THE EFFECTIVENESS OF THERAPIST SELF-DISCLOSURE ON DRUG COURT ATTENDEES' PARTICIPATION LEVEL

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Abstract

THE EFFECTIVENESS OF THERAPIST SELF-DISCLOSURE ON DRUG COURT ATTENDEES' PARTICIPATION LEVEL

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This paper examines the relationship between DTC participant success and therapist self-disclosure. Through a review of existing literature, it concludes that DTC participants constitute their own culture and thus, require their own therapeutic approach. This paper studies the benefits and costs of therapist self-disclosure in the criminal justice system and how it applies to this specific demographic.

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Chapter One: Introduction

About 9.4% of the US population reported current illegal drug use on a recent survey (SAMHSA, 2014). That same survey found that 52.2% of the US population reported recent alcohol use. Alcohol and illegal drug use combined cost the US government over $400 billion each year (NIDA, 2015). And the national rates for overdose have steadily increased over the past 15 years, with heroin and prescription pain medicine overdose more than doubling. Most would agree that drug use in the US is a concerning problem that has not been solved by conventional methods.

While the U.S. has focused mainly on incarceration as a solution to reduce the availability of drugs, incarceration does not appear to have reduced the amount of drugs used. National Council on Alcohol and Drug Dependence estimated that about 80% of offenders for all types of crimes use drugs or alcohol and about 50% of inmates are addicts (NCADD, 2015). Fewer than 20% of offenders receive treatment for mental health or substance use disorders. As our prison population continues to increase, being either at or over capacity, criminal justice systems have been forced to consider treatment as another option in reducing crime related to drug and alcohol use. Over the last 30 years, diversion programs or court-mandated treatment has begun to increase in popularity, offering another avenue to recovery.

With the launching of thousands of Drug Treatment Courts (DTCs) in various cities across the country, the criminal justice system has finally taken steps to merge with therapeutic intervention (NDCI, 2011). This attempt to bring counseling and therapy to high-risk individuals has brought up a unique opportunity for counselors and therapists to serve a dual role as both social agent and healer. Because these clients are generally determined to be high risk, whoever is providing treatment will not only need to counsel, but also serve as case manager, coach, and

support while the client establishes and learns to maintain sobriety. While the stringent rules regarding therapist self-disclosure may still apply to the general population, flexibility is required when treating this new demographic. This study aims to explore the value of therapist self-disclosure among DTC attendees' participation rates.

It can generally be assumed that the more successful a participant is, the less likely they would be to reoffend, thus reducing the recidivism rate. This also assumes that reduction in drug use will lower recidivism as well. In order for therapists of DTC attendees to be effective, they first need clear understanding of what the population needs are, and this includes some modification of previously existing therapeutic approaches. For this study, participation refers to the client's own self-disclosure and completion of a DTC program. Currently, there is minimal research on court-mandated clients. This study aims to understand the relationship between therapeutic approach and success rate.

Statement of the Problem

The problem to be addressed is, does therapist self-disclosure improve outcomes among drug treatment court participants, and if so to what degree?

Definition of Terms

DTC (Drug Treatment Court): A structured treatment approach in which the courts have oversight of a client's progress. Drug Treatment Courts incorporate various levels of treatment including individual outpatient, intensive outpatient, day treatment, and residential treatment. Usually, clients receive some benefit when participating, whether it be expungement of a record or a lighter sentence. A DTC typically excludes violent offenders or high level drug offenders (Gifford, Eldred, McCutchan, & Sloan 2014).

Therapist: Any person holding a credential who provides counseling or therapy to clients with mental health or substance abuse issues.

Therapist Self-Disclosure: For purposes of this study, therapist self-disclosure refers to the disclosure of a personal recovery story.

Delimitations of Research

As there have been very few studies conducted with the use of a personal recovery story, this study is limited in its findings. Another limit is that demographics vary by the location of each study examined. In many studies, there is no control group to measure whether therapist self-disclosure is just as effective in clients who are not court ordered, or is there a control group to measure the ineffectiveness of therapist self-disclosure among DTC clients.

Method of Approach

A brief review of the origins and theories related to therapist self-disclosure was conducted. Both qualitative and quantitative research studies were reviewed. The cultural need of the therapeutic relationship of several different cultures was reviewed as well. Another review of literature on related research was conducted. The findings were summarized and recommendations made.

Chapter Two: Review of Related Literature

Introduction

Alcohol and drug use affect all areas of a person's life. Often the hopelessness, guilt, and resentment associated with addiction continue to cause relapse. For those who are especially high risk, this cycle becomes normal, even expected, and recovery can seem impossible. It is not only important to the individual to achieve sustained sobriety, but beneficial to society as well.

A relatively new approach to criminality associated with substance abuse is the introduction of drug treatment courts (DTCs). In 1989, at the height of the crack cocaine epidemic, the first drug treatment court opened in Miami, Florida (NDCI, 2011). Ten years later the National Drug Treatment Court Institute (NDCI) was founded, and almost 350 drug treatment courts were in existence. Now there are over 2500 drug treatment courts in operation nationally, serving over 70,000 clients at any given time. With the widespread success of drug treatment courts, it is important to revise therapist techniques and approaches with the needs of the population in mind.

Purpose and Effectiveness of Drug Treatment Courts

Drug Treatment Courts (DTCs) began as a means of preserving jail and prison space for violent, serious offenders by offering non-violent drug offenders treatment instead of incarceration (Evans 2011). Usually, offenders are able to go to treatment as a way to reduce their convictions or amount of jail time. Drug Treatment Courts combine the efforts of the criminal justice system and treatment professionals to reduce the recidivism rate of drug-related crimes (NDCI 2011). The belief is that individuals who resort to crime in order to meet the needs of an addiction will be less likely to reoffend if that addiction is resolved.

Often individuals who are higher risk, who cannot be safely or effectively monitored by standard probation, are the targeted candidates for drug treatment court participation (NDCI 2011). Brown and Glasman (2013) found that the most common crimes in DTCs are Possession (100%), forgery (80%) and theft (65%). Generally, violent offenders are not eligible for participation in a DTC program, nor are high-level drug offenders (Brown, et al 2013).

Many programs find that DTCs reduce recidivism which results in less spending of taxpayer dollars over time (Evans, 2011). Unfortunately, about 67% of U.S. states and territories report being underfunded and unable to meet the demand for treatment services (NDCI, 2011).

It is now widely accepted that treatment is more effective than incarceration in reducing recidivism. Studies have found that both crime and relapse of regular drug use are reduced among DTC participants, compared to other conventionally adjudicated individuals (Brown 2011). Gifford et al., (2014) found that even though violent offenders are excluded from DTCs, violent felony offenses decreased 1.3% among those who completed a DTC program versus those who started but did not complete. This implies that completion of a DTC program even reduced the risk of potential violence in the community.

Drug Treatment Court Participants' Barriers to Participation and Completion

Cosden, Baker, Benki, Patz, Walker and Sullivan (2010) interviewed 190 individuals from a county in Southern California who had either completed or dropped out of a DTC program and compared experiences that the individuals felt were most or least effective. Of the 190 people surveyed, 94 completed successfully and 96 did not complete their program. The study took one year and only individuals willing to share their experiences were interviewed.

The study found that the therapeutic relationship can serve as a support or a barrier to recovery. While 55% of those who completed the program successfully stated that group therapy was the most important intervention, 46% reported that the therapeutic relationship was a close second (Cosden et al, 2010). This included statements like, "It helped me to have counselors who have recovered themselves and know what it is like to recover" (Cosden et al, 2010, p. 1039). On the other hand, problems with staff was the most important reason participants who did not complete treatment failed. The results of this study illustrate how consequential the therapeutic relationship is.

Although it is important to assess the impact of a therapist's approach, one must also account for external factors that are not related to the therapeutic relationship. A second study found that education and employment are the primary barriers to participation and completion of DTC programs. Brown (2010) found that the primary reason participants did not complete treatment was because of unemployment and low educational attainment. He surveyed 355 participants of DTCs in one Midwest state from 1996-2004. Because of the conflicting literature, any one specific barrier is hard to identify as the most important, but it can be seen that the therapeutic relationship, employment, and education are important barriers to address in and after treatment.

Characteristics of Drug Treatment Court Participants

There is an overwhelming quantity of literature aimed at understanding who the typical DTC participant is and how to predict success. Several studies described below sought to identify psychological traits that might indicate level of need and expected outcomes. Some researchers study the socioeconomic factors that contribute to continued recidivism. In looking at

all of these different traits, histories, and identities, one can see the clear impact therapist self-disclosure could have on participants.

When looking at the background of a typical DTC participant, one must consider the neighborhoods from which participants come, as this influences an individual's drug of choice. Brown (2010) found that among DTC participants, those with a cocaine use disorder were at a significantly higher risk of reoffending than with any other drug of choice. The primary drug of choice in urban DTCs is cocaine or crack (NDCI, 2011). In suburban DTCs marijuana is the primary drug of choice, and in rural areas, methamphetamine is the drug of choice. As can bee seen by the national statistics, drug of choice is influenced by the type of community in which a participant resides.

One way to categorize DTC participants is to assess the correct level of risk for reoffending. Evans, et al., (2011) sought out indicators for higher risk characteristics in order to make accurate treatment recommendations based on an individual's level of need. In order to make an appropriate recommendation, researchers looked at DTC participant scores from the Addiction Severity Index (ASI) and Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) over a 30-month time span. The study argued that participants must be matched with appropriate treatment based on their level of need according to these two tests. Five counties in California were selected for this study, and clinical staff members conducted surveys on all DTC participants, which included over 1500 participants (Evans, et al. 2011). Researchers then gathered information on the individuals to assess whether or not they reoffended after completion of treatment.

The researchers assessed for level of risk at intake and monitored each individual for up to 30 months after intake (Evans et al., 2011). In determining risk, this study found that high risk

characteristics include being younger, being male, having a psychiatric condition, the number of arrests and convictions, and incarceration within the past 30 days (Evans et al., 2011). It is important to note that if low-risk participants were given treatment appropriate for high-risk behavior, recidivism increased. In some cases, where a higher of level of care was recommended than was necessary, participants were more likely to re-offend, thus making DTC more harmful and ineffective. So, when assessing for risk, it is important to consider age, gender, mental health history and legal record so that the correct level of care can be recommended, thus reducing the recidivism rate.

Another study attempted to identify psychosocial traits among DTC participants. Researchers used Latent Class Analysis (LCA) on over 1000 individuals to determine subgroups of DTC participants (Larson, Nylund-Gibson, & Cosden, 2014). This study examined risk factors related to mental health, education and employment in a county in central California between 2001 and 2012.

Larson, et al. (2014) found three distinct groups: Sub-threshold Need, Psychological Problems and Early Delinquents. The Sub-threshold Need group had lower likelihood of mental health issues and lower likelihood of early delinquency. This is the lowest level of need group, and the study found that they did worse if put in a treatment setting with too high a level of care, e.g., residential treatment (Larson, et al. 2014). The psychological problems group had a history of severe mental illness and was the highest need group. There were no detrimental treatments. The recommendation for this group was generally combined treatment of the substance use and mental health issues. The early delinquency group had a higher likelihood of offenses early in life, significantly lower graduation rates, and the highest level of recidivism (Larson, et al. 2014). This group experienced significant barriers vocationally and required more intervention

educationally or vocationally. This study showed that psychological and vocational needs must also be considered when assessing for the risk of reoffending.

Considerations for the Drug Treatment Court Therapist

The clinician who chooses to work within the criminal justice system has a very different role in the community than a typical outpatient therapist. Clinicians working with mandated clients are often faced with ethical dilemmas inherent in their role as therapist and social agent (Bitar et al., 2014). Bitar et al. (2014) argue that therapists working with court mandated clients are accountable to the criminal justice system at the same time they are accountable to their clients, putting them in a problematic double-bind at times. This might interfere with the therapeutic relationship if the counselor is seen as another authority in the criminal justice system hierarchy. Whereas a typical outpatient therapist is able to focus on the individual, therapists working in the criminal justice system have to also consider the risk to the community. This additional feature of the relationship could cause clients to be less comfortable self-disclosing.

Defining Therapist Self-Disclosure

Because therapist self-disclosure is a vital part of the therapeutic relationship with court mandated clients, it is important to identify limits within disclosing. There have been various definitions of therapist self-disclosure used in the literature. Some definitions refer to the amount of in-session disclosure of thoughts, feelings, and perspectives. Others refer to disclosure of specific details about the therapist's life and choices. For purposes of this study therapist self-disclosure refers to the therapist sharing his or her own recovery story, when applicable to the topic of discussion. The use of therapist self-disclosure continues to evolve as the population of those seeking treatment expands.

When the theoretical approaches to counseling were first formed, most discouraged any type of therapist self-disclosure. Sigmund Freud, the founder of psychoanalytic therapy, promoted what is sometimes called the blank-screen approach (Corey, 2013). It suggests that the therapist engage in essentially no self-disclosure, which would encourage the client to make projections onto the therapist. This technique made therapist self disclosure taboo, and posited that the void created between therapist and client would lead to the uncovering of unconscious issues that could then be solved (Ziv-Beiman, 2013). Since then, therapeutic approaches have evolved to encompass client-centered techniques which soften the rigidity of therapist-self disclosure.

The shift from early models of counseling to more client-centered treatment began with Carl Rogers increasing the use of self in the 1950's (Bitar, et al., 2014). Evidence-based methods, like cognitive behavioral models, encourage therapist self-disclosure to a degree (Ziv-Beiman, et al., 2013). Because there is an emphasis on creating a warm, egalitarian relationship, the therapist is required to be open and direct about their own beliefs when appropriate (Corey, 2013). This however, does not encompass the therapist's self-disclosure of a personal history. Regardless of the theoretical model, the goal of therapy is always to let the client speak more than the therapist. Sometimes it helps clients begin their own disclosures if therapists lead by example, however.

More recently, humanistic-existential approaches view therapist self-disclosure as a primary technique in problem solving (Ziv-Beiman, 2013). Here, the therapist is encouraged to disclose personal coping strategies, which is thought to help clients feel motivated to find their own authentic self and way of coping. It emphasizes a relationship where the therapist serves as

a guide, coach and role-model. While this therapeutic approach may seem unorthodox, the clientele in DTC programs are not typical outpatient clients.

The literature presents conflicting viewpoints about how therapist self-disclosure positively and negatively affects the therapeutic process. Ziv-Beiman (2013) in a review of literature, examined several areas of therapist self-disclosure: frequency, rationale, perceived efficacy, and effect on patient outcomes. This study found that limited self-disclosure is beneficial to clients in all five of the areas examined. Minimal therapist self-disclosure may be appropriate for the typical outpatient client. However, clients involved in repeated criminal offenses related to drug or alcohol use may require more extensive self-disclosure than does the general outpatient population.

When clinicians began experimenting with self-disclosure as an accepted practice, there were no guidelines for self-disclosure from an ethical or legal standpoint, which led to detrimental boundary crossing that would now be considered unethical (Gibson, 2012). For example, sexual disclosures have historically been considered unethical or irrelevant and not beneficial to the client. However, with the widely successful LGBTQ movement, this may be up for debate when it comes to counseling related to identity as an LGBTQ person. The point here is that in special cases a client might benefit from a disclosure previously thought to be unethical. Gibson (2012, p. 294) writes, "The professional codes have been altered in recent years to recognize the increasing flexibility of therapeutic boundaries in terms of self-disclosure". The disclosure needs to create warmth, without too much intimacy.

Boundaries between the therapist and counselor deserve consideration when choosing to disclose. One study found that self-disclosure was more beneficial than harmful, but that in instances where it was harmful, it was so because it led to role confusion. Audet and Everall

(2010) found that disclosures created uncertainty about the role of the counselor. It could be helpful to first ask the client if they mind if you relate a personal anecdote.

Building the Therapeutic Relationship

The most important task for a therapist working in any setting is to build a working therapeutic relationship. Bitar, Kimball, Bermudez and Drew (2014) argue that therapist self-disclosure facilitates a therapeutic alliance, including early connection to the therapist. Cosden, et al. (2010) found that early connection to the therapist was a crucial key in engaging court mandated clients a study that surveyed 190 voluntary participants after ending a DTC program in a southern California county. They discovered that 23% of participants who did not complete DTC programming left within the first month after being unable to form a positive therapeutic relationship. This indicates that early engagement and connection are vital to increased participation, completion of DTC programming, and essentially, reduced recidivism.

Another aspect of therapist self-disclosure in treatment with DTC participants is the need for authenticity. Bitar, et al. (2014) interviewed ten Mexican-American court-mandated clients in a phenomenological study. Their findings conclude that authenticity and genuineness are essential to building a positive, working therapeutic relationship. One way to express genuineness is to express thoughts, feelings and attitudes when appropriate (Corey, 2013). This client-centered belief holds that a client will form distrust if a therapist demonstrates incongruence. As can be seen, therapist self-disclosure aids in building the therapeutic relationship by aiding in early connection and establishing the genuineness of the therapist.

Addressing the Power Differential

Drug Treatment Court participants are generally familiar with the criminal justice system, as their risk of reoffending is established by having a history of repeat offenses. After continued exposure to authority in this way, it is natural that a DTC participant may view a therapist as another untrustworthy member of the criminal justice system. The perception of a counselor as another authority figure, sent to punish, is not conducive to a therapeutic working relationship. Hansen (2005) argues "a relationship which power imbalances are minimized can in itself be therapeutically beneficial" (p. 102). This makes it very important for the therapist to address the power differential and begin building the therapeutic relationship. One way to do that is by using therapist self-disclosure to clearly define and acknowledge the therapist's unique role and purpose at the beginning of a program, which will establish transparency and continued genuineness.

Therapists and clients in a court-ordered treatment setting are working in an environment where there is a distinct hierarchy. Ziv Bieman (2013) argues that self-disclosure allows the client to feel equal to the therapist, enabling therapist and client to relate on a human level. Bitar et al. (2014) suggests using therapist self-disclosure to soften the power differential in situations in cases where power dynamics are more pronounced than usual. Audet and Everall (2010) conducted a phenomenological study of nine individuals and found that disclosure did not eliminate the power differential, but reduced it. In this case, therapist self-disclosure equalizes the entities working within the therapeutic relationship.

Establishing Therapist Expertise

Often, therapist self-disclosure is deemed unprofessional or taboo by other clinicians (Ziv-Beiman, 2013). However, some may argue that participants might view a therapist with a recovery story as an expert in recovery since they were able to accomplish recovery. Audet and Everall (2010) conducted a phenomenological study of therapy with nine individuals. All but two individuals found that therapist self-disclosure made them feel more comfortable (Audet & Everall, 2010). The research also showed that in the two cases where therapist self-disclosure was not beneficial, clients felt the disclosure made their own therapy seem less meaningful. The self-disclosure changed the client's perspectives, placing the therapist in a subordinate role, rather than in the role of expert on the topic. As can be seen from these results, therapist self-disclosure must be administered skillfully so that the therapist's expertise is not at risk. When applied to a population that values life experiences, over education and status, expertise may be measured by experience, not book knowledge. However, therapists should take care to perform the self disclosure in a way that does not cause clients to doubt their expertise.

Empathy and Judgement

One goal of therapist self-disclosure is to alleviate feelings of shame or guilt the client might have. It can be argued that if a therapist has experienced a drug addiction, they would be less likely to make harsh judgments or criticisms of a participant struggling with addiction. This might encourage clients to self-disclose by promoting a safe space for the client to reveal parts of themselves that they feel shameful about. And perhaps the therapist has even greater empathy and deeper understanding of barriers for the client via shared experiences.

Patterson (1985) weighed the pros and cons of therapist self-disclosure. He found that comparison of the therapist's personal history to a client's could lead to the client's either positive or negative evaluation of: themselves, the severity of the issue, the validity of their thoughts and beliefs, and their self-esteem. On the other hand, Patterson says that therapist self-disclosure of differences could minimize the severity or legitimacy of a client's current struggle. The comparison a client might make internally could be positive or negative. It is also possible that the client would make a judgment of the therapist as a projection of the client's own feelings about addiction.

Another goal of therapist self-disclosure is to develop positive expectations and increase motivation for change (Ziv-Bieman et al, 2013). One goal of therapist self-disclosure is to inspire change. The message is usually along the lines of "I did it; so can you," thereby empowering the participant to set a higher expectation for the outcome of treatment. The client would then be inspired and motivated for sobriety while engaging in a working therapeutic relationship.

Cultural Considerations

Because the incarcerated population does not usually reflect the population as a whole, it is important to look at the needs of different demographics of DTCs. Perhaps the reason for low participation and completion rates can better be understood by making therapeutic interventions for this population more culturally competent. Bitar, et al (2014) argues that therapist self-disclosure helps alleviate cultural mistrust, demonstrates cultural competence, and establishes therapist expertness.

Counseling the Black community. When discussing the demographics of DTC participants, one must acknowledge that Black men are disproportionately incarcerated

compared to Latino and White men. According to the NAACP (2016), although five times more Whites are using drugs than Blacks, Blacks are sent to prison for drug-related offenses ten times more frequently than Whites.

Brown (2009) surveyed all DTCs in Dane County, Wisconsin by demographic in order to find trends. He found that Blacks have the lowest DTC completion rate compared to all other ethnic groups (Brown, 2009). Other characteristics that contribute to continued recidivism are cocaine being the primary drug of choice and lower education level. Both of these characteristics disproportionately apply to the Black community.

Sue and Sue (2008) have found that Blacks respond better to the use of metaphor and storytelling than to reading educational facts. They also recommend using music and poetry as a means to engage Blacks in sharing their experiences and feelings. Sue and Sue report that only nine percent of Blacks in the U.S. believe they are treated the same as Whites and identify a defense mechanism known as cultural mistrust. Because of this cultural mistrust, Sue and Sue stress that Blacks need transparency, authenticity and empathy from counselors. People of African American descent are especially reluctant to disclose to White counselors, choosing cautiously when and what to disclose. For the therapist, transparency begins with explaining the relationship between the counselor and the referring agency (the courts or probation agent in this case) and establishing an egalitarian relationship accomplished through self-disclosure.

Counseling the Latino community. Bitar, et al. (2014) found that therapist self-disclosure among court-mandated Mexican American clients increased bonding between client and therapist, modeled how to open up, leveled the hierarchy, and normalized client experiences. Because Latino values include equality, dignity, mutuality, reciprocity and respect, self-

disclosure is one way to establish safety and respect in the therapeutic relationship (Bitar et al, 2014).

However, Bitar, et al. (2014) found that males, especially, view sharing feelings as a sign of weakness and/or may not have had a role-model to show them how to disclose. This is especially relevant to counseling members of a culture that "might have a tendency to internalize dominant social norms that equate certain levels of self-disclosure as a feminine act of weakness" (Bitar et al, 2014, p. 423). It is important for the therapist to serve as a role-model and counteract the client's problematic perceptions of self-disclosure.

Counseling the Asian community. There is very little literature on Asian-Americans in DTC programs. However, it is important to note that egalitarianism in the relationship with a traditional Asian-American may be counter-productive to the therapeutic relationship (Sue & Sue, 2008). Due to the hierarchical nature of relationships within the traditional Asian family, leveling the hierarchy might make someone from this background uncomfortable. For this group, self-disclosure should be done with extreme caution.

Parameters of Self-Disclosure

So, therapist self-disclosure can be an effective tool, specifically for DTC participants, in evening the power differential, building a therapeutic relationship, and establishing expertise or credibility, but to what degree? How much should a therapist disclose, and how personal should it be?

Bitar, et al. (2014) found that therapist self-disclosure should be brief, offering up a personal experience that is relevant to the client in the moment and returns the focus back to the

client as soon as possible. If the point of self-disclosure is to increase motivation, whatever the therapist chooses to disclose must be relevant to the client's current struggle. After the disclosure, the therapist should return to how the disclosure relates to the participant. Gibson (2012) reiterates this same message, setting similar guidelines for use: use appropriate content, fit the disclosure to participant needs, and return the focus to the client afterwards.

Gibson (2012) states that disclosures should be used infrequently. Other research shows that the focus shifts from the client to the therapist if the therapist self-discloses too frequently (Knox, et al., 2003). By using therapist self-disclosure sparingly, the client may value it more when it is given.

Whether the majority of current day therapists approve of therapist self-disclosure because it is unavoidable or because they have found it beneficial, most believe that it "should be evaluated in the context of the specific therapeutic dyad and the specific timing within the process" (Ziv-Bieman et al, 2013). It is always of primary importance that the client benefit from the therapist's self-disclosure. If DTC participants build better relationships with therapists, learn how to self-disclose, and feel less shame when a therapist self-discloses, they may require some level of therapist self-disclosure.

Summary

In summary, therapist self-disclosure is a fairly well accepted practice among therapists, though it is used with caution. Not many agree with using personal history as a part of self-disclosure. However, therapist self-disclosure has the potential to level the hierarchy in therapeutic relationships, model self-disclosure, establish expertise, build the therapeutic relationship, demonstrate cultural competency, and engage clients early in treatment. Several of

these benefits are exponentially more important to participants of Drug Treatment Court programs, where participants are more likely to experience mistrust. Using therapist self-disclosure with DTC participants will likely have beneficial outcomes including higher completion rates and lower recidivism after completion.

Chapter Three: Conclusions and Recommendations

This paper examined the relationship between therapist self-disclosure and DTC completion rates. With the assumption that higher completion rates will yield reduced recidivism, predictions can be made. Although several factors contribute to the reduction in recidivism, a problematic therapeutic relationship need not be one of them. In order for therapy to be effective for participants who have developed mistrust of the criminal justice system, therapists must realize that a more personal level of self-disclosure is a tool for establishing trust, expertise and respect. More specifically, if a therapist shares a story of recovery, this has proved beneficial for DTC participants in planning their own recoveries.

The existing literature on the topics leads to the conclusion that DTC participants will be more likely to engage in treatment if the therapist chooses to self-disclose a story of their own recovery. One study found that the therapeutic relationship was the second most important part of treatment among DTC participants (Cosden, et al., 2010). It also found that problems with staff were the most important reason why participants dropped out of treatment. Another reason the therapeutic relationship is so important is the fact that therapists of DTC participants also work as a monitor or social agent. Therapists must work hard to establish trust as they engage the client in treatment, if an authentic representation of a participant is going to be given to the courts.

Often, a therapist is seen as another person of authority in the criminal justice system. Because of this, it is important that participants perceive a therapist as something of an equal. Sharing a recovery story levels the power differential and makes the therapist more relatable. It also establishes expertise by demonstrating that recovery is possible. Professionals with a

recovery story also serve as an example of what recovery entails. Sharing a recovery story also has the potential to ease any trepidation about judgement or criticism on the therapist's behalf.

In order to address the most effective treatment for DTC participants, the demographics and cultural needs of DTC participants must be examined. Blacks are disproportionately incarcerated compared to whites and Latinos. Some experts argue that even without involvement in the criminal justice system, cultural mistrust evolves as a defense mechanism. Because of this, Black clients require therapists who are especially transparent. Similarly, Latinos generally value dignity and equality, and would benefit from having a therapist who can address the power differential with self-disclosure.

Based on these conclusions, it is recommended that therapists working with DTC participants engage the client by means of some form of self-disclosure. A story of recovery or overcoming adversity seems to be the most effective. Some argue that this level of self-disclosure could be detrimental to the therapeutic relationship. However, one must realize that DTC participants comprise a unique culture, one that practices mistrust and skepticism as a means of survival and self-preservation. What is required of the therapist will be unique.

Limitations

Many of the articles examined here employed a predominantly White sample (Brown 2010). This may be representative of participants in DTCs. If so, this indicates that the population of DTC participants who are accepted into DTC programs is still not representative of the incarceration population, or even the population of drug related offenders who are incarcerated. This may, in part, be due to lack of resources and knowledge about DTCs among disadvantaged communities of color. Perhaps the same disparity applied to offenders of color in

policing are applied at admission to DTC programs. This could lead one to believe that DTC admissions processes need more scrutiny.

Much of the literature is qualitative in nature. There have been no controlled studies examining whether therapist self-disclosure is beneficial or detrimental in the context of DTCs. Such research would be difficult to perform, due to unique qualities of each counselor-client relationship, the varied goals of individual DTC clients, and the cultural issues at play. Standardization of self-disclosure is impossible, because it is born in the moment, part of the art of counseling, more than the science of counseling.

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