion variables (Baron & Kenny, 1986). Once a mediator variable is removed, the relationship between the predictor and criterion variable is no longer significant (Baron & Kenny, 1986). It is not believed that TSD could have a strong influence on the relationship between therapeutic alliance and dropout such that if a counselor did not disclose personal information, the client would be more likely to drop out. Therefore, possible mediating effects of TSD on the relationship between therapeutic alliance and dropout were not examined in this study.

Statement of the Problem

Substance abuse treatment providers need more information regarding how to prevent treatment dropout. One factor that has received some attention is the therapeutic alliance. Only a few researchers have found that the therapeutic alliance can affect dropout from substance abuse treatment (Barber et al., 2001; Meier et al., 2005, 2006). However, the therapeutic alliance has often been cited as a significant therapist factor in other positive treatment outcomes (Horvath, 2000, 2001, 2006). There is no available research to date that specifically addresses the possibility that TSD might moderate the relationship between the therapeutic alliance and treatment dropout (of any type of treatment). Therefore, more research is needed to clarify this issue.

More specifically, it could be that if therapists disclose very personal negative information to clients with whom they have not yet established strong therapeutic bonds, this TSD may lower the probability that clients drop out of treatment. Conversely, if a therapist discloses very personal negative information to a client with whom the therapist

has not established a strong bond, the probability that the client may drop out of therapy may be raised. However, little is known regarding whether or not TSD moderates the relationship between the therapeutic alliance and dropout from substance abuse treatment. As there is no research currently available that directly answers this question, treatment providers are left to speculate as to whether or not TSD influences the relationship between therapeutic alliance and dropout. This insufficient amount of empirical evidence on TSD, its potential influence on the therapeutic alliance, and its possible effect on dropout creates a problem for substance abuse treatment providers. Substance abuse treatment providers need to know how to enhance treatment so that they can provide optimal conditions for their clients, thus raising the probability that clients remain in treatment. Retaining clients in therapy also raises the probability that clients learn to manage their addictions more effectively.

Research Question and Hypotheses

The following research question was examined in this study:

RQ1: Does TSD moderate the relationship between perceived therapeutic alliance and dropout expectancy?

The research question was tested using the following null and alternative hypotheses, which emerged from relevant research. These hypotheses were analyzed using hierarchical logistic regression:

$H_0$1: TSD will not moderate the relationship between perceived therapeutic alliance and dropout expectancy.

$H_1$1: TSD will moderate the relationship between perceived therapeutic alliance and dropout expectancy.

Chapter 3 will include a description of how this research question and these hypotheses will be examined.

Purpose of the Study

Given this paucity of empirical evidence regarding the use of TSD on the relationship between the therapeutic alliance and treatment dropout, the purpose of the present study was to provide clarity for directors and counselors of residential substance abuse treatment facilities by providing empirical evidence for these issues. More specifically, this study was an examination of whether or not a therapist's disclosure that he struggled with alcohol addiction and that he sought treatment moderated the relationship between the perceived therapeutic alliance and dropout expectancy. Therefore, the moderator variable was TSD (personal TSD versus no TSD), the predictor variable was perceived therapeutic alliance (weak versus strong) and the outcome variable was dropout expectancy.

Rationale and Theoretical Basis for the Study

The purpose of this study was to examine whether or not TSD moderated the relationship between the perceived therapeutic alliance and dropout expectancy. The following subsections will present a brief theoretical background of TSD and the therapeutic alliance.

Therapist Self-Disclosure

TSD is a counseling skill that can be used by therapists from various counseling orientations. Theorists of various counseling orientations have offered some direction regarding whether TSD should or should not be used. For example, Freud originally suggested that TSD should not be used because therapists should attempt to be a blank screen onto which clients should project their own needs and meanings (Freud, 1910, 1959).

In contrast to Freud, Carl Rogers (1980) suggested that therapists' disclosure of their immediate feelings and reactions to their clients, delivered in a genuine way, promoted client change. This disclosure helped clients to become aware of dysfunctional relationship patterns that they used repeatedly without awareness (Rogers, 1980).

TSD can also be used in cognitive-behavioral therapy (CBT) to model effective ways of coping, to reduce clients' fears, and to normalize symptoms (Goldfried, Burckell, & Eubanks-Carter, 2003). The main aim of CBT is to discover and dispute maladaptive thoughts or thought patterns that can lead to distress and dysfunctional behaviors (Beck, Rush, Shaw, & Emery, 1979; Ellis & Grieger, 1977). In treating addictions, CBT can be used to address thinking errors that surround clients' assumptions regarding the benefits of alcohol and the woes of withdrawal (e.g., that the client cannot stand the withdrawal process; Ellis & Grieger, 1977).

Feminist therapists aspire to form egalitarian relationships with their clients (Simi & Mahalik, 1997). These therapists use TSD with the intention of lowering the power differential between client and therapist (Simi & Mahalik, 1997). Simi and Mahalik

(1997) suggest that TSD makes the therapist seem less idealized and more human. From this perspective, feminist therapists who disclose that they have struggled with addiction would likely lower the power differential with clients who have addiction problems.

Therapeutic Alliance

Theorists of various counseling orientations have also hypothesized about the importance of the therapeutic alliance. For example, Bordin (1979) theorized about a *working alliance* as a pantheoretical concept that had grown from psychodynamic roots. Bordin posited that the working alliance was important in all therapeutic relationships. Bordin described the working alliance as composed of three factors: goals, tasks, and bond. The goals were the objectives that the client and therapist set as their purpose of the therapy (Bordin, 1979). The tasks were defined as the activities needed to attain the goals (Bordin, 1979). The bond was the rapport and collaboration that occurred between client and therapist (Bordin, 1979).

Hatcher and Barends (2006) suggested that a strong therapeutic alliance occurred when a therapist and a client engaged in a collaborative and purposive endeavor. In order for therapy to be collaborative, therapists and clients need to trust each other and develop an attachment (or a bond; Hatcher & Barends, 2006). They also need to concur regarding the purpose of their union (e.g., what the goals are and how they will achieve them; Hatcher & Barends, 2006). Hatcher and Barends suggested that the therapeutic alliance and the therapeutic relationship were not the same thing. They stated that the therapeutic relationship reflects, embodies, and assists the purposive and collaborative work of therapy. Hatcher and Barends also suggested that the therapeutic alliance could not occur

without the use of therapy techniques because therapists used techniques to achieve the purposes of therapy. Techniques were used to engage clients in purposive work.

Hatcher and Barends (2006) theorized that there was an optimal level of this bond that would enhance therapeutic outcome. They (Hatcher & Barends, 2006) hypothesized that a bond could be too close in that such a bond could inhibit clients' disagreement with their therapists; thus thwarting possible improvement through lack of exploration.

Operational Definitions

Addiction: For the purposes of this study, addiction will refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision *(DSM-IV-TR,* APA, 2000) definition of substance abuse and/or substance dependence.

Dropout Expectancy is operationally defined as the research participants' answer to a question regarding whether or not they would continue treatment with a therapist that was depicted in a DVD shown to them as part of this study.

Perceived Therapeutic Alliance: I described either a weak or a strong therapeutic alliance to the research participants before watching a DVD of a role-play of an intake interview. Therefore, participants formed a perception of the therapeutic alliance based on the descriptions I provided them.

Therapeutic Alliance: is defined as the relationship that forms between a client and a therapist based on the strength and quality of the bond formed between them and the ability they have to collaborate such that they can achieve therapeutic goals (Horvath, 2001).

Therapist and counselor: refer to a person who delivers substance abuse treatment. He or she has at least a diploma in substance abuse counseling.

Therapist Self-Disclosure (TSD): is defined as therapists' verbal disclosures of personal information (Hill & Knox, 2001). For the purposes of this study, only one TSD was examined: a therapist's disclosure that he previously struggled with alcohol addiction and that he sought treatment.

Assumptions

The assumptions of this study were as follows:

1. The research participants will pay attention throughout the DVD presentation.
2. The research participants will report their demographic information accurately.
3. The research participants will answer the questionnaire accurately and honestly.

Limitations

This study was limited to men attending 90-day residential treatment near the West Coast of British Columbia, Canada. Therefore, cultural factors may limit the generalization of these results to other regions and countries. Furthermore, people attending residential substance abuse facilities may have unique characteristics that may limit the generalization of findings to other therapy populations.

Significance of the Study

The social change implication of this research is that change may ensue if there is empirical evidence for the utility of substance abuse therapists' disclosures that they have struggled with addiction. If there is evidence or if there is no evidence that disclosing this information affects treatment dropout, then treatment providers can act accordingly.

Consequently, dropout rates may be reduced because treatment providers may be better equipped to create optimal conditions that raise the probability that their clients will complete treatment. If clients with addictions complete substance abuse treatment they are more likely to learn to manage their addictions rather than continuing to suffer (Troller et al., 2006).

In addition, if a better understanding of TSD, the therapeutic alliance, and treatment dropout can be achieved, this information can be shared in treatment settings and counselor training courses. This information would thus contribute to better-educated counselors who would be better prepared to create conditions that prevent treatment dropout.

Summary of the Introduction

This chapter introduced the present study, which examined whether or not a therapist's disclosure that he struggled with alcohol addiction and sought treatment moderated the relationship between the perceived therapeutic alliance and treatment dropout expectancy. As there is no research currently available that directly answers this question, treatment providers are left to speculate whether TSD in the context of a weak or strong alliance will affect dropout. Treatment providers need to know this information to enable them to provide optimal conditions that will promote treatment retention.

The scarce amount of research on TSD and the therapeutic alliance is mixed although most researchers (Audet, 2004; Bedi et al., 2005; Burkard et al., 2006; Hanson, 2004, 2005) found that the use of TSD enhanced the therapeutic alliance. An interaction between TSD and the therapeutic alliance has also been found. When the alliance was

weak, research participants who experienced very personal TSD rated the therapist less favorably (Myers, 2004). When the alliance was strong, the participants (who also experienced very personal TSD) rated the therapist more favorably (Myers, 2004). However, there are possible confounds in this study which are discussed in chapter 2.

The following chapter will explore the literature regarding what is known, what is contradictory, and what remains to be explored regarding TSD, the therapeutic alliance, and dropout. This exploration will demonstrate the need for research on the complex relationship between the therapeutic relationship and dropout and how TSD may moderate this relationship. Specific research questions and how this study was executed are described in chapter 3.

Chapter 2: Review of the Literature

Introduction

At present, there is little known regarding TSD and how it might influence the relationship between the therapeutic alliance and treatment dropout. TSD may enhance the therapeutic alliance (Audet 2004; Bedi et al., 2005; Burkard et al., 2006; Hanson, 2004; Keijsers, Schaap, & Hoogduin, 2000). It is also possible that TSD may affect treatment dropout but there is little research currently available that specifically explores this possible connection. TSD could weaken the therapeutic alliance by compromising client-therapist boundaries (Audet, 2004) by moving the focus away from the client and onto the therapist and/or by burdening the client with the therapist's personal issues (Goldstein, 1997). These effects could possibly weaken the therapeutic alliance and perhaps promote treatment dropout. However, there is no empirical evidence to date for this potential connection either. Whether beneficial or not, TSD is one of the few specific events that clients remember long after therapy (Hanson, 2005).

It is therefore important to develop a good understanding of TSD, therapeutic alliance, and treatment dropout so that ultimately, conditions for substance abuse treatment can be enhanced to promote treatment completion and thereby increasing the likelihood that clients will learn to manage their addictions. The present study sought to clarify these issues by exploring whether TSD moderated the relationship between the perceived therapeutic alliance and substance abuse treatment dropout expectancy.

Organization of the Literature Review

Chapter 2 is a comprehensive review of the literature on TSD, therapeutic alliance, and treatment dropout. The first section reviews the TSD construct, including its definition, perceived benefits and detriments, and the available research. The second section is a literature review of the therapeutic alliance, including theoretical history, variables that may affect it, treatment outcomes associated with it, and therapeutic alliance processes. The third section is a review of the literature on the relationship between TSD and the therapeutic alliance. The fourth section initially addresses dropout from mental health treatment and then focuses more specifically on dropout from substance abuse treatment. The final section reviews the literature on the effect of the therapeutic alliance on treatment dropout.

Literature Search Strategy

To gain a better understanding of TSD, therapeutic alliance, and treatment dropout, a thorough search was conducted. The following databases were used: Academic Search Premier, Google Scholar, Proquest Articles and Dissertations, PsycARTICLES, PsycINFO, and Sage publications. Because there was little research conducted in the area of TSD, all available studies were reviewed and relevant ones are described below. Articles that were reviewed and not included were those that solely provided opinions without empirical support. In the areas of therapeutic alliance and treatment dropout, many studies were available and therefore only studies published since 2003 (5 years before the original literature search for this study began) were included with some exceptions. Exceptions included articles regarding theory, literature reviews,

and meta-analyses. These articles were included to demonstrate the historical background of the variables studied in the present research.

The list of search terms used to conduct the literature search included *therapist self-disclosure, self-disclosure, disclosure, therapeutic alliance, working alliance, drop out*, and *treatment termination.* Resources regarding power analysis, logistic regression, and moderator variables were also searched.

Therapist Self-Disclosure

TSD can be defined broadly as any personal information a client obtains from a therapist (Hill & Knox, 2001). Personal information about a therapist can be gained through verbal or nonverbal communication (Hill & Knox, 2001). For instance, therapists reveal much about themselves in direct and indirect ways. They reveal their values, theoretical positions, personal reactions, beliefs, and preferences through their facial expressions, choice of office art and décor, choice of clothing, sitting position, degrees/certificates displayed, questions asked and not asked, and information emphasized and ignored (Hill & Knox, 2001).

Watkins (1990) defined TSD as personal revelations that therapists share with their clients. Similarly, Hill and Knox (2002) defined TSD as therapist statements that reveal something personal about the therapist. Barrett and Berman (2001) extended Hill and Knox's definition by suggesting that TSD should be considered as the disclosure of personal information that one would not typically share with a stranger.

Hill and Knox (2002) suggested that immediacy statements should not be considered as TSD. Immediacy statements refer to a therapeutic technique in which

therapists explain to their clients how the clients' behaviors affects them (Goldfried, Burckell, & Eubanks-Carter, 2003). This therapeutic technique reveals little personal information about the therapist and therefore does not appear to be a form of TSD.

One type of TSD is disclosure of situations that are similar to the clients' experiences. Byrne (1961) advanced the similarity hypothesis that suggested that people are attracted to others who have similar beliefs. Perhaps Byrne's hypothesis could be extended to therapeutic relationships. It is possible that clients may like therapists who share similar beliefs and who have had similar experiences. Furthermore, it could be that using TSD to increase client-therapist similarity may enhance therapeutic alliance because clients might think that therapists who have had similar experiences can better understand them than therapists who have not had similar experiences.

Possible Benefits of TSD

It is speculated in the literature that TSD is potentially very beneficial (e.g., Goldfried et al., 2003; Hill & Knox, 2001). The most frequently endorsed reason for using TSD, in a survey of therapists of various orientations, was to increase client-therapist similarities and to model appropriate behaviors (Edwards & Murdock, 1994).

Some therapists use TSD to reveal client-therapist similarities in an attempt to facilitate client change. Goldfried et al. (2003) hypothesized that the use of similarity TSD may enhance clients' expectations and motivation to change by fostering a sense of hope for recovery. For example, therapists who disclose situations similar to those of the client, in which the therapist struggled and overcame an adverse behavior such as addiction, may raise clients' hope for recovery (e.g., if you can do it so can I). Similarly,

TSD can also be used to model effective ways of coping (Goldfried et al., 2003; Hill & Knox, 2001). For instance, if therapists who have struggled with addiction tell clients that they say to themselves "one day at a time," they are modeling effective coping (according to Alcoholics Anonymous).

Researchers have also suggested that TSD can be beneficial when used to normalize clients' feelings and experiences so that clients do not feel that they are "sick," "weird" or that they are the only ones struggling with a disorder (Wandschneider, 2007). Therapists might tell their depressed clients that they too have been depressed, therefore making depression seem less unusual. There is some comfort in knowing that there are others who suffer from the same psychological issues (Yalom, 1998).

Possible Detriments of TSD

TSD may make clients feel uncomfortable when used in new relationships where bonds are not yet established. For example, in one study, when male strangers told male listeners a very personal disclosure regarding intimate relationship difficulties, listeners had greater anxiety (as measured by greater heart rate increases, greater galvanic skin responses, and higher self-reported discomfort) than when they were told superficial information about a university class (Ashworth, Furman, Chaiken, & Derlega, 1976). Ashworth et al. (1976) hypothesized that the discomfort participants felt in this study after experiencing an inappropriate intimate disclosure could be similar to the discomfort a client may feel in a new therapeutic relationship if a therapist disclosed something very personal without an established bond.

There are other potentially harmful effects of TSD when considered with other factors. For example, therapists lacking firm personal boundaries may engage in "mental incontinence" rather than "responsible self-disclosure" (Kempler, 1987, p. 231). Mental incontinence can misdirect the therapy focus from the client onto the therapist (Kempler, 1987) thus possibly burdening distressed clients and wasting their session time.

Another possible detriment of TSD is that a client may misinterpret a therapist's intentions. A client may erroneously believe that the TSD is an example of how the therapist is more successful than the client (Wandschneider, 2007). This erroneous belief could lead a client to misinterpret that the therapist's discourse is an attempt to outdo the client (Wandschneider, 2007). Clients interviewed in Wandschneider's (2007) qualitative study reported that TSD was not helpful when the disclosure resulted in the clients feeling that their experiences were minimized.

Research on TSD

TSD has been researched using several different research methods, such as qualitative, analogue, and empirical studies. The following sections describe this research.

Qualitative Research

Although theoretical justifications for using TSD are appealing because they seem reasonable, most of these proposed benefits and detriments do not have much empirical support. The majority of articles written concerning TSD are based on clinical opinion, case studies, or qualitative studies. For example, based on nine participants' responses,

Audet (2004) found that TSD led clients to feel engaged, that clients felt that power was equalized, and that clients felt that their therapist had empathy for them.

Hanson (2005) conducted a qualitative study involving 18 people who reported 131 incidents of TSD and 26 incidents of non-TSD. She asked her research participants an open-ended question: "What has your therapy experience been like generally?" (Hanson, 2005, p. 97). Interviewees often spontaneously reported incidents of TSD or incidents in which the therapists did not disclose (non-TSD). Hanson found that TSD was twice as likely to be considered as helpful as not helpful. Clients reported that TSD was helpful in terms of: fostering alliance, feeling that the relationship was more egalitarian, modeling skills, enhancing insight or learning, validating decisions, normalizing clients' concerns, making transitions in therapy, establishing credibility, and comparing morals. Hanson also found that when therapists did not disclose, this nondisclosure was twice as likely to be rated as not helpful as was when the therapist did disclose.

It appears that results from the few qualitative studies available on TSD are congruent with theoretical predictions. Predictions such as TSD helps foster alliance (Audet, 2004; Hanson, 2005), makes the relationship more egalitarian (Audet, 2004; Hanson, 2005), makes the client feel more normal (Hanson, 2005), and is helpful in modeling new skills (Hanson, 2005) have been supported by qualitative studies.

Analogue Research

Potential effects of TSD have also been measured using analogue research. Although a commonly cited criticism of analogue research is that research participants (who are usually university students) may not respond to questionnaires the same way

actual clients might respond, Hendrick (1990) found otherwise. Hendrick compared therapy clients' ratings of what types of disclosures clients would prefer to university students' responses. She found no significant differences between these two groups. Hendrick noted that both clients and students wanted therapists to disclose about their feelings, relationships, professional issues (e.g., degree, experience, and theoretical approach), successes, and failures. Both clients and students had little interest in therapists' attitudes (e.g., religious beliefs and political views), health, movie, and book preferences, and sexual matters (e.g., attitudes toward sex, sexual orientation, and whether or not the therapist was sexually or physically abused).

In their review of the literature, Hill and Knox (2001) noted that the majority of the analogue studies reported that clients rated therapists positively when therapists disclosed moderately personal information. In general, research participants in these studies reported that TSD was helpful and that it facilitated greater involvement of their emotions (Hill & Knox, 2001).

Armour (2007) studied the effect of disclosing very personal information on therapist selection. Armour's research participants, who were introductory psychology students, selected a therapist from written descriptions. The manipulated variable was whether or not the therapists disclosed that they had previously engaged in personal therapy. Armour found that this information had no significant impact on whether or not the students would select this person for therapy. However, students were more likely to pick the therapist who completed therapy for more severe issues such as depression and anxiety than for less serious problems such as academic stress and relationship issues.

Friedlander and colleagues (e.g. Peca-Baker & Friedlander, 1989; Klein & Friedlander, 1987) conducted a series of analogue studies examining various aspects of TSD. Peca-Baker and Friedlander (1987) first asked a group of introductory psychology students to watch a seven minute DVD of a role-played therapy session. The students rated the self-disclosing counselor more favorably than the non-disclosing counselor.

Klein and Friedlander (1987) then questioned which aspects of TSD affected participants' opinions. Klein and Friedlander manipulated the relevance and the valence of the therapist's disclosure. They found that when the disclosure was relevant, clients perceived therapists who disclosed negative information as showing more regard than when the therapist disclosed positive relevant information. Thus, when therapists simply disclosed any information about themselves it did not affect clients' perceptions. Therefore, information has to be relevant and possibly negative in order to demonstrate the similarity between the client and therapist.

Peca-Baker and Friedlander (1989) later questioned whether people rated self-disclosing therapists more favorably because therapists revealed personal information or whether it was because the disclosure was similar to the client's experiences. They recruited university students to role-play a therapy session in which the mock client's presenting problem was dating anxiety. There were four conditions: (a) no self-disclosure, (b) a similarity disclosure (therapist said that she had dating anxiety too), (c) a cohort told the client before the session that the therapist had dating anxiety when she was in college, and (d) a dissimilar disclosure (therapist said she had a friend die when she was in college). In each disclosure condition, the opening words of the role-played

therapy session were the therapist's disclosure. Peca-Baker and Friedlander found that the four groups did not differ on their ratings of therapist attractiveness (as defined as warmth, friendliness, likeability, and sociability) and core facilitative conditions (defined as congruence, positive regard, and unconditional acceptance). Peca-Baker and Friedlander concluded that TSD was not as important as they originally thought.

There appears, however, to be several confounds in Peca-Baker and Friedlander's (1989) study. First, each of the four TSD conditions only had 15 participants. This small cell size may not have provided enough statistical power to find results that might otherwise have been significant. Second, the therapist disclosed at the beginning of the session before the client said anything. The timing of the TSD may have caused some discomfort for the client, as it may have been too much too soon (e.g., Ashworth et al., 1976). Third, the condition in which the cohort told the role-playing client that the therapist had dating anxiety was rather artificial and may have caused a negative first impression. The client may have wondered if there was something wrong with the therapist before meeting her that she had to be warned about her. Therefore, if this study was replicated after addressing these confounding influences, perhaps different results would be obtained.

Curtis (1982) found discordant results to many of the other studies on TSD. He asked therapy clients to read vignettes that described a therapist as using either personal, superficial, or no TSD. Clients rated the therapist on measures of empathy, competence, and trust. The personal TSD was, "I sometimes feel depressed" (p. 56). The superficial TSD was, "We all get depressed sometimes" (p. 56). The no TSD condition was, "It must

have made you depressed" (p. 56). Curtis found that the therapists who did not disclose anything were rated as more empathic, more competent, and more trustworthy than the therapists that disclosed personal or superficial information. Curtis attributed his discordant results to surveying actual therapy clients rather than university students. However, it appears that therapists telling clients that they sometimes felt depressed may have given the impression that they were not able to cope with depression. Therefore this impression might have contributed to the lower competency ratings.

Empirical Studies

There were only two studies (Barrett & Berman, 2001; Kelly & Rodriguez, 2007) available in which researchers either manipulated or observed the effect of different levels of TSD in actual therapy sessions. Barrett and Berman (2001) instructed one group of doctoral student therapists to provide TSD that was at an intimacy level similar to that of their clients. For instance, if a client disclosed relationship difficulties, the therapist was instructed to disclose similar experiences. The other group of doctoral students was instructed to not disclose any personal information. Instead, they were instructed to reflect requests for personal information back to the client. For example, they could explore the reasons why the client might want to know personal information about the therapist. Barrett and Berman found that clients whose therapists used TSD reported lower levels of symptom distress. They also found that clients liked the disclosing therapists more than those that did not disclose.

Kelly and Rodriguez (2007) surveyed psychiatric hospital patients. They found that TSD and symptom reduction were not related. They suggested that one particular

intervention, such as TSD, was not likely to cause measurable change in therapy outcome.

Therapeutic Alliance

Therapeutic alliance refers to the strength and quality of a collaborative client-therapist relationship (Horvath & Symonds, 1991). A strong alliance involves mutual feelings of trust, liking, and respect (Horvath & Symonds, 1991). It includes therapist-client agreement on the goals of therapy and the means by which clients achieve these treatment goals (Horvath & Luborsky, 1993). Thus, building a good therapeutic alliance is a conscious and purposeful endeavor (Horvath, 2006).

Building a strong alliance is also an important endeavor. Researchers over the last couple of decades have found a consistent and robust relationship between the strength of the therapeutic alliance and client change regardless of type of therapy or length of treatment (Catty 2004; DeRubeis, Brotman, & Gibbons, 2005; Horvath & Symonds, 1991; Horvath 2000, 2001, 2006). Therefore, understanding which factors affect the therapeutic alliance is important in order to facilitate client change.

Theoretical History

Roots of the therapeutic alliance can be traced back to Freud (1909, 1963) who postulated that patients formed positive transferences for their psychiatrists. Transference refers to clients' displacement of feelings applicable to other people onto others, especially their therapists (English & English, 1958). Freud theorized that these positive client transferences were based on feelings these clients had for people who had previously treated them with affection.

The actual term *therapeutic alliance* was first used by Zetzel in 1956, who much like Freud, considered it a positive form of transference that was a prerequisite for analysis (Catty, 2004). Greenson (1967) expanded upon Zetzel's concept and emphasized the importance of a collaborative effort between the therapist and the client in order to make therapeutic gains possible.

Although the term *working alliance* was first used to describe dynamic processes in psychoanalytic therapy, Catty (2004) noted that "In other models of therapy, however, it inevitably finds different incarnations" (p. 259). For example, Bordin (1979) suggested that the therapeutic alliance was a pantheoretical concept that did not exclusively apply to psychodynamic treatment but that it applied to all forms of psychotherapy. He described the therapeutic alliance as composed of three factors: goals, tasks, and bond (Bordin, 1979). The goals were the outcome expectations that the client and therapist set as their purpose of therapy, the tasks were defined as the activities needed to attain the goals, and the bond referred to the attachment, rapport, and collaboration that should occur between client and therapist (Bordin, 1979).

Client Variables that Affect the Therapeutic Alliance

A wide range of client factors can affect clients' ability to form good therapeutic alliances with their therapists. For example, in a literature review of client pretreatment expectations, Dew and Bickman (2005) found that regardless of symptom reduction, clients who had greater pretreatment expectations of improvement tended to form stronger therapeutic alliances than clients with lower expectations.

Clemence, Hilsenroth, Ackerman, Strassle, and Handler (2005) studied *confident collaboration*, which is another form of client pretreatment expectations. Confident collaboration is defined as a combination of two factors: the extent to which clients believe that therapy can help them and the extent to which clients are committed to engaging in therapy. Clemence et al. found that clients who perceived that they had a strong therapeutic alliance also perceived that they made greater therapeutic gains than clients who perceived that they had weak alliances with their therapists.

Other pretreatment client factors can also enhance the therapeutic alliance. One group of researchers found that clients who were more motivated, had better coping strategies, better social support, and had secure attachment styles developed stronger therapeutic alliances than those who were less motivated, had less effective coping strategies, less social support, and insecure attachment styles (Meier et al., 2005). Goldman and Anderson (2007) also found that secure attachment was related to the development of a strong early therapeutic alliance. However, the magnitude of this relationship between secure attachment and therapeutic alliance decreased over accruing sessions (Goldman & Anderson, 2007). It could be that clients who were able to trust, were comfortable with intimacy, and who could rely on others without fearing rejection, were more likely to form a strong therapeutic alliance in the first few sessions (Goldman & Anderson, 2007).

There are mixed results regarding whether male or female clients form stronger therapeutic alliances. Gibbons et al. (2003) found that female clients tended to rate the

therapeutic alliance as stronger than did male clients. However, other researchers (Hersoug et al., 2002) did not find a relationship between gender and alliance.

Other client factors can weaken the therapeutic alliance. For instance, clients with a hostile and dominant personality style, not surprisingly, formed weaker therapeutic alliances than clients with affiliative relationship patterns (Gibbons et al., 2003; Puschner, Bauer, Horowitz, & Kordy, 2005). Clients with external motivation formed weaker therapeutic alliances than people with internal motivation (Meier, 2005.) Clients in the precontemplation stage of change tended to rate the therapeutic alliance as weaker than clients in the other stages (Rochlen, Rude, & Baron, 2005). Clients who tended to self-criticize excessively tended to rate the therapeutic alliance as weaker than those who did not self-criticize as much (Whelton, Paulson, & Marusiak, 2007).

Berretta et al. (2005) studied client's core conflictual relationship themes and the extent to which these themes affected the therapeutic alliance during a four-session brief psychodynamic therapy. They (Beretta et al., 2005) found that clients who formed weak alliances tended to think of others as not helpful. These clients also tended to expect others to be untrustworthy and they expected others to do hurtful behaviors (Beretta et al., 2005). In addition, clients who formed weak alliances were likely to wish that they could accept others and to be close to others; however, their negative outlook of others conflicted with their desire to have close relationships (Beretta et al., 2005). This process tended to be reflected in their relationship with their therapists (Berretta et al., 2005).

Findings regarding the relationship between symptom distress and therapeutic alliance have been mixed. Meier, Donmall, Barrowclough, McElduff, and Heller (2005)

found that a higher number of psychological problems were related to weaker therapeutic alliances. Horvath (2001) found that problem severity and type of problem can weaken therapeutic alliance. However, Gibbons et al. (2003) found that pretreatment symptom distress did not predict the therapeutic alliance. Horvath (2001) found that it was more difficult for clients who have personality disorders, and especially for clients who have Borderline Personality Disorder, to develop strong therapeutic alliances than clients without personality disorders (Horvath, 2001).

Therapist Characteristics

Rogers (1957) was one of the first theorists to focus mostly on therapist variables that can affect the therapeutic relationship. Rogers theorized that clients would change if therapists were congruent, empathic, and if therapists provided unconditional positive regard. Rogers elaborated that the therapist had to be congruent, which he described as someone whose actual experience was the same as his awareness of himself. Rogers defined empathy as the therapist's ability to sense the client's understanding of his or her world as if it were the therapist's world without losing the ability to understand the client's world in an "as if" state. He referred to unconditional positive regard as a warm acceptance of all aspects of a client's experience (Rogers, 1957). It appears that Rogers implied that these conditions–unconditional positive regard, empathy, and congruence–were the therapist factors that were necessary and sufficient to form a good therapeutic relationship regardless of orientation. Indeed, Watson and Geller (2005) found that these Rogerian variables led to the development and maintenance of good therapeutic alliances regardless of type of therapy.

Other researchers have found congruent results. For example, in their literature review, Ackerman and Hilsenroth (2003) found that therapists' personal characteristics that were associated with the ability to form strong therapeutic alliances were flexibility, honesty, respectfulness, trustworthiness, confidence, warmth, openness, dependability, and responsiveness. Furthermore, therapists who conveyed trust, appreciation, warmth, and understanding were more likely to form strong therapeutic alliances and were more likely to see clients return for treatment than therapists who did not convey these factors (Hilsenroth & Cromer, 2007).

In addition to personal characteristics, the use of basic counseling skills such as facilitating, encouraging, and exploring emotions, as well as exploring and reflecting content, can positively affect the formation of the therapeutic alliance (Ackerman & Hilsenroth, 2003, 2005; Bedi et al., 2005). Sessions that involved both cognitive and emotional content, as opposed to sessions that focused on just one of these areas, were more likely to lead to strong therapeutic alliances (Hilsenroth & Cromer, 2007).

Other counseling skills such as reminding clients of past therapy successes, encouraging clients to initiate discussion about important issues, examining in-session interpersonal processes, and identifying defense mechanisms early in treatment were also found to enhance the therapeutic alliance (Ackerman, Hilsenroth, & Knowles, 2005). Other skills such as keeping an active focus on treatment, discussing progress, facilitating insight, and providing new knowledge about disorders have been positively related to stronger therapeutic alliances (Hilsenroth & Cromer, 2007). Ackerman and Hilsenroth (2005) also found that conducting longer and more in-depth sessions were related to

higher ratings of the therapeutic alliance. Therapist experience, which may be an underlying factor of many of the above variables, has also been found to be related to therapeutic alliance (Ackerman & Hilsenroth, 2003).

Results have been mixed regarding whether the therapist's attachment style is related to the therapeutic alliance. Black, Hardy, Turpin, and Parry (2005) found that therapists with a secure attachment style were more likely to report stronger therapeutic alliances than therapists with an insecure attachment. However, Ligiero and Gelso (2002) did not find a correlation between attachment and therapeutic alliance in a study of master's and doctoral level student-therapists. Sauer, Lopez, and Gormley (2003) found that therapists with an anxious attachment, which is a form of insecure attachment, formed good therapeutic alliances during the first session but that the therapeutic alliance weakened in subsequent sessions.

Similar to attachment style, Lowson and Brossart (2003) studied doctoral students' relationships with their parents and the extent to which these relationships affected the students' ability to develop therapeutic alliances with clients. Lowson and Brossart found that the therapists' relational pattern with their parents was a significant predictor of client ratings of the therapeutic alliance. Healthy patterns (such as intimacy and individuation) as well as less healthy (such as fusion and triangulation) patterns of therapists' relationships with their parents predicted clients' positive ratings of therapeutic alliance. In explaining this surprising finding (that less healthy relational patterns could also predict strong therapeutic alliances), Lowson and Brossart hypothesized that these therapists had experience dealing with unhealthy relationship

dynamics and emotionally difficult situations since an early age. They (Lowson & Brossart, 2003) hypothesized that these experiences likely enhanced the students' ability to form strong therapeutic alliances because they were accustomed to mediating between parents and themselves.

There are a few therapist variables that negatively affect the therapeutic alliance. For example, therapeutic alliance was weakened when therapists appeared less engaged, gave superficial advice or information, made statements lacking in emotion, and were consistently silent (Hilsenroth & Cromer, 2007). Not surprisingly, Ligiero and Gelso (2002) found that when therapists withdrew from intimacy and avoided their clients' difficult issues, clients rated the therapeutic alliance much lower than when therapists were engaged with their clients. In addition, therapists who controlled sessions negatively affected the therapeutic alliance (Horvath, 2001). However, Dinger, Strack, Leichsenring, and Schauenburg (2007) found that therapists with a dominant relationship style did not negatively affect the therapeutic alliance.

Meier et al. (2005) studied therapist variables that affected therapeutic alliance in a large and unique sample of mostly male, unemployed, antisocial people who injected heroin daily. Meier et al. found that these clients rated the therapeutic alliance with counselors that had addiction issues as stronger than with counselors who did not have addiction issues. Unfortunately, it is not known whether or not the counselors that had addiction issues disclosed this information to their clients. Meier et al. also found that this group of clients rated the therapeutic alliance with more experienced substance abuse

counselors and counselors with formal training less positively than with less experienced and less trained counselors.

Therapeutic Alliance and Outcome

The quality of the therapeutic alliance has been consistently found to be related to client change over the past two decades (Catty, 2004; DeRubeis et al., 2005; Horvath, 2001; Sexton & Whiston, 1994). In a literature review of 195 sources (Sexton & Whiston, 1994) and in a meta-analysis of 90 studies (Horvath, 2001), researchers concluded that after examining therapeutic techniques and orientations, and both client and therapist factors, it was only the therapeutic relationship that has been consistently found to affect client change. Horvath (2001) also noted that approximately half of the variance accounted for regarding the beneficial effects of treatment could be attributed to the strength of the therapeutic alliance (although the effect size was modest).

Many specific client outcomes are related to the therapeutic alliance. For example, Baldwin, Wampold, and Imel (2007) found that clients who formed stronger therapeutic alliances experienced less anxiety, depression, loneliness, and fewer disagreements at work and school than clients that formed weaker alliances.

Even therapists' adherence to treatment manuals can affect the therapeutic alliance. In a study of cocaine-addicted clients' relapse rates, Barber et al. (2006) found that when the therapeutic alliance was strong, adherence to a treatment manual was not significant. When the therapeutic alliance was weak, moderate adherence predicted less relapse (Barber et al., 2006).

Therapeutic Alliance Processes

Given that intimate relationships become enriched and more complex over time and given that the intensity of these relationships also vary over time, it appears that therapeutic relationships might also go through similar processes (Horvath, 2001). Researchers have identified four processes. Stable processes are those in which the therapeutic alliance is rated at approximately the same level each session (DeRoten et al., 2004). Linear growth processes emerge when the therapeutic alliance is initially low and then increases in subsequent sessions (DeRoten et al., 2004). A "U-shaped" pattern is expected if the therapeutic alliance is initially rated high during early sessions, goes through a low period during the middle of therapy, and is then rated high at the end of therapy (DeRoten et al., 2004). It appears that this process is indicative of therapy that goes through a period of rupture and repair (Gelso & Carter, 1994). Jagged patterns are expected if clients and therapists go through several periods of rupture and repair (Lorentzen, Sexton, & Hoglend, 2004).

Three groups of researchers (Ambresin, De Roten, Drapeua, & Despland, 2007; DeRoten et al., 2004; Kramer, DeRoten, Beretta, Michel, & Despland, 2008) studied the impact of the therapeutic alliance process on client change. In all three studies, the therapeutic alliance was rated by the clients. Two groups of researchers (Ambresin et al., 2007; DeRoten et al., 2004) compared a group of clients who completed a four-session psychodynamic intervention that formed a linear pattern of therapeutic alliance with groups that formed a stable-low and a stable-high alliance pattern. DeRoten et al. (2004) found that clients that formed a linear growth pattern experienced significantly more

symptom reduction than clients with a stable therapeutic alliance. Similarly, Ambresin et al. (2007) found that the group of clients that formed a linear growth pattern significantly decreased their use of projection while the groups that formed a stable-high and a stable-low alliance did not show significant change in this area.

However, Kramer et al. (2008) found contradictory results. They found that a high-stable process of therapeutic alliance, as rated by the therapist, predicted symptom reduction while the other therapeutic alliance processes did not predict symptom reduction. In addition, they found that client ratings did not predict symptom reduction.

TSD and Therapeutic Alliance

Some researchers have studied the possible effects of TSD on the therapeutic alliance. For example, Bedi et al. (2005), using critical incidents qualitative research, studied 107 responses from nine research participants who had engaged in therapy. They asked participants which specific events or therapist behaviors were the most helpful in establishing a good therapeutic alliance. They found that about half of the critical incidents involved TSD. More specifically, about 10% of the critical incidents that contributed to the development of a strong therapeutic alliance involved the therapist sharing personal experiences that were similar to the client, or sharing something that was intimate or sacred about themselves.

Other researchers using qualitative methods have found similar results. After examining cross-cultural critical incidents, Burkard, Knox, Groen, Hess, and Perez (2006) reported that TSD positively contributed to the therapeutic relationship. Hanson (2005) found that TSD was more than twice as likely to be experienced as helpful than as

unhelpful. Research participants in Hanson's study also reported that not using TSD was detrimental to the alliance. After surveying clients and therapists, Kelly and Rodriguez (2007) found that TSD and therapeutic alliance were not related.

Myers (2004) was the only researcher who systematically studied different levels of TSD (no TSD, low intimacy, and very personal TSD) in the context of a weak and a strong therapeutic alliance. Myers's young research participants (university students with an average age of 20.4) first read a statement that either described a weak or a strong therapeutic alliance. Afterwards they viewed one of three vignettes. All vignettes portrayed two male actors who role-played a simulated therapy session. One group of participants viewed a vignette with no TSD. In the second vignette, the therapist disclosed a low intimacy TSD, which was "I don't like drinking either, in my undergrad days I was the designated driver too" (Myers, 2004, p. 103). In the third vignette, the therapist disclosed a very personal TSD, which was "Your childhood reminds me of my own and how for a long time I shut myself and others off from that vulnerable part of me. I couldn't bring myself to risk being hurt like I was as a child. To be honest, I still struggle with this, and don't let many people close enough to me to really know me. It is a lonely place at times. I bet it's lonely for you always wondering if others will leave you" (Myers, 2004, p. 89).

Participants rated their perceptions of therapist's expertness, attractiveness, and trustworthiness (Myers, 2004). Participants also rated session depth, smoothness, and emotional tone (Myers, 2004). Myers found that when the therapist used low-intimacy TSD, research participants rated him as more trustworthy than when the therapist either

did not disclose or when he disclosed very personal information. Myers's participants also rated the therapist who used low-intimacy TSD higher on expertness than when the therapist did not disclose any personal information. When the therapist disclosed low-intimacy or very personal TSD, he was rated as more attractive (defined as the likelihood that research participants would want to engage in treatment with him) than when he did not disclose anything (Myers, 2004).

Myers (2004) also found significant interactions between TSD and the therapeutic alliance. When the therapeutic alliance was depicted as weak, and when the therapist disclosed either low-intimacy or very personal information, he was rated lower on expertness and the session was rated as shallower as compared to when he did not disclose at all. When the therapeutic alliance was depicted as strong, and when the therapist used low-intimacy TSD or very personal information, he was rated higher on expertness and the session was rated as deeper as compared to the no-disclosure condition. Myers therefore recommended that therapists should not disclose very personal information if a good therapeutic alliance has not yet been established. Myers also suggested that superficial TSD is more beneficial than disclosures about therapists' very personal and unresolved issues. However, the very intimate disclosure was not separated from the information that the therapist still struggled with personal issues. Therefore, it is not known whether the results were due to the information that the therapist still struggled or that the TSD was very personal. Therefore these two variables should be separated in future research.

Treatment Dropout

Dropout rates from mental health treatment vary widely. A meta-analysis of 125 studies, across a variety of clinical contexts and treatments, found that the average dropout rate was about 47% (Wierzbicki & Pekarik, 1993). People who drop out, usually do so in the early stages of treatment (King & Canada, 2004; Sayre et al., 2002). For example, Bados, Balaguer, and Saldana (2007) found that about 28% of people that dropped out did so after the first session. Connell, Grant, and Mullin (2006) found that half of the people that dropped out did so after their first or second session. Bados et al. found that 44% dropped out between the first and the fifth sessions.

Researchers use a wide variety of terms to describe dropout, such as non-mutual therapy termination (Hopwood, Ambwani, & Morey, 2007) treatment attrition (Hoffman & Suvak, 2006), unilateral treatment exit (Pulford, Adams, & Sheridan, 2006), time in treatment (Siqueland et al., 2002), and treatment discontinuity (Berghofer, Schmidl, Rudas, Steiner, & Schmitz, 2002). These various terms for dropout are defined in various ways which can greatly impact dropout rates and results (Wierzbicki & Pekarik, 1993). Definitions of dropout include terminating therapy before achieving treatment goals, stopping therapy without discussing it with the treatment provider, and not attending an arranged appointment, (and not requesting another appointment) (Berghofer et al., 2002; Hoffman& Suvak, 2006; Hopwood et al., 2007; Pulford et al.,2006; Siqueland et al., 2002). Further complicating the matter, some researchers define dropouts as people who complete an intake session but do not attend treatment, whereas other researchers do not

consider these clients as dropouts because they technically did not start therapy (Siqueland et al., 2002).

Dropout rates can vary widely depending on how researchers define dropout (Wierzbicki & Pekarik, 1993). Siqueland et al.'s (2002) study provides a good example of this variation. Siqueland et al. studied people attending treatment for cocaine abuse. They completed intake assessments on 924 people who met their inclusion criteria. If Siqueland et al. defined dropout as someone who attended an intake assessment and then did not attend treatment, their dropout rate would have been 84%. However, they defined dropouts as people who completed less than five months out of their six month treatment program. Using this definition, they reported their dropout rate as 69%. (There was no indication of how many people completed the six months of treatment.)

People who drop out of treatment tend to not fare as well as people that complete treatment. People that dropped out had significantly more problems and more symptoms of mental illness than people who completed treatment (Troller et al., 2006). For instance, people that dropped out of Ong, Kuo, & Manbar's (2008) study reported higher levels of depression and more serious symptoms such as not being able to sleep for more than four hours per night.

However, people also drop out of treatment for positive reasons. About 55% of the people who provided reasons for dropping out of one study indicated that they did so because they felt improvement (Pulford, Adams, & Sheridan, 2006).

Demographic Variables

Literature on treatment dropout from counseling centers or mental health clinics has resulted in mixed findings. On most demographic variables, there were as many studies that found that a variable in question was a significant predictor of treatment dropout as there were studies that found that the variable in question was not a significant variable. For example, age has been found to be a significant predictor of dropout (Berghofer et al., 2002, Graff, Griffin, & Weiss, 2008; Johansson & Eklund, 2006) and not a significant predictor (Bados et al., 2007; Hofmann & Suvak, 2006; Reitzel et al. 2006). In one study, more men dropped out of treatment than women (Troller et al., 2006). In other studies, there were no significant gender differences regarding dropout (Bados et al. 2007; Berghofer et al. 2002; Connell et al. 2006; Davis, Hooke, & Page, 2006; Graff et al., 2008; Hofmann & Suvak, 2006; Johansson & Eklund, 2006; Reitzel et al., 2006).

Living with someone sometimes increases the likelihood one will drop out of treatment (Berghofer et al., 2002, Lincoln et al., 2005) and often times it does not make a significant difference (Bados et al., 2007; Berghofer et al., 2002; Graff et al., 2008; Hofmann & Suvak, 2006). Somewhat related to living with someone is the concept of attachment. Golman and Anderson (2007) found that client attachment style was not related to dropout. Sauer et al. (2003) found that therapist attachment style did not make a difference on dropout rates either.

People with less years of education sometimes drop out at higher rates than people with more education (Graff et al., 2008). However, some researchers found that

years of education was not a predictor of dropout (Hofmann & Suvak, 2006). Sometimes people who are unemployed drop out at higher rates than employed people (Berghofer et al. 2002) and often employment does not make a difference on dropout rates (Bados et al. 2007; Berghofer et al. 2002; Graff et al., 2008). Sometimes number of previous attempts at treatment is a significant predictor of dropout (Berghofer et al., 2002) and sometimes it is not (Bados et al., 2007; Graff et al., 2008). Corning and Malofeeva (2004) found that being referred by others increased the risk of dropout.

Psychological Variables

Research on psychological variables that can affect dropout from counseling centers is also mixed. Davis et al. (2006) found that low self-esteem at intake predicted dropout whereas Meier, Donmall, McElduff, Barrowclough, and Heller (2006) found that pre-treatment self-esteem made no significant difference on dropout. Furthermore, dropout rates for people who completed a program addressing self-esteem did not differ from those that did not complete the program (Davis et al., 2006).

Johansson and Eklund (2006) found that diagnosis did not affect dropout whereas a recent mood episode was found to be related to dropout in one study (Graff et al., 2008). Some researchers found that the presence of a personality disorder predicted dropout (Minnix et al., 2005) whereas others found that presence of a personality disorder made no significant difference (Reitzel et al. 2006). Closely related, number of clinical scale elevations on the MMPI-2 (Minnix et al., 2005) and number of co-occurring diagnoses (Lincoln et al., 2005) predicted dropout in two studies.

Some researchers found that the clinician's Global Assessment of Functioning rating (as specified in the DSM-IV-TR; APA, 2000) predicted dropout (Minnix et al., 2005) whereas others found it made no significant difference (Reitzel et al. 2006). Berghofer et al. (2002) found that clients who rated their own GAF as high were more likely to drop out of treatment.

Corning, Malofeeva and Bucchianeri (2007) studied a unique variable that other researchers had not considered. They examined the discrepancy between clients' and therapists' rating of the presenting problem's severity. They found that the higher the discrepancy, the lower the odds were of completing treatment. This finding provides some evidence for the necessity of therapist-client agreement on important issues in therapy.

Another unique factor studied regarding dropout was the client's expectations of therapy. Expectations were defined as the client's beliefs and anticipations about what therapy would be like, how therapy was conducted, what they would accomplish, and what they thought therapists should do (Dew & Bickman, 2005). Dew and Bickman (2005) reviewed the literature on expectations and found mixed results. They found several studies in which expectancies did and did not affect dropout.

Substance Abuse Treatment Dropout

People who drop out of substance abuse treatment have several factors that are similar to clients of mental health clinics and several factors that are unique. For instance, both settings have an average dropout rate of approximately 50% (Sayre et al., 2002; Wierzbicki & Pekarik, 1993). Dropout from both settings is associated with poorer

outcomes. People who discontinued their attendance of 12-step meetings were three times more likely to abuse substances than those that continued (Kelly & Moos, 2003). People on probation who terminated their substance abuse treatment early were more likely to be rearrested within a four year period than people who completed treatment (Huebner & Cobbina, 2007). For example, Huebner and Cobbina (2007) found that 67% of people who dropped out and 37% of people who completed treatment were charged with new crimes.

Client Variables with Mixed Results

Four salient client variables have emerged from the substance abuse treatment literature. Firstly, some researchers have found that younger clients were more likely to drop out of substance abuse treatment than were older clients (Saarnio & Knuutila, 2003; Siqueland et al., 2002). Siqueland et al. (2002) found that for every one year that a person aged there was a 2.8% increase in the likelihood of staying in treatment until completion. Other researchers found no significant differences between younger and older clients (Daughters et al., 2008; King & Canada, 2004).

Secondly, mixed results have been found regarding client gender. Some researchers have found that women who abused substances were more likely to drop out of treatment (King & Canada, 2004; Sayre et al., 2002). Other researchers found no significant gender differences unless the females had more psychiatric symptoms, which put them at greater risk for dropout (Siqueland et al., 2002). Other researchers found that client gender made no significant difference on dropout rates (Meier et al., 2006).

Thirdly, research in the area of addiction severity is also inconclusive. Some researchers have found people with more severe addictions dropped out at higher rates (Meier et al., 2006; King & Canada, 2004). However, other researchers found that addiction severity did not affect dropout (Sayre et al., 2002; Siqueland et al., 2002).

Fourthly, research in the area of motivation has produced mixed results. Ball et al. (2006) surveyed people who dropped out of substance abuse treatment. Approximately 50% of them attributed dropping out to motivational inconsistencies such as changing their mind about attending the program, not having good reasons to end their addictions, and losing hope in their ability to change. However, Meier et al. (2006) found that clients with greater motivation and better treatment readiness did not drop out at different rates than those with weaker motivation and lesser treatment readiness.

Some researchers found interesting interactions between motivation and other factors. For example, Saarnio and Knuttila (2003) found interactions between age and motivation. Younger clients at the more rudimentary stages of change (e.g., precontemplation and contemplation) were more likely to drop out than older clients at later stages of change (e.g., active change and maintenance). Hopwood, Ambwani, and Morey (2007) found that clients with high pretreatment motivation who were more aggressive, had more severe mental illnesses, were more impulsive, and who were less psychologically-minded were more likely to drop out than clients with less severe ratings on aggression, mental illness, impulsivity, and psychological-mindedness.

Client Variables with Consensus

There are two variables in the literature that have some consensus regarding reliable effects on dropout of substance abuse treatment. The first factor is whether there were legal sanctions associated with dropout. Clients who were court-mandated to attend substance abuse treatment dropped out of treatment at lower rates than clients who attended treatment voluntarily (Daughters et al., 2008; Lejuez et al., 2008; Perron & Bright, 2008; Sung & Richter, 2007). Brochu et al. (2006) found that substance abuse treatment clients who were waiting for trial or sentencing stayed in treatment longer than clients who did not have judicial pressures.

The other factor that seems to have some consensus in the literature is the effect of Antisocial Personality Disorder (ASPD) when examined with other variables. Daughters et al. (2008) found that males with ASPD who voluntarily took treatment were more likely to drop out than those that were court-mandated with or without ASPD. Other researchers also found that ASPD was a predictor of dropout (Meier & Barrowclough, 2009; Siqueland et al., 2002). However, when demographic factors (e.g., race, employment, age, and education) were entered into Siqueland et al.'s regression model, ASPD was not a significant predictor. It is interesting to add that Meier and Barrowclough found that other personality disorders, such as Borderline Personality Disorder, were not significant predictors of dropout.

Hesse and Pedersen (2006) conducted a meta-analysis of 17 studies and found a nonsignificant effect size (-.05) of ASPD on treatment retention. However, when they disaggregated the data into two programs, outpatient treatment and therapeutic

communities, ASPD had a significant effect on retention. They found that people with ASPD were more likely to drop out of outpatient treatment. However, Hesse and Pedersen found that people with ASPD were more likely to complete therapeutic community treatment than people without ASPD. Therapeutic Communities are drug-free residential settings in which clients stay for 18 to 24 months (National Institute on Drug Abuse; NIDA, 2008). During that time, they progress through different stages of treatment conducted by professionals and peers (NIDA, 2008).

Mariani et al. (2008) examined the influence of ASPD on retention of people seeking treatment for cocaine and cannabis dependence. They examined three categories of ASPD: conduct disorder alone (no progression into adult antisocial behavior), adult antisocial behavior without childhood conduct disorder, and those that met the criteria for a full diagnosis of ASPD (e.g., both childhood conduct disorder and adult antisocial behavior). Mariani et al. found that people with substance dependence (either cocaine or cannabis) who had adult antisocial behavior or ASPD were no more or less likely to complete treatment than those without these behaviors.

There is some consensus in the literature regarding two other variables that intuitively should affect dropout rates but do not. One factor is the effect of previous substance abuse treatment attempts on dropout. Researchers found that people who dropped out did not differ from people who completed substance abuse treatment with regard to number of previous attempts at treatment (Ball et al., 2006; Daughters et al., 2008; Meier et al., 2006; Pulford et al., 2006).

The other factor is the presence of mental illness. Meier and Barrowclough (2009) conducted a literature review of 58 studies on dropout from substance abuse treatment. They found that histories of mental illness did not predict dropout. They also found that most studies concluded that neither the presence nor the severity of depression, anxiety, or other Axis I disorders predicted dropout.

Unique Client Variables

Three variables that are unique to the substance abuse treatment literature have received very little attention. One factor is clients' perceptions of normal versus problem drinking. O'Connor, Davies, Heffernan, and Van Eijk (2003) had substance abuse treatment clients read 40 vignettes. Twenty of these vignettes described non-problem alcohol use and 20 vignettes depicted behavior of someone with a substance abuse disorder as defined by the DSM-IV-TR (APA, 2000). People who dropped out were less likely to classify problem drinking vignettes as such. These results suggest that people who drop out of substance abuse treatment may not have a good understanding of the severity of their own drinking problems.

The second variable is distress tolerance. Daughters et al. (2005) studied people attending a 30-day residential substance abuse facility. They subjected clients to tasks that were designed to be frustrating. In one task, clients were asked to add up numbers flashed on a computer screen. The time provided to add up the numbers became increasingly shorter. In another frustrating task, clients were asked to trace a red dot along a star on a computer screen with a mouse-driven cursor. The cursor went in the opposite direction of the mouse's movements. Daughters et al. (2005) found that people

who could not tolerate distress, as measured by time it took to quit these frustrating tasks, were also more likely to drop out than those that quit these tasks significantly later.

The last variable, which is similar to distress tolerance, is anxiety sensitivity. Lejuez et al. (2008) defined anxiety sensitivity as hypersensitivity to negative events, general inability to tolerate uncomfortable sensations, and fear of the sensations associated with anxiety. Lejuez et al. studied a unique sample of mostly middle aged (mean age = 42.2) primarily African American (94% of sample), males (67%) who were court-ordered (78%) to receive treatment for their cocaine and/or heroin dependence. Lejuez et al. found that the clients who dropped out, as compared to those that completed treatment, had significantly more anxiety sensitivity.

First Nations Clients and Dropout

The present study was conducted in treatment centers near the West Coast of Canada. The population of clients that attend these treatment centers are approximately 84% Caucasian, 15% First Nations people, and 1% other (Indo-Canadian and Asian). Given that Canadian First Nations people self-reported that substance abuse is one of the most prevalent threats to their health and quality of life (Aboriginal Healing Foundation, 2007), dropout of First Nations people from substance abuse treatment is an important social change issue. Studying 877 First Nations research participants, Callaghan (2003) reported a 29% dropout rate from an assessment/detoxification unit of a hospital (length of program was not specified) in northern BC, Canada. Factors Callaghan studied were younger age, addiction to illicit drugs in addition to alcohol, injection drug use, having no fixed address, unemployment, previous admission for detoxification in the same facility,

and being self-referred. Only self-referral and preference for illicit drugs in addition to alcohol were weakly correlated with dropout from this detoxification program.

Li, Sun, Puri, Marsh, and Anis (2007) studied 2,566 clients, of which 17.5% were First Nations people, attending a west coast Canadian detoxification center. They found that one of the predictors of dropout was being a person of First Nations descent. In addition, Li et al. found that First Nations people were significantly more likely to drop out before treatment commenced than people of other ethnicities.

Therapist Variables

Little is known about the related therapist variables that can affect dropout from substance abuse treatment as only a few variables have been examined. Two therapist variables found to affect dropout were staff-client conflict (Ball et al., 2006) and clients' perception of their therapists as being controlling and as having poor ability to convey empathy (McKellar, Harris, & Moos, 2006). About 25% of the participants in Ball et al.'s study felt that the staff did not like, respect, or want to help them.

Meier et al. (2006) examined the effects of therapists' experience, age, qualifications, and whether or not they had addiction issues on substance abuse treatment retention. They found that clients who had treatment with more experienced counselors remained in treatment longer. Somewhat contrary to this finding, they also found that clients of older therapists were less likely to stay in treatment than clients of younger therapists. Therapist's qualifications and whether the therapist struggled with addiction were not predictors of retention. Unfortunately, the researchers did not question the clients as to whether or not the therapists disclosed that they struggled with addiction.

Dropout and Therapeutic Alliance

Results on a possible relationship between the therapeutic alliance and substance abuse dropout were mixed. For example, after reviewing 11 studies, Meier et al.'s (2005) key conclusion was that early therapeutic alliance consistently predicted engagement and retention in drug abuse treatment. They found moderate effect sizes that explained about 5% to 15% of the variance between therapeutic alliance and dropout.

Horvath (2001) found conflicting results in his meta-analysis of therapeutic alliance and dropout. Four of the studies he reviewed found that a weak therapeutic alliance at intake or after the first session was a good predictor of dropout. More recent studies, including a meta-analysis by Meier et al. (2005) have supported Horvath's results that people who drop out of therapy tend to rate the therapeutic alliance as weaker than people who complete therapy (Johansson & Eklund, 2006; Saatsi, Hardy, & Cahill, 2007). Horvath also found two studies (Florsheim et al., 2000; Joyce & Piper, 1998) in which a high initial therapeutic alliance was related to dropout. Horvath speculated that research participants in these two studies may have had unrealistic and unfilled expectations. Other researchers found that therapeutic alliance did not predict retention or dropout (Barber et al., 2001, Brocato & Wagner, 2008; Sauer et al., 2003).

Other researchers have not found relationships between therapeutic alliance and dropout. However, they found that specific scales of therapeutic alliance measures predicted dropout. For example, Lingiardi, Filippucci and Baiocco (2005) found that two scales of the California Psychotherapy Alliance Scales that addressed client-therapist agreement and that addressed therapist understanding and involvement predicted dropout.

In addition, Principe, Marci, Glick, and Ablon (2006) found that the bond subscale of the Working Alliance Inventory predicted whether or not clients would return for therapy after the initial intake session.

It could be that results have been mixed because variables that could moderate the relationship between the therapeutic alliance and dropout have not been examined. For instance, a therapist's disclosure that s/he is a recovering addict is a common practice in substance abuse treatment facilities (S. Lloyd, personal communication, October 2, 2008) and yet there is no empirical evidence available to date that either supports or discourages this practice.

Summary

This literature review described previous research findings concerning TSD, the therapeutic alliance, and treatment dropout. For example, participants rated therapists as having more positive regard when the therapist disclosed an issue that was similar to the client's issue (Klein & Friedlander, 1987). Clients whose therapists disclosed at an intimacy level similar to that of the client's level reported lower levels of symptom distress and reported that they liked their therapists more than clients whose therapists did not use TSD (Barrett & Berman, 2001). If people struggled with more serious issues, they would rather choose a therapist who has engaged in therapy than one who had not (Armour, 2007). However, if therapists disclosed to clients struggling with depression that they (the therapists) too sometimes struggled with depression, the clients rated them as less empathic, less competent, and less trustworthy than therapists who did not disclose this information (Curtis, 1982).

Little is known about how TSD might influence the relationship between the therapeutic alliance and dropout. There is some evidence that TSD can contribute to the development of a strong alliance (Bedi et al., 2005; Hanson, 2005) especially when the therapist discloses information that is similar to the information disclosed by the client (Bedi et al., 2005). When the therapeutic alliance was strong, and when the therapist disclosed very personal information involving the therapists' current issues, clients rated the therapist higher on expertness and they rated the session as deeper as compared to when the therapist did not disclose (Myers, 2004). Therapists that did not disclose were rated less favorably than therapists that did disclose (Hanson, 2005).

TSD can also have detrimental effects on the therapeutic alliance. If a therapist discloses highly personal information in a relationship where a bond has not yet been established, clients are likely to feel uncomfortable (Ashworth et al., 1976) and are likely to rate the therapist less favorably (Myers, 2004). Clients are more likely to drop out of treatment if they feel uncomfortable with the therapist or they have not established a strong therapeutic alliance (Meier et al., 2005).

Given these research findings, it can be speculated that when therapists disclose personal information in an established relationship, in an intimacy level similar to that of the client, that it is likely that this TSD may facilitate the development of the therapeutic alliance. However, there is no available research to date that has examined whether substance abuse treatment counselors who disclose that they had addiction issues help or hinder their relationships with clients by disclosing this information. Helping or hindering the therapeutic alliance may affect dropout. Therefore, the purpose of this study was to

provide clarity for substance abuse treatment providers by exploring whether or not the use of very personal TSD (the therapist disclosing that he struggled with addiction and sought treatment) moderated the relationship between the perceived therapeutic alliance and dropout expectancy from substance abuse treatment.

Chapter 3 is a description of the research design that was used to explore whether TSD moderated the relationship between the perceived therapeutic alliance and dropout expectancy from substance abuse treatment. The sample and setting as well as the methods for collecting and analyzing data will be described in this chapter. Finally, methods used to protect the confidentiality of the research participants will also be outlined in this chapter.

Chapter 3: Research Method

Introduction

Chapter 3 describes the design of this study, a description of the research participants, the measures used, and the procedures used for data collection and analysis. Using hierarchical logistic regression analysis, this study examined whether or not a therapist's disclosure that he struggled with alcohol addiction and that he sought treatment moderated the relationship between the perceived therapeutic alliance and treatment dropout expectancy.

Research Design

I chose an analogue design to address the problem statement and the research question because this design was best suited for these purposes. The analogue design with random assignment controlled and isolated the variables of interest (TSD and the perceived therapeutic alliance) while it held important variables constant such as the variability between sessions and between therapists that often occur in natural settings. The research question was: Does TSD moderate the relationship between the perceived therapeutic alliance and dropout expectancy from substance abuse treatment?

Setting and Sample

Research participants from three 90-day residential substance abuse treatment facilities near the West Coast of British Columbia, Canada participated in this study. These facilities provided individual and group therapy using cognitive behavioral and emotion-focused therapy for adult males.

After IRB approval from Walden University (IRB #05-26-10-0314427) and the treatment facilities, I sent residents a flyer that provided information about this study and that invited them to participate (see Appendix A). Thus, I created a convenience sample. No deception or external rewards were used. No dual relationships occurred as I was not affiliated with the treatment centers.

I conducted a power analysis using the software program GPower (for a description and relevant background of this program please refer to Erdfelder & Buchner, 1996). It was determined that a total sample size of at least 128 people (32 people in each of four conditions) would be needed to reach a .80 level of power with an alpha level of .05, with three degrees of freedom in the regression equation (variables: TSD, therapeutic alliance, and cross product) and an expected medium-sized interaction effect (e.g., partial r-square value of .06, equivalent to $f^2 = .064$) based on previous research (e.g., Horvath, 2001).

To be eligible for this study, participants needed to meet the treatment centers' admission criteria, which were that they were males older than 18 years with a severe addiction who had detoxified for at least 72 hours, and who were not psychotic or severely mentally challenged. Also, participants needed to be willing to participate without any external motivation.

Researcher's Role

I invited potential research participants to participate in this study. I answered questions, reviewed issues of anonymous consent, introduced the study to the research participants, showed participants the stimulus DVD, asked participants to complete

questionnaires, and debriefed participants after viewing the DVD used in this study. I developed the questionnaires for this study and entered and analyzed the data. I also sent results to the treatment centers.

Materials

Flyer Given to Potential Research Participants

I invited residents to participate in this study by sending them a flyer (see Appendix A) that they received at least 2 days before the researcher attended the treatment facility to invite them to participate (in person). The flyer included information regarding the purpose of this study (to examine substance abuse treatment dropout), expected duration (about 30 minutes), and possible benefits of the research (that they can contribute to research that may facilitate the reduction of dropout from treatment). In addition, the flyer stated that there was no discomfort or harm involved and that there was no remuneration for participation. It also explained the procedure used and that their involvement was anonymous.

Introductory Statements

Two introductory statements were used in this study. Both statements described a client's first impressions of a therapist after an intake interview. The two introductory statements differed in one way. One statement described the client's first impressions of the therapist in a way that described a weak therapeutic alliance (see Appendix B). More specifically, the statement explained that the client thought that the client's and the therapist's main goal of the interview was different. In addition, the statement depicted the client as not liking, trusting, or respecting the therapist.

The other introductory statement described a strong therapeutic alliance (see Appendix C). For example, the statement explained that the client thought that the client's and the therapist's main goal was the same and that the client liked, trusted, and respected the therapist.

Intake Interview DVDs

The stimulus materials for this research were two DVDs that depicted a section of an intake interview. The two DVDs differed in only one way. In one DVD, the therapist disclosed that he had struggled with alcohol addiction and that he sought treatment for it (see Appendix D). The second DVD was the same as the first one with the disclosure edited out of it. The DVDs were approximately 7 minutes long. The DVDs involved two European Canadian males (ages 49 and 46) role-playing a scripted intake interview. The male actor, who role-played the therapist, was one of my colleagues who had worked as a therapist for over 20 years.

Post-DVD Questionnaires

Participants were asked to complete a post-DVD questionnaire (see Appendix E). This questionnaire contained one question that formed the dependent measure, which was whether or not the participant would continue treatment with the therapist depicted in the DVD if he was the client in this session. The questionnaire also contained two items that served as manipulation checks. The questions inquired about whether or not the therapist and the client had a good bond and whether or not the therapist disclosed anything about himself. This study also included a demographic questionnaire that posed questions regarding age, income, living arrangements, and so on (see Appendix F).

Procedure

At least 2 business days before data collection, I sent all residents a flyer which provided them with information about the study and that invited them to participate (Appendix A). Attached to the flyer was a sample consent form (see Appendix G) that showed that one could consent in an anonymous way (by placing a check mark rather than a signature on the form).

Before going to the research site on data collection day, the researcher randomly picked (by using numbers out of a hat) which groups would participate in which of the four conditions. The conditions were:

1. Weak therapeutic alliance, no TSD,
2. Weak therapeutic alliance, TSD,
3. Strong therapeutic alliance, no TSD,
4. Strong therapeutic alliance, TSD.

I went to the sites on prearranged days (as agreed with the clinical director) to meet with the clinical director. I went to the facilities on several mornings and afternoons until 132 research participants had completed questionnaires. The clinical director escorted me to therapy rooms, introduced me to the facilitators and groups, and then left. The group therapy rooms contained 12 to 15 men and a therapist who had just finished a morning (11 AM) or an afternoon (3 PM) therapy session.

I told the potential research participants that the study's purpose was to examine dropout from residential treatment centers. I indicated that I would introduce the DVD they were about to watch, that they would be asked to watch a 7 minute DVD, and that I

would ask them to complete a brief questionnaire. I explained that their participation would take about 30 minutes. I informed them that they had the right to decline participation or to withdraw at any time and that there were no consequences for doing so. I stated that the benefit of participation was that they could contribute to research that may help to reduce dropout. I indicaated that they would not be paid and that participation would not cause them discomfort. I then asked the potential research participants if they had any questions.

After answering questions, I stated that I needed 10 minutes to set up (so that potential research participants could leave the room rather than feel pressured to participate). I told the group that if they were interested in participating in this study, that they should come back in 10 minutes. I told them that no one from the treatment center would know whether or not they participated and that participation in no way affected how they would be treated in the facility. In other words, there were no consequences for choosing to or choosing not to participate.

After the 10 minutes had transpired and the group members who had chosen to participate had been seated in the room, (only me, the researcher, and the research participants were in the room) I asked if they had any more questions. After answering questions, I gave each participant another consent form (they had received the first consent form 2 business days before data collection day). I asked participants to place a check mark on the consent form to signify that they had read the consent form and that they agreed to the information on the consent form.

After consent forms were collected, I read one of the two introductory statements describing the therapeutic alliance. I read either the statement that described a weak or a strong alliance, depending on to which condition the group was randomly assigned. Regardless of condition, I asked participants to imagine that they were the client in the DVD they were about to watch.

Afterward, I asked participants to watch one of two DVDs (depending on which condition the group was randomly assigned to) depicting 7 minutes of an intake session. I then asked them to respond to the post-DVD and demographic questionnaires. After completing these questionnaires, I conducted the debriefing session by reading the statement contained in Appendix H.

Data Collection and Analysis

Research participants' responses to the post-DVD and demographic questionnaires formed the data for this study. I entered demographic information and responses to the dependent measure question (yes/no responses to the question regarding whether or not participants would continue therapy) into the Statistical Package for Social Sciences (SPSS) version 18. I analyzed data in the following way.

First I used frequency data from the demographic information to describe the participants' demographic characteristics. Afterwards, I computed a hierarchical logistic regression in which I entered TSD and therapeutic alliance in the first step and the cross product of TSD and therapeutic alliance in the second step to predict dropout expectancy.

Measures Taken to Ensure Participants' Rights

The College of Psychologists of British Columbia's (CPBC) Code of Conduct (2009; herein referred to as the Code) requires that researchers must obtain institutional approval (Section 16.12) and must fulfill the requirements necessary for research participants to provide informed consent (Section 4.13) before participation in research. In order for research participants to be able to provide informed consent, I informed them of the following information as outlined by CPBC's Section 4.13, which is as follows:

1. The study's purpose, expected duration, and procedures.
2. The respondents have the right to decline participation or to withdraw at any time.
3. There were no consequences of declining or withdrawing.
4. There were no factors that could cause discomfort or adverse effects.
5. The research benefits of this study were that service providers and treatment directors may become better informed about TSD, the therapeutic alliance, and treatment dropout.
6. All information obtained from questionnaires was anonymous.
7. There were no external incentives for participation.
8. The name and contact information of Dr. Ford, who was the supervisor of this study, was provided to participants,
9. The researcher answered all questions.

In addition, five relevant areas of section 16 of the Code (CPBC, 2009) concerning research were also followed. First, in accordance with section 16.9 of the

Code, I conducted competent research while respecting the dignity and welfare of the participants. Second, I corrected any misconceptions that participants had as well as provided them with information concerning the nature, results, and conclusions of the study in accordance with Section 16.14. Third, in accordance with section 16.16, I only contacted the participants and interfered with the treatment environment in a manner consistent with the research design and consistent with the role as a researcher. Fourth, I honored all commitments made to the participants (Section 16.17) and to the treatment facilities. Fifth, I did not falsify any research data or results (Section 16.18).

In addition, I told participants that a signed consent form did not waive any legal rights nor did it release the program, staff, and/or research project staff from liability for negligence. I collected data in a way that protected the information and identity of the participants. I gave research participants a coded questionnaire that indicated the condition in which they participated. Therefore, participants' responses were anonymous.

Summary

This chapter was a description of the analogue research design used to measure whether TSD moderated the relationship between the perceived therapeutic alliance and dropout expectancy from residential substance abuse treatment. The 132 participants that completed this study were derived from a convenience sample of people attending residential substance abuse treatment near the West Coast of British Columbia, Canada. Participants attending these facilities met the centers' inclusion criteria, which were that they were not actively psychotic, were over 18-years-old, had a severe addiction problem, and were capable of consenting to participate in treatment. Data from research

participants were collected from a post-DVD and a demographic questionnaire. Data were analyzed using hierarchical logistic regression.

Chapter 4: Results

Introduction

This study was designed to investigate whether or not TSD moderated the relationship between perceived therapeutic alliance and dropout expectancy from residential substance abuse treatment. This study was approved by Walden University's Institutional Review Board (approval #05-26-10-0314427).

This study first involved reading a statement to participants that described either a weak or a strong therapeutic alliance. Afterwards, I showed participants a DVD of a role-played intake session that either contained or did not contain TSD. Therefore, this study involved four conditions:

1. Weak therapeutic alliance, no TSD,
2. Weak therapeutic alliance, TSD,
3. Strong therapeutic alliance, no TSD,
4. Strong therapeutic alliance, TSD.

After viewing the DVD, research participants were asked to complete the post-DVD questionnaire that contained the questions that formed the demographic information used to describe the sample below and the question that formed the criterion (dependent) variable. The criterion variable, dropout expectancy, was operationalized by a closed-ended question (yes/no) on this questionnaire. This question (that formed the criterion variable) was: If you were the client in the DVD that you viewed, would you want to continue therapy with the depicted therapist?

Results of this study are presented in Chapter 4. The following section of this chapter is a description of the research participants followed by results from the hierarchical logistic regression which will be used to address the research hypothesis.

Sample Description

A total of 171 men from three residential substance abuse treatment centers near the West Coast of Canada were invited to participate in this study. Of these 171 men, 132 men (77%) volunteered and consented to participate in this study. I invited groups of men to participate in this study. I randomly assigned these groups to participate in one of the four conditions. A total of 31 men or 23.5% of the total sample completed the weak alliance, no TSD, condition and a total of 36 men (or 27.3%) completed the strong alliance, no TSD condition. A total of 31 men (23.5%) completed the weak alliance with TSD condition. A total of 34 men (25.8%) completed the strong alliance with TSD condition.

The men who participated in this study were between the ages of 19 and 64 years. Less than 25% of these men were less than 25 years old, 24.2% were between the ages of 25 to 34, 28% were between the ages of 35 to 44, 21.2% were between the ages of 45 to 54, and 2.3% were between the ages of 55 to 64. Just over 92% of these men were born in Canada, 2.3% were born in the United States, and the remaining research participants were born elsewhere. Just under 13% of them were of Aboriginal descent.

About 57% of the research participants were single, 4.5% of them were never married, 11.4% were married or living with a significant other, 22.7% of them were separated or divorced, 1.5% were widowers, and 3% were unsure of their marital status at

the time they completed the questionnaire. Just under 38% of them had under grade 12 education, 38% had completed high school, and 24% had between one and over five years of college or university education.

About 69% lived in a residence before attending residential substance abuse treatment, 20.5% were of no fixed address, 7.6% were incarcerated, and 3% had other living arrangements. Approximately 23% of them had full-time employment after completing treatment, 4.5% had part-time employment after treatment completion, 61.4% had no post-treatment pre-arranged employment, 1.5% were retired, and 9.1% were on disability pensions. About 86% of respondents were not attending treatment due to legal coercion whereas 4.5% of them were on parole, 3% were on probation, 2.3% were on Statutory Release, and 2.3% were on bail. About 75% of the research participants had never quit residential substance abuse treatment, whereas 13.6% had quit once before, 3.8% quit twice before, 2.3% quit three times before, 2.3% had quit four times before, and 3% quit five times or more.

Results

The data for the criterion variable of the hierarchical logistic regression analysis consisted of yes/no answers to one question on the post-DVD questionnaire. The data were entered and analyzed using SPSS Version 18. In general, 45.5% of respondents indicated that they would want to continue therapy with the therapist depicted in the DVD, while 54.5% indicated they did not. About 75% of the research participants who were told that the therapist and the client's bond was weak or strong indicated that they thought the client-therapist bond was as I had described it, whereas 25% described it in

the opposite direction than I had described. Also, 2.7% incorrectly indicated that the therapist disclosed something personal about himself when he did not.

The purpose of this study was to address the following hypotheses:

$H_0$1: TSD will not moderate the effect of perceived TA on dropout expectancy.

$H_1$1: TSD will moderate the effect of perceived TA on dropout expectancy.

The variables in this study were coded as follows. A zero was assigned to the "no" response and a one was assigned to the "yes" response to the question that formed the criterion variable (Would you want to continue treatment with this therapist?). Weak therapeutic alliance was coded as a zero and strong therapeutic alliance was coded as a one. A zero was assigned to the "no TSD" condition and a one was assigned to the condition in which TSD was included.

To explore these hypotheses, correlations between dropout expectancy, TSD, and therapeutic alliance were first conducted. A Spearman Rho correlation test revealed that therapeutic alliance and dropout expectancy were significantly and strongly related $r(132) = .47$, $p < .001$. Thus, 22% of the variance in dropout expectancy was explained by the therapeutic alliance. Correlations between dropout expectancy, therapeutic alliance, and TSD are reported in Table 1.

Table 1

Correlations between Dropout Expectancy, Therapeutic Alliance, and TSD

Variable	1	2	3
1. Dropout Expectancy	---		
2. Therapeutic Alliance	.470***	---	
3. TSD	.097	-.014	---

*** $p < .0001$

Table 2 summarizes the results of a hierarchical logistic regression that predicted dropout expectancy using TSD, therapeutic alliance, and the product of TSD and therapeutic alliance as predictors: $\chi^2(3, N = 132) = 33.902$, $p < .001$, Nagelkerke $R^2 = .303$, with classification results of 72.2% no, 75.0% yes, 73.5% overall. Therapeutic alliance was strongly related to dropout expectancy with a weak therapeutic alliance predicting dropout. TSD was not a significant predictor in this model nor was the product between TSD and therapeutic alliance.

Table 2

Logistic Regression Analysis of TA and TSD on Dropout Expectancy (N = 132)

Predictor	*B*	Wald^2	*p*	OR	95% CI
Constant	-1.232	8.228	.004	.292	
Therapeutic Alliance	1.558	7.653	.006	4.747	[0.444, 2.671]
TSD	-.021	.001	.972	.980	[-1.184, 1.142]
TSD x TA	1.045	1.661	.197	2.844	[-0.560, 2.650]

Note. OR = odds ratio; CI = confidence interval; Omnibus $\chi^2(3, N = 132) = 33.902$, $p < .001$; Hosmer and Lemeshow Goodness of Fit $\chi^2(2, N = 132) = 000$, $p = 1.000$; Cox and Snell $R^2 = .227$; Nagelkerke $R^2 = .303$; Classification results: 72.2% no, 75.0% yes, 73.5% overall.

Summary

This chapter described the research participants and the results of the present study. The research participants in this study were men, between the ages of 19 and 64, attending residential substance abuse treatment in three treatment facilities near the West Coast of Canada. The findings from this study failed to reject the null hypothesis which was that TSD had no significant effect on the relationship between the therapeutic alliance and dropout expectancy. However, a weak therapeutic alliance was found to be a significant predictor of dropout expectancy.

Chapter 5: Discussion

Introduction

Chapter 5 is a discussion of the present study's findings including how these findings relate to other researchers' results, implications of these findings for practice and social change, strengths and limitations, and recommendations for future research. This study examined the possibility that TSD had a moderating effect on the relationship between perceived therapeutic alliance and dropout expectancy from residential substance abuse treatment. The main finding of this study was that TSD did not significantly affect research participants' opinions regarding whether or not they would continue treatment with the depicted therapist regardless of whether the therapeutic alliance was described as weak or strong. The other finding of this study was that a perceived weak therapeutic alliance was found to be a good predictor of dropout expectancy from residential substance abuse treatment.

Results from the present study were not congruent with Myers's (2004) study. Myers found that when the therapeutic alliance was depicted as weak and when the therapist disclosed very personal information, the participants rated the therapist lower on expertness and they rated the session as shallower than when the therapeutic alliance was described as strong and the therapist disclosed the same very personal information. However, Myers's very personal information included disclosure that the therapist was abused (as was the client in this study) and that the therapist still struggled with sequelae of his abuse. In the present study, the therapist disclosed that he struggled with addiction issues and that he got help and got things sorted out. The disparate results between these

two studies may have occurred due to the dissimilarity of these disclosures as well as that both studies had dissimilar dependent measures. Myers's research participants in the weak therapeutic alliance condition may have been negatively impacted by the information that the therapist had current struggles.

It is also interesting to note that Myers (2004) excluded data from research participants who incorrectly answered the manipulation check questions. For instance, if participants misperceived a weak alliance as a strong alliance or a strong alliance as a weak one, Myers excluded their data from the analyses. In the present study, three research participants answered the manipulation question regarding TSD incorrectly. They indicated that the therapist disclosed something personal about himself when they were in the condition that did not include TSD. In addition, 25% of the research participants incorrectly answered the manipulation check question regarding the therapeutic alliance. About 7% stated that the alliance was weak after they participated in the condition in which the alliance was described as strong. The other 18% indicated that the alliance was strong despite being told that the alliance was weak. I analyzed the data with and without the 27.3% of participants who incorrectly answered the manipulation check questions and found that the results did not differ. Therefore, the results described in the present study were from the whole sample.

Hanson (2005) found in her qualitative study that TSD fostered the alliance however in the present study, TSD had no significant impact. These differences may have occurred due to the different methods and populations used in these studies. Hanson conducted her study by asking open-ended questions to mostly female European

American therapy clients. The present study involved an analogue design with mostly European Canadian men who were struggling with severe addictions. Although the men who participated in the present study may have also felt that TSD enhanced the therapeutic alliance, the present study did not capture this possible effect. Alternatively, given the severe problems and lifestyles of these men, TSD may not have affected the present study's research participants as greatly as did the research participants in Hanson's study.

The present study was also incongruent with Klein and Friedlander's (1987) research. They conducted an analogue study in which they found that therapists who disclosed personal information were rated more favorably when the disclosure demonstrated client-therapist similarity and possibly when this disclosure was negative. Although the present study was similar in this regard (that the therapist's disclosure was similar to the client's disclosure and that the disclosure was negative information), the TSD in the present study did not have enough of an impact to significantly affect the therapeutic alliance-dropout relationship. Therefore, the present study may not have involved as sensitive a measurement of the possible impact of this disclosure as did Klein and Friedlander's research or the similar and negative disclosure simply did not significantly affect the unique research participants in the present study.

Results from the present study, that therapeutic alliance predicts dropout, are congruent with Meier et al.'s (2005) literature review. Meier et al. also found that the early therapeutic alliance consistently predicted retention in drug abuse treatment. In

addition, consistent with the present study, Horvath (2001) found that a weak therapeutic alliance at intake was a good predictor of dropout.

Implications for Residential Substance Abuse Treatment and Social Change

These findings—that the therapeutic alliance was a good predictor of dropout and that TSD did not significantly affect the therapeutic alliance-dropout relationship—emphasize the importance of cultivating the therapeutic alliance in order to prevent dropout from residential substance abuse treatment. Directors of residential substance abuse facilities in general, and specifically therapists, need to be aware that the therapeutic alliance is important in preventing dropout and therefore any ruptures of this alliance need to be attended to promptly or clients may dropout as a result. These findings also suggest that because TSD does not have a significant effect on the therapeutic alliance-dropout relationship, this study does not provide support for substance abuse treatment facilities exclusively hiring people who have struggled with addiction.

Strengths and Limitations

The main strength of this study, as a virtue of its design, was also its main weakness. This study was an analogue design in which therapist self-disclosure and the therapeutic alliance were carefully manipulated. Measuring the therapeutic alliance as it occurs in therapy is usually difficult because most clients usually rate the alliance with the top two most favorable ratings, thus creating lack of variance (Horvath, 2001). This study specifically manipulated the alliance: I told the participants that the alliance was either weak or strong, thus avoiding the problem of trying to find clients who rated the alliance as weak or strong. This design also avoided the lack of variance problem. In

addition, therapist disclosure was carefully manipulated by making a DVD and showing half the participants the DVD with the disclosure and showing half the participants the same DVD with the disclosure edited out. Thus, the analogue design provided the ideal method and conducting this research in actual residential substance abuse treatment facilities provided ideal environments in which both these variables (therapeutic alliance and disclosure) could be manipulated and measured.

Using an analogue design also has inherent weaknesses. I created an artificial situation in which research participants were asked to imagine that they were the client in an intake session and they were told that the therapeutic alliance was either weak or strong. Research participants were asked to indicate what they would expect or intend to do, given the situation. The artificiality of this situation may or may not generalize to actual situations. For example, what people expect or intend to do is often different from what they actually do.

A limitation of this study was that only West Coast Canadian men participated in this study. Results from this study therefore may not generalize to men from other regions and cultures. It could be that men from other cultures may react to TSD differently than did the men in the present study.

Recommendations for Future Research

Although intuitively it seems that TSD would affect the relationship between therapeutic alliance and dropout, this study did not provide support for this belief. However, both these constructs (therapeutic alliance and dropout) are complex areas of research with possibly many influencing factors. Therefore, future researchers may want

to explore the role of other therapeutic techniques (such as empathy, confrontation, making decisional balance sheets), in concert with TSD, so that the therapeutic alliance-dropout relationship can be better understood.

Conclusion

Results from this study indicated that TSD did not significantly moderate the relationship between the therapeutic alliance and dropout from residential substance abuse treatment. However, empirical evidence for the importance of building a strong therapeutic alliance in order to prevent dropout was found. This study therefore underlies the importance of cultivating the therapeutic alliance as it is an important factor in the prevention of dropout from residential substance abuse treatment.

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Appendix A: Invitation to Participate In Research

Flyer Given To Residents Of Treatment Centers

My name is Elise Reeh. I am doing a study on how the bond one establishes with his therapist might affect dropout of residential substance abuse treatment. I am doing this study as part of the requirements to finish my doctorate degree in Clinical Psychology. The study involves listening to a brief introduction, watching a seven minute DVD on an intake session, and then answering some questions on a survey afterwards. This study would take about 30 minutes of your time.

Participation in this study is confidential and voluntary. If you agree to participate in this study, I would not ask anyone for their name. The facilitators and directors of your treatment center will not know who participated or not in this study. The questionnaires that you would fill out if you participate will not have anyone's name on it.

Choosing to not participate in this study in no way affects how you are treated at your treatment center. You can also choose to participate and change your mind at any time and quit participating. If you do that, there are no consequences from your treatment center to quitting your participation.

The benefits of participating in this study are that you would be contributing to research that can help substance abuse counselors and directors make residential substance abuse treatment even better and your it may help to reduce dropout. You will not be paid to participate. I don't think that participation in this study would cause you any discomfort.

When I get the results from this study, I will make a one or two page presentation and I will hang it up in your treatment center so that people will know the results. I will also post a date and time where I am presenting the results in person and you can drop in to hear and discuss them.

Appendix B: Therapeutic Alliance Statement: Weak

The section of an intake interview that you are about to watch is between a substance abuse counselor, Andrew, and a client, John. Please imagine that you are the client, John, in this therapy session.

After this first interview, John was asked about his first impressions of his future therapist, Andrew. John felt that Andrew's main goal of the interview was to get him into residential substance abuse counseling whereas John's goal was to see whether he needed the residential treatment or not. After this session, John stated that he did not really like, trust, or respect Andrew.

Appendix C: Therapeutic Alliance Statement: Strong

The section of an intake interview that you are about to watch is between a substance abuse counselor, Andrew, and a client, John. Please imagine that you are the client, John, in this therapy session.

After this first interview, John was asked about his first impressions of his future therapist, Andrew. John felt that his goal and his future therapist's goal was to get him into residential substance abuse counseling. After this session, John said that he liked, trusted, and respected Andrew.

Appendix D: Intake Interview Script

1) T: Let's talk about sleep now; do you have any trouble with sleep?

C: Yes, I have trouble falling asleep, a lot of nights I just lie there and I can't fall asleep even though I'm really tired. Other nights, I can fall asleep but after an hour or so I wake up and just lay there again and I just can't seem to fall asleep.

2) T: Hmm hmm, sounds like you're having problems with sleep. How does this lack of sleep affect your life?

C: Waking up is tough but I have to get up early to drive to work. I'm not very awake and I'm grouchy in the morning. My wife thinks I'm mad at her but I'm just really tired. When I'm driving to work, I'm really dozy. Sometimes I'm afraid that I'm going to fall asleep at the red lights. Then I get to work usually on time but I'm not very productive, I'm grouchy and I kind of keep to myself and I don't talk to the other guys. Then the other guys are mad at me because I'm dragging my butt.

3) T: Yeah, it looks like this lack of sleep is affecting your relationships and work, especially in the mornings. How do you think it affects the rest of your day?

C: After I drink lots of coffee in the morning, I eventually get into the groove of work but after lunch I feel pretty dozy during the mid and late afternoons. Driving home from work is also hard because I think I'll fall asleep at the red lights. Sometimes I pull over and have a nap. Then I have a nap when I get home at 6.

4) T: So it's a struggle for you all day. What keeps you awake at night?

C: All sorts of things, sometimes its work-related, sometimes it's relationship-related and sometimes it's nothing in particular. I try to shut off my mind but it just keeps going.

5) T: You try to shut off your mind but it keeps going, sometimes you can't shut off your mind because of work, tell me more about that.

   C: Sometimes when I'm working slow and we have lots of work to do I'm afraid the boss might see me not working hard and maybe he'll think he should lay me off and get rid of me. So I worry about getting fired, you know, stuff like that and then how would I pay the rent and stuff.

6) T: So you sometimes fear getting laid off because you think you don't work hard enough. You said that sometimes your inability to fall asleep is relationship related. What did you mean by that?

C: Usually my wife and I get along pretty well but sometimes things get rocky and sometimes we fight, usually about money. We end up spending too much and then at the end of the month, we blame each other for overspending. Then, other times she gives me a rough time about going out with the boys after work and spending too much money when it should go to the rent and bills and stuff like that.

7) T: It sounds like you have some financial issues you may need to work out. Just thinking about your sleep problems, what do you do during the evenings that might affect your ability to fall asleep: Tell me what a typical weekday evening would be like for you?

C: Well I get home at 6 and I have a nap for about an hour because I'm so bagged by the end of the day. Then I have a big cup of coffee to wake me up. We usually make supper and then we eat at about 8. Then, we watch TV for a few hours. Then, when we're watching the news, I usually have a few beers or a few Jack Daniels to make me tired so I can get some sleep. Then, we usually go to bed about 11 and then I can't fall asleep, like I told you, I just toss and turn.

8) T: So your evening consists of having a nap, some coffee, some supper, you watch TV for awhile, and then you'll have a few drinks. How much would you normally drink in one week?

C: I don't know, not a lot, I'm not sure

9) T: Sounds like you find it difficult to talk about your drinking?

C: Yeah.

10) **T: I used to drink a bit too much: it caused a bunch of problems with my wife and job too**. **I got some help and I got things sorted out.** So what happens to you when you drink?

C: Well, sometimes I fight with my wife because she doesn't like to see me drinking so much. She says it's bad for me and it's a waste of money but it's not a big deal, it's not a problem.

11) T: Sounds like your wife doesn't like it when you are drinking. What happens when you go drinking with the boys?

C: I can get really loud and rowdy. Sometimes I'll get into fights if someone's looking at me the wrong way or gives me attitude. Sometimes I do stupid things like drive home when I'm really in no shape to be doing that.

12) T: So you can get yourself into trouble and you do things you regret later. Anything else?

C: I don't know. That's about it.

Appendix E: Post DVD Questionnaire

1. After viewing this section of the intake interview, and after imagining that you were the client, John, in this interview, would you want to continue treatment with this therapist?

_____Yes

_____No

2. Did the therapist in the DVD disclose something personal about himself?

__Yes, If Yes, What was it? _____

__No

3. Did the therapist and client in the session you watched have a good bond (also known as rapport)?

_____Yes

_____No

Appendix F: Demographic Questionnaire

1. What is your age?

__ Less than 25 years
__ 25-34 years
__35-44 years
__ 45-54 years
__ 55-64 years
__ 65-74 years
__over 75 years

2. In which area were you born?

__ Canada
__ United States
__ Central or South America
__ Australia or New Zealand
__ British Isles (England, Scotland, Ireland, Wales)
__ Western Europe
__ Eastern Europe
__ Middle East
__ Far East
__ Northern Africa
__ Central/Southern Africa
__ Other

3. Are you of Aboriginal descent?

__Yes
__No

4. What is your marital status?

__ Single
__ Never Married
__ Married
__ Living with a partner
__ Separated/ Divorced
__ Widowed
__ Unsure right now

5. What is the highest level of education you completed?

__ Grade 6
__ Grade 7-9
__ Grade 10
__ Grade 11
__ Grade 12
__ One year of university/college
__ Two years of university/college
__ Three years of university/college
__ Four years of university/college
__ Five years or over

6. Which of the following best describes your living arrangements before going to the treatment centre?

__ I lived in a residence
__ I was of no fixed address
__ I was incarcerated
__ Other, please specify _____

7. Who else lives in your residence with you? Check all that apply.

__ No-one, I live alone
__ Spouse/partner/common-law
__ Non-related room-mate
__ Children
__ Mother and/or Father
__ Brothers and/or sisters
__ Other relatives
__ Anyone else, please specify_____

8. Do you have a job to go to after completing treatment?

__ Yes, full time (at least 35-40 hours per week)
__ Yes, part-time (34 hours per week or less)
__ No
__ Retired
__ On disability

9. Are you attending the treatment centre as a requirement of a conditional release?

___ No
___ Yes, I am on parole
___ Yes, I am on probation
___ Yes, I am on statutory release
___ Other, please specify_____

10. Have you ever attempted residential substance abuse treatment before?

__ Yes
__ No

If you answered no, you are finished this questionnaire. If you answered yes, please answer the next two questions.

11. How many times have you completed residential treatment?

__1
__2
__3
__4
__more than 4 times

12. How many times have you quit residential treatment before the official end of it?

__1
__2
__3
__4
__5
__ More, please specify____

END OF QUESTIONNAIRE
Thank-you for completing this questionnaire.

Appendix G: Informed Consent Form

Hi, my name is Elise Reeh and I am doing research as part of the requirements of a doctorate degree in clinical psychology.

The purpose of this study is to examine how the bond one establishes with his therapist might affect dropout from residential substance abuse treatment. I am asking you to participate because you are attending substance abuse treatment so I need your input on this subject.

If you agree to participate in this study, you will be asked to

Listen to a brief introduction
Watch a 7 minute DVD on an intake session and
Complete two questionnaires

The total time it would take to participate in this study is approximately 30 minutes.

Participation in this study is voluntary. If you choose to participate, I will ask you to read this consent form and put a checkmark at the bottom of it to signify that you have read and that you agree to the information stated on this consent form.

Your name will be unknown to me (the researcher) and therefore will not be put on any of the questionnaires and will not be used in any of the reports about this study. Also, the data from this research will not be used for any other purposes other than for research.

If you choose to participate, you are free to withdraw at any time. If you do not participate in this study or if you decide to withdraw, there are no consequences to you. You will also not be paid or compensated for your participation.

This research will not expose you to any physical or emotional harm as the topics studied are not particularly sensitive. One possible benefit for you if you choose to participate in this study is that your responses may help to improve substance abuse treatment. Also, a signed consent form does not waive any legal rights nor does it release the program, staff and/or research project staff from liability for negligence.

You may keep this consent form if you wish. If you choose to participate, you will be asked to put a check mark on a copy of this consent form, which the researcher will keep.

Further Questions: Please feel free to ask me any questions about this study. If you have questions later, please contact me at Harriett.Reeh@Waldenu.edu.

Contact Information: The person conducting this research is Elise Reeh. The supervisor of this research is Dr. Rodney Ford. You can contact him at Rodney.Ford@Waldenu.edu.

If you would like to speak privately about your rights, please contact Dr. Leilani Endicott at 1-800-925-3368 ext. 1210.

Statement of Consent: I have read the above information. I have had all my questions answered. I consent to participate in this study.

_____
Place check mark here

_____
Date

Appendix H: Debriefing Statement

The study in which you participated in is about factors that may affect dropout. More specifically, the two factors that I am looking at are therapeutic alliance and therapist self disclosure.

Therapeutic alliance refers to the strength and quality of a collaborative client-therapist relationship (Horvath & Symonds, 1991). A strong alliance involves mutual feelings of trust, liking, and respect (Horvath & Symonds). It includes therapist-client agreement on the goals of therapy and the means by which clients achieve these treatment goals (Horvath & Luborsky, 1993). The introductory statement that I read either described a weak or a strong alliance. It is expected that people who form strong alliances with their therapists are more likely to finish therapy than people who form weak alliances.

This study is also looking at therapist self disclosure. Some groups saw a DVD of a therapist who disclosed that he also had struggles with alcohol addiction whereas other groups saw a DVD in which the therapist did not disclose. It is expected that people who feel they have a good bond with their therapists and who feel that their therapists are similar to them are more likely to complete treatment.

I'd like to ask you to not talk to the other residents who will be participating in this study about this study so that they participate in the study with a fresh perspective just like you did.

When I find out the results of this study, I will bring them to the centre and post them on the bulletin board for you. I will also post a date and time when I will present the results in person to all interested residents. If you have any questions about this study please ask me now, or if you think or them later, please email me. Thank-you for your time and effort, I really appreciate it.

Curriculum Vitae
Harriett Elizabeth Reeh

RELEVANT CAREER HISTORY

June 1996 to November 2010	**Correctional Services of Canada** Position: Registered Psychologist Duties: Conducting group and individual psychotherapy. Consulting, writing risk assessments and therapy reports. Responding to psychological crises, including self-harm and suicide attempts.
June 1995 to May 1996	**Calgary Remand Centre & NatFor (National Forensic and Medico-Legal Services)** Position: Provisional Chartered Psychologist in Alberta Duties: Same as above.
Jan 1995 to April 1995	**Young Offender's Centre** Position: Practicum Counsellor Duties: Conducting research and counseling as part of the requirements for Master's Degree
September 1993 to April 1995	**University of Calgary** Position: Graduate Teacher's Assistant in Statistics and Practicum Guidance Counseling Courses for Education Students in Bachelor Level Courses
May 1990 to April 1992	**Parents Anonymous** Position: Volunteer Crisis Line Responder Duties: Responding to crisis phone line for parents in distress.
May 1992 to August 1993	**Calgary Police Service** Position: Victim Assistance Crisis Line Responder Duties: Responding to crisis calls from victims of crime. One four month paid position and one year volunteer.
May 1993 to August 1993	**Calgary Police Service** Position: Researcher, Quality of Service Study Duties: With one other student, I developed a questionnaire, conducted a phone survey, completed & presented results.

ACADEMIC HISTORY

2005-2010	Walden University PhD, Clinical Psychology
1993-1995	University of Calgary M.Sc., Educational Psychology, Counseling
1991-1993	University of Calgary B.Sc. Honours Degree, Psychology (First Class Honours)
1989-1990	Mount Royal College University Transfer Program

PROFESSIONAL MEMBERSHIP

September 2002 – present	College of Psychologists of BC, Registered Psychologist #1656
June 1996 – September 2002	College of Psychologists of Alberta Registered Psychologist #2294
May 2008 to present	British Columbia Psychological Association

GRANTS

In 1993, I was a recipient of the Soroptimist's Scholarship for Outstanding Women. All Canadian women attending post-secondary institutions were invited to compete for this award. The final decision was based on academic excellence and community involvement (At that time, I had three years of volunteer experience for the Victim's Assistance Unit of the Calgary Police Service and Parents Anonymous)

In 1990, I was a recipient of the George Kerby Award for academic excellence.

PROFESSIONAL PRESENTATIONS

In 1995, I presented the results of my Master's thesis research at the AERA (American Educational Research Association) conference in San Francisco

PUBLICATIONS

Reeh, H.E., Hiebert, B.A., & Cairns, K. (1998). Adolescent Health: The Relationships Between Health Locus of Control, Beliefs, and Behaviours. *Guidance and Counseling, 13*, 3.

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THESES

Reeh, H.E. (1995). Adolescent Health Beliefs and Behaviours. Unpublished Master's thesis, University of Calgary, Alberta, Canada.

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