The Impact of Shame on Medication Assisted Therapy Treatment Outcomes for individuals with a Severe Opiate Use Disorder.

Cameron Davis McClure

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

Year: 2023

The Impact of Shame on Medication-Assisted Therapy Treatment Outcomes for Individuals with a Severe Opiate Use Disorder.

Cameron Davis McClure

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University, Lynchburg, VA

Year: 2023

Approved by:

Gary Probst, Psy.D, Committee Chair

Albert Sarno, PhD., Committee Member

Abstract

Shame has a significant impact on various psychopathologies including depression (Pinto et al., 2012), anxiety, and posttraumatic stress disorder (Bryan et al., 2013). The gap in this research is the quantitative impact of shame on the relapse cycle in individuals with a severe opioid use disorder. This research study will demonstrate the impact of shame on the expression of addictive behavior in patients that have a diagnosed opiate use disorder and are currently actively enrolled in a medication-assisted therapy treatment program. This research study will illustrate how the presence of increased therapeutic alliance strength can result in the reduction of addictive behavior and shame. This proposal seeks to establish shame as a predictor of addictive behavior. Showing how, even when the biological use cycle is considered with the use of well-established pharmaceutical therapies, the impact of shame is so great that addictive behaviors increase. This study will explore research surrounding the impact of shame on opiate use disorders, the development of therapeutic/working alliances, and the role that this relationship has on shame reduction and the reduction of addictive behaviors.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Post-traumatic stress disorder (PTSD)

Working Alliance Inventory(WOI)

Therapeutic Alliance(TA)

Test of Self-Conscious Affect-3 (TOSCA-3)

Dialectic Behavioral Therapy(DBT)

Cognitive Behavioral Therapy(CBT)

Motivational Interviewing(MI)

Medication Assisted Therapy(MAT)

Chapter 1

Overview

Shame is a series of negative emotions surrounding a person's image of themself. The presence of shame has been seen to exacerbate and possibly cause other mental health disorders. This research will focus on the relationship between shame and the presence of positive symptoms documented in clients with an opiate use disorder who are enrolled in a medication-assisted therapy program. The research will focus on the predictive nature of shame and negative treatment outcomes as well as therapeutic alliance strength and its ability to predict positive treatment outcomes.

Background

The body of research indicates that the presence of increased shame is consistent with an exacerbation of symptoms of depression and an increase in paranoia (Pinto et al., 2012). The exacerbation of depression symptoms and paranoia are linked to the presence of shame memories throughout the patient's life (Pinto et al., 2012). The shame memories are often associated with severe trauma and result in an increased presence of internal and external shame (Pinto et al., 2012).

The presence of trauma is the key element for the diagnosis of post-traumatic stress disorder and the presence of shame can exacerbate the negative feelings associated with trauma increasing the frequency of suicidal ideation, depression, anxiety, and post-traumatic stress disorder in military personnel (Bryan et al., 2013).

Shame and guilt have a significant association with anxiety, depression post-traumatic stress disorder, and suicidal ideation however, guilt showed greater predictability of suicidal ideation than shame (Bryan et al, 2013). The significance of this relationship between shame and trauma could be used as a predictor of an exacerbation of depression, anxiety, and PTSD symptoms in military personnel (Bryan et al., 2013). Shame can also create a significant impact on the expression of symptoms for those diagnosed with a mental health disorder (Owen & Fox, 2011). Shame is defined as a feeling of self-deprecation that continues to develop into intense feelings of worthlessness (Owen & Fox, 2011).

In juvenile offenders, high levels of shame are associated with increased aggression, malevolent behavior, and overall misplaced aggression (Owen & Fox, 2011). Impulsivity frequently accompanies increased aggression and malevolent behavior in juvenile offenders (Owen & Fox, 2011). The use of illicit substances and addictive behavior are also frequently impulsive. As feelings of shame increase for someone in remission from severe opiate use disorder, an increase in potential relapse over time is present due to the increased impulsive behavior associated with the trauma and shame (Owen & Fox, 2011). This increase in addictive behavior eventually results in use and relapse directly stemming from poor impulse control and maladaptive coping associated with shame trauma (Owen & Fox, 2011). By reducing shame, over time a reduction in addictive behavior/relapse behavior and a return to baseline shame can be seen.

Problem Statement

There is a well-documented impact of shame on various psychopathologies such as depression (Pinto-Gouveia, et al., 2012), and post-traumatic stress disorder (Bryan, et al., 2013), however, one area that is lacking is the quantitative impact of shame on the relapse cycle in individuals with a severe substance use disorder. By discovering a significant relationship between the presence of shame and relapse in individuals with a severe use disorder the way treatment is approached could be significantly impacted. As the strength of the relationship between addictive behavior leading to relapse and shame is studied and defined additional means to effectively treat clients impacted by shame while in recovery are needed.

There is documentation that shows shame having a positive correlation to an increase in symptoms of mental health disorders symptoms (Pinto-Gouveia, et al., 2012). Based on this body of research there is an indication that a correlation between increased shame and mental health disorders exists, the same should be true when this information is applied to individuals with a substance use disorder.

As shame increases the presence of addictive behavior will also increase eventually leading to a relapse. If there is a causal element to the relationship between shame and addictive behavior, then by reducing the presence of shame there should also be a reduction in the presence of addictive behavior.

A strong therapeutic alliance will show the client and the therapist agree on the direction of therapy, long-term, and short-term goals. This allows the client and therapist to feel that they are both working toward a common goal as a part of a team. T

This would indicate a negative correlation between the strength of the therapeutic alliance and the development of increased shame. There is a significant lack of research that looks at the impact of shame and its impact on clients with a severe opiate use disorder in medication-assisted therapy. There is also a lack of research that shows a relationship between shame and the therapeutic alliance as it relates to addictive behavior and relapse.

Purpose Statement

The purpose of the study is to discover the significance of the relationship between shame and addictive behavior leading to relapse in clients with a severe opiate use disorder who are actively engaged in a medication-assisted treatment program. Moving a step further this research will also focus on ways to reduce the impact of shame on addictive behavior by strengthening the therapeutic alliance between the clients and the counselor. An additional purpose of this study is to impact the treatment methodologies that are currently in practice nationwide. If the relationship between shame and relapse is significant then focusing on shame in the therapeutic process may reduce overdoses. The most significant purpose of this study is the purpose to save lives by developing a treatment plan and modalities that will reduce shame impacting the response to recovery.

Significance of the Study

This project focuses on two impacts on the population being studied. The impact of shame on addictive behaviors in individuals with an opiate use disorder and the impact of a strong therapeutic alliance on addictive behaviors in the same population.

A strong therapeutic alliance has a positive impact on several mental health disorders including depression, anxiety, adjustment, and personality disorders (Munder et al., 2010). If

shame is seen as a predictor of maladaptive behavior (Owen & Fox, 2011), and a strong therapeutic alliance is seen as a predictor of the successful treatment outcome (Munder et al., 2010), it can be hypothesized that a strong therapeutic alliance and high feelings of shame would be unable to exist in the same space. Therefore, it is the goal of this study to show that increased shame will predict an increase in addictive behavior and increased therapeutic alliance strength will predict both a reduction in addictive behavior and shame.

Therapeutic alliance strength can serve as a predictor for positive treatment outcomes. One challenge is the presence of significant mental health comorbidities with a significant impact on the completion of an opiate treatment program (Bickel & Petry, 1999). When the presence of the comorbid mental health disorder is so severe that it impacts the use behavior and attrition rate of the client the significant impact of the therapeutic alliance became more clear showing that among those with a moderate to severe mental health disorder, the completion rate was 25 percent when the client had a weak therapeutic alliance and 75 percent when the alliance was strong (Bickel & Petry, 1999).

To achieve the goal of illustrating the predictability of certain behaviors based on the therapeutic alliance, the researcher will use Working Alliance Inventory (WAI), and the TOSCA-3 as a measure of shame and working alliance strength. The researcher will draw from various models of counseling to increase the bond between counselor and client, increase agreement on tasks, and agree on treatment.

The use of Dialectic Behavioral Therapy's acceptance-based approach, in conjunction with Cognitive Behavioral Therapy and behavior modification, develop a stronger therapeutic alliance in juvenile offenders in a longer-term incarceration setting (Fasulo et al., 2015). The

development of a strong therapeutic alliance is the first goal a therapist should strive for in session (Fasulo et al., 2015).

Motivational Interviewing techniques illustrate and increase the bond between client and counselor (Miller & Rollnick 2012). Due to the non-directed approach to Motivational Interviewing, the client and counselor are frequently in agreement on tasks and goals (Miller & Rollnick, 2012). The effective use of treatment modalities including but not limited to MI, CBT, and DBT will present a possible increase in the strength of a therapeutic alliance. The specific tools that will allow the client and therapist to build rapport, trust, and a bond in the therapeutic relationship will be laid out within the body of research. The importance of developing a non-judgmental atmosphere and a team approach to recovery with the client and therapist will be key in establishing the bond to increase the therapeutic relationship and combat the severe impact that shame has on the client's recovery.

Highlighting ways to increase the therapeutic alliance in the counseling experience, this project will focus on making a naturally occurring relationship more intentional and therefore more impactful. Research shows a significant relationship between shame and several other mental health disorders. This research will show the significance of opiate use disorder and show that the intentional focus on the therapeutic alliance between the therapist and the client will show a significant reduction in behaviors that precede relapse.

Research Questions

RQ1: Does a significant relationship exist between the presence of increased shame and the expression of addictive behavior that is defined as a relapse?

RQ2: If such a relationship exists then what is the level of impact and how can a counselor effectively impact the level of shame to stop the increase and reduce the presence of additive behavior?

Definitions

1. Therapeutic Alliance- The Working Alliance Inventory is developed to measure the strength of the working/therapeutic alliance by measuring 3 sub-scales; bound, agreement on goals, and agreement on tasks in therapy (WAI © A. O. Horvath 1981, 1984, 1992). This scale will be used to define the therapeutic alliance.
2. Shame is defined as a severe negative self-perception. This indicates that a person experiences a severe negative impacted by how they perceive themselves as a person. This will be measured in the term of shame proneness as seen in the TOSCA-3 Scale.
3. Addictive Behavior: is defined in this study as missing appointments without notice, overusing medication, not taking, or diverting medication, a urine drug screen indicating the use of opiates, and admitting using of opiates.
4. Biological Use Cycle: This is the cycle of cravings, use, and withdrawal that takes place in individuals with a severe opiate use disorder. The participants in the study will be individuals that have reported that this biological use cycle is well maintained by the medication.
5. Positive Treatment Outcome: This is a reduction in addictive behavior or remaining baseline compliant in all tested treatment goals.
6. Negative Treatment Outcome: An increase from the baseline of addictive behavior during an allotted time frame or the removal of the client from treatment against clinical advice.

Summary

The impact of opiate use disorder is commonplace today and is exhibited daily in the media. The purpose of the study is to continue to develop research that identifies exacerbations of opiate use disorder and examines shame as a major contributor to this exacerbation and identifies it as a cause of addictive behavior in individuals dealing with an opiate use disorder on medication maintenance therapy. Following the identification of shame as a cause of increased addictive behavior this research will study the impact of a strong therapeutic alliance on reducing the presence of shame and therefore reducing the presence of addictive behavior.

Chapter 2

Overview

The research in this review will show the significant impact that shame has across several mental health and substance use disorders. The research shows that shame will increase the presence of other exacerbators such as personal withdrawal and stigma. This research shows how shame can significantly increase the duration and severity of symptoms while also reducing the impact of treatment measures. The research also shows the significance of the therapeutic alliance and its ability to reduce the impact of shame by reducing the feelings of isolation that a central to feelings of shame.

Conceptual and Theoretical Framework

Motivational Enhancement Interviewing is a client-centered nondirective approach that is frequently used in substance use treatment. The reason Motivational Interviewing is at the center of the theoretical framework of this project is because the core principles of Motivational

Interviewing are Partnership, Compassion, Evocation, and Acceptance (Miller & Rollick,2012). The principles are at the center of the development of a strong therapeutic alliance and are key to the structure of the hypothesis being proposed. The partnership shows clients that they are not alone and that the therapist is on their side for this therapeutic journey. A core principle of the Working Alliance Inventory which measures the client and therapist's level of mutual goal setting and agreement also relies heavily on developing partnership in the therapeutic process (Horvath, & Greenberg,1989). Acceptance and Evocation both speak to the nature of meeting the client where they are and working to aid the client in recognizing their self-worth and discovering the strength within that is needed to enact meaningful change (Miller & Rollick). These principles stand in opposition to the isolated nature of shame. Compassion is the final portion of MI which connects with the individual on a personal human level elevating the client's self-worth while also showing a willingness to meet them where they are to walk the journey of change further reducing the feeling of isolation. Compassion is actively working to promote a person's well-being (Miller & Rollick,2012). In the spirit of motivational interviewing, this project will identify the areas where the client is having difficulties with shame and addictive behavior and, through the development of a strong therapeutic alliance ,develop an environment that will reduce the impact of shame and allow for the client to reduce the presence of addictive behavior.

The second theoretical framework is based on the theory of Behaviorism. John Watson, the father of Behaviorism, notes there is a predictability to human behavior when the same stimulus results in similar reactions. An example is someone seeing a red light and then receiving a shock to the hand. Eventually the individual will move the hand before the shock at the sight of the light (Watson, 2017). Watson operates from the premise that a stimulus generates a certain

reaction and if repeated over and over, this behavior will strengthen. This is closely related to the idea of a biological use cycle, the concept that as an individual uses a substance and has a euphoric experience, they are conditioned to repeat the process. As the euphoria is diminished, through tolerance, they are conditioned to use more and if there is a negative response to not using, for example, withdrawal symptoms, then the person will be conditioned to begin use again to stop the negative reaction. Watson focused on the environmental stimulus giving little regard for the genetics of the individual, although it is believed that genetics play a significant role in the presence of addictive behavior, it is also important to note that the quantity of substance use, frequency of dosing and length of time using also are regarded as significant factors in addiction.

The third and final piece of the theoretical framework is the theory of Cognitive Behavioral Therapy. Where behaviorism is limited to a stimulus-response format, the CBT approach uses a stimulus, cognition, and response approach (Sarno, 2014). This formula suggests that individuals may be stimulated or triggered to use either due to genetics, a physical reaction, or psychological impulse but they can use cognitive thoughts to have varying reactions. The likelihood of an individual in full physical withdrawal not seeking physical relief is very small. This is why, when combing all aspects of this framework, the project will control for the physical stimulus by only working with a population on a controlled medication, using Motivational Interviewing to increase the therapeutic alliance while also employing cognitive behavioral therapy techniques to reduce the presence of shame to decrease the presence of shame and subsequently addictive behaviors.

Related Literature

Shame causes individuals living with addiction and comorbid mental health issues to experience an exacerbation of symptoms. How a client views different events in their life

impacts the development of behaviors that lead to relapse or an extension of a relapse (Prosek et al., 2017). Research indicates that shame can significantly impact the presence of symptoms of depression, anxiety, and schizophrenia (Keen et al., 2017). As the presence of shame impacts the presence of symptoms of mental health disorders it is hypothesized that shame will impact the presence of symptoms of addiction.

Shame is considered a self-conscious emotion and runs deeper than basic emotions such as anger or anxiety because, shame requires self-awareness and a sense of self-identity (Black et al., 2013). Developing ways to measure shame and how shame can impact behaviors that affect symptoms of mental health is important to prolonged research on this subject (De France et al., 2017).

Complex self-conscious emotions like shame, guilt, and pride are greatly impacted by the client's perception of themselves (Black et al., 2013). The perception that a client has of cravings and other addictive behaviors could also potentially impact the presence of shame in a client's life, acting as a catalyst for increased shame (Gubi, & Marsden-Hughes 2013). Perceived stigma in the diagnosis and treatment of addiction and comorbid disorder increases feelings of shame (Luoma, et al., 2014). The increase in perceived stigma resulted in longer residential stays in therapy and continued reductions in the client's ability to progress in therapy (Luoma, et al, 2014).

This body of research works to prevent feelings of stigma and shame that may come about during treatment and work to reduce these feelings through the development of a stronger therapeutic alliance. If the client and therapist can form a stronger therapeutic bond early in the

session, then it is hypothesized that the attrition rate and addictive behaviors in therapy will decrease resulting in higher successful completion and overall success in recovery.

The presence of shame causes an exacerbation of symptoms of several pathogenies, as shame can also be a barrier to treatment progress due to the development of a treatment stigma (Wallhed Finn, et al., 2014) By working to reduce shame in the client, a reduction in the presence of stigma will be present, which if not reduced, continues to exist as a barrier to treatment progress (Wallhed Finn, et al., 2014).

Self-criticism is a symptom that can evolve into feelings of shame causing lasting difficulty in the client's treatment process and outcome in recovery (Brennan, et al., 2015). The presence of self-criticism can also develop into a stronger resistance to change, increasing ambivalence to the change process and reducing the chances of a favorable outcome (Brennan, et al., 2015). The physiological response to shame results in an increase in stress hormones resulting in negative emotional responses and further increased feelings of shame (Lupis, et al., 2016). During a long-term medical health crisis an individual can experience many negative emotions that increase the likelihood of experiencing anxiety, depression, and other mental health disorders (Carr, et al., 2014). The body of research continues to examine the impact of shame that the client feels and how a counselor can impact the development of this shame (Wallhed Finn, et al., 2014). The counselor's interaction with the client can directly impact the level of shame that a client feels (Wallhed, et al., 2014). It is hypothesized that if the counselor and client can form a strong therapeutic alliance a significant reduction in negative behaviors will take place. In connection with other addiction disorders, shame, and stigma are thought to be significant barriers to progress in treatment for alcohol use disorders (Wallhed Finn, et al., 2014). By working to reduce shame in the client these barriers to treatment can be reduced.

Shame is defined in this study as having chronic negative feelings concerning a person's view on their self-worth and worldview. Post-traumatic Stress Disorder and Dissociative Identity Disorder are possibly caused by increased trauma in a person's life which also increases their level of shame (Dorahy, et al., 2017). This study also indicates that the increased trauma that is present in these disorders will also indicate an increased presence of comorbid disorders including substance use disorders (Dorahy, et al., 2017). The feelings that are associated with the presence of the trauma that is brought on by the development of mental health and substance use disorders can also be exacerbated by the presence of shame memory (Matos, et al., 2012). Individuals with chronic psychological disorders that present with psychotic features or psychosis experience varying levels of stigma, reducing their desire to seek treatment and prolonging symptoms (Wood, & Irons, 2017). The stigma of chronic substance use could have the same effect on the development of shame as it does on individuals with chronic psychosis. Increased self-stigma is a powerful force that can negatively impact progress in treatment by working to increase acceptance. Then, a therapist can work to assist the client in reducing self-stigma and increase the effectiveness of treatment (Luoma, et al., 2008). Substance use disorders have a physiological component to the disorder causing isolation of the individual as shame increases (Rance, et al., 2017).

When treating an individual with a substance use disorder, the use of Motivational Interviewing and the development of a therapeutic alliance is a widely used treatment modality and is considered highly effective at reducing the frequency, and duration of substance use and abuse (Miller, & Rollnick 2013). The development of a strong therapeutic alliance can be negatively impacted by an increase in a sense of shame in the client (Black, et al., 2013). By engaging with the client and reducing the presence of shame a counselor will be able to continue

to build an effective therapeutic alliance increasing the effectiveness of treatment (McCabe, et al, 2013). Building a strong therapeutic alliance is also vitally important to increasing engagement and retention in the treatment process (McCabe, et al, 2013). The client's continuation of treatment and effectiveness in treatment should also increase while reducing stigma simultaneously (McCabe, et al, 2013). Shame also impedes the assessment and diagnostic process in the treatment of mental health disorders (Keen, et al., 2017).

Working to determine the presence of shame is best accomplished with the use of a scale that can accurately measure the level of shame (Schalkwijk, et al., 2016). Once the connection is made that indicates shame can impact the presence of relapse behaviors in people that are dealing with a severe use disorder then working to reduce the presence of shame is even more imperative. Developing tools to all allow a client to learn to better self-regulate negative feelings can be useful when trying to reduce shame (Schalkwijk, et al., 2016). The response that a therapist exhibits when a client discloses feelings of shame can impact the effectiveness of care (Dorahy, et al., 2015). This study examined the perceived helpfulness of the responses of the clients when the clients disclose feelings of shame (Dorahy, et al., 2015). The result was that the greater the shame, then the greater tendency for withdrawal by the therapist, and withdrawal was noted as being the least helpful response (Dorahy, et al., 2015).

When working to measure the presence of shame in a client an effective scale must be employed to complete this task. The Working Alliance Inventory is a widely used scale that has been translated into multiple languages and is regarded as an effective tool for measuring (Munder, et al., 2010). The working alliance inventory uses three subscales to measure the working alliance: agreement on tasks, agreement on goals, and the development of a bond between the client and the counselor (Munder, et al., 2010).

Empathy is a person's reactions to other individuals' expressions (Ruckstaetter, et al., 2017). When empathy is employed and a client feels that the counselor is "on the client's team" a strong therapeutic alliance can be developed and ambivalence can be resolved (Miller, & Rollnick 2013). When working to reduce shame in a client the use of empathy is an effective tool to achieve this goal (Ruckstaetter, et al., 2017). When a client experiences empathy from the counselor there will be a shame reduction and the effectiveness of the empathetic responses is particularly seen in crises such as a relapse. During a crisis, a client who has a shame reduction will see an increase in the effectiveness of care and respond to treatment better.

Shame is described as linked to a person's global focus on self (Owen & Fox 2011). Shame is related to the way a person sees themselves and their personal worldview (Owen & Fox 2011). The negative self-perception that develops into greater levels of shame is often expressed in more maladaptive social behaviors (Owen & Fox 2011). In contrast, empathy is believed to be essential for normal social behavior (Owen & Fox 2011). When working with individuals with a substance use disorder the maladaptive social behaviors associated with the illicit use and abuse of drugs represent an increase in symptoms of the disorder. If a counselor works to express empathy and foster an atmosphere that is conducive to the client receiving empathy, then the risk for maladaptive behavior should be mitigated. Increasing the effectiveness of care by reducing the presence of symptoms will allow the client to experience higher self-worth reducing shame and increasing stability in recovery. As shame increases, the effectiveness of treatment reduces. To increase the effectiveness of care and reduce shame the development of a strong therapeutic alliance is imperative (Easter, et al 2016).

Shame is described as an intensely negative emotion rooted in self-consciousness (Gao, et al., 2010). The body of research consistently indicates that shame lies within the perception

that a client has about themselves and is linked to their perception of self-worth. An important consequence of shame is social disengagement (Chao, et al., 2011). The individuals that feel more shame will be less likely to engage with other individuals or work with a partner to complete tasks (Chao, et al., 2011).

When shame proneness is present in the life of a child the likelihood of this individual participating in high-risk behavior increases (Stuewig, et al., 2015). Risky behavior includes but is not limited to substance use, increased sexual behavior, and criminality in adolescence (Stuewig, et al., 2015). In contrast, guilt-proneness in childhood showed a reduction in risky behavior in adolescence (Stuewig, et al., 2015). Shame can take root in any part of the client's life and the impact of this shame can reverberate throughout the client's life. The impact of this shame in early childhood results in the client experiencing failures throughout their early life leading to increased shame. (Stuewig, et al., 2015). As shame increases throughout the child's life the age at which the child uses alcohol or illicit substance also decreases and aggression will increase (Stuewig, et al., 2015). Working with a client to reduce the impact of shame in their life at an early age can result in a reduction in risky behavior.

Other research indicates that the response to shame in childhood can vary depending on internalized or externalized shame with internalized resulting in withdrawal from others and the environment (Thomaes, 2007). Externalizing shame results in narcissistic behavior, altered self-perception, and increased aggression. As the client perceives external behaviors these negative behaviors increase (Thomaes, 2007). When a client is experiencing shame, it can continually result in increased negative behaviors and if shame is reduced these behaviors should reduce.

When an individual is experiencing the symptoms of a substance use disorder obsessive thoughts about using can become a frequent occurrence. Working to resolve these feelings, yet

still experiencing, them could result in feelings of shame and guilt. Continued use while exhibiting addictive behavior can often feel repetitive and ritualistic. By working to reduce the feelings of obsession associated with substance abuse the risk of comorbidity with other mental health disorders such as anxiety and depression could be mitigated (Moritz and Jelinek 2011).

When working in the field of counseling it should be a common practice that the accepted mode of therapy concentrates on the whole person. When examining substance use disorder from a holistic perspective it may be seen as both an expression of a mental health disorder and a moral issue, which may cause guilt, shame, and reduced empathy, when combined play key roles in moral development (Silver, et al, 2008). By employing empathy in the therapeutic relationship, the counselor can work to develop an alliance that may reduce feelings of shame in a moral crisis. The effectiveness of treatment can increase significantly when the correct tools are employed for the right issue and person. The use of corrective experience is defined as "ones in which a person comes to understand or experience effectively an event or relationship differently and unexpectedly" (Roussos, et al., 2017). The use of this tool can assist the clients in better understanding the experiences that they have had and assist in changing their perspective (Roussos, et al., 2017).

The study used both pre-interview surveys and post-session interviews to gauge the response of the client to the intervention. The way that a client perceives their recovery journey will impact the effectiveness of treatment. The concept of lapse, relapse, and recovery have been examined, and mean different things to different people (Maffina, et al., 2013). By working to understand the client's perspective on recovery, the counselor can work to assist the client in developing treatment goals and increase the strength of the therapeutic alliance.

To properly treat an individual for a substance use disorder or mental health disorder, a holistic approach must be taken, including addressing mental, physical, and spiritual factors (Klingemann, et al., 2013). This use of expression addresses spiritual struggles and perspectives in treating trauma and reducing the presence of compulsive behavior (Sarno, 2009). This study explores religious behavior from the client's perspective and notes that the clients indicate that the use equates to deviating behavior in some perspectives (Klingemann, et al., 2013). By working to change the focus from deviant behavior to a symptom of a disorder then the shame that is experienced could be reduced.

In substance use treatment it is not uncommon to hear a client justify continued use after a lapse due to the continued feeling of loss and shame. Forgiveness specifically self-forgiveness is essential in stopping the progression from a lapse to relapse (Rangcanadhan and Todorov, 2010). Self-forgiveness has an important relationship with empathy, shame, and guilt, all these emotions are routes to self-forgiveness and reconciliation, however, the most effective is empathy (Rangcanadhan and Todorov, 2010). Forgiveness is essential to move past and learn to cope with a transgression on the behavioral level which produces guilt. Forgiveness for another is helpful but, self-forgiveness is much more effective at learning to cope with and move beyond these negative behaviors (Rangcanadhan and Todorov, 2010). To foster an atmosphere that is conducive to self-forgiveness a strong therapeutic alliance must be formed. The development of this alliance allows trust to build and self-healing to take place (Long, et al., 2016). The development of the therapeutic alliance allows the client a haven to disclose things that they would not normally disclose (Baumann, & Hill, 2016). The nature of this secrecy can breed feelings of shame and doubt. Working to foster a relationship that allows for this type of disclosure and reduces shame will increase the effectiveness of care (Baumann, & Hill, 2016).

Clients can benefit from a therapeutic alliance providing better motivation, coping strategies, social support, and a secure attachment style (Meier, et al., 2005). These findings also indicated that the relationship to the counselor's characteristics was not clear. Clients rated their relationships with counselors for recovery as better for experienced counselors and male counselors, believing they are stronger, while more experienced counselors rated their alliances as weaker (Meier, et al., 2005). This demonstrates the potential frustration of counselor matching and perceptions of counselor abilities for the working alliance and the counselor's own doubts.

Motivational Interviewing has been effectively used for reducing ambivalence and increasing the motivation for change in clients (Miller & Rollnick, 2002). The success of Motivational Interviewing is well documented but, there is little evidence of how it works (Faris, et al., 2009. An atmosphere of empathy and building a therapeutic alliance align to enhance the client's positive perspective while reducing ambivalence and shame allowing the client to actively influence the course of treatment (Faris, et al., 2009). Existential therapy is also non-directive and does not force a focus on change. After therapy, the perspective of the client is evaluated, concerning the most significant parts of therapy. The client benefits from a non-judgmental attitude, validation of the emotional experience, and knowledge shared by the therapist (Oliveira, et al., 2012). After completing therapy two the three most important factors for success are attributed to the client's perspective on the counselors' reactions in therapy (Oliveira, et al, 2012).

When treating individuals with an opiate use disorder medication-assisted therapy is a frequent component of treatment. It is debated that the use of medication alone is sometimes sufficient to treat a client with this disorder noting that most frequently combination therapy and

medication are most effective but, individuals must have individualized treatment and that may not always call for counseling (Day & Mitcheson 2017).

A tool that can be used to achieve the goal of increasing treatment effectiveness through the development of a strong therapeutic alliance is calculated self-disclosure. When using self-disclosure, it is important that the client does not perceive the self-disclosure as a violation of boundaries (Audet, 2011). Specific counselor behaviors have yet to be identified that increase or decrease the therapeutic alliance but the impact that a counselor's behavior has on the therapeutic alliance is well documented (Duff, & Bedi, 2010).

Acceptance and Commitment Therapy is centered on behavioral therapy, mindfulness, and relational frame theory (Gutierrez, & Hagedorn, 2013). This form of therapy is an evidenced-based therapy that works specifically to reduce shame in individuals dealing with psychopathologies that seem to have roots or are exacerbated by shame (Gutierrez, & Hagedorn, 2013).

By using the client's resources for motivation, problem-solving, and being goal driven the motivational interviewing modality can allow the clients to develop tools that will aid in reduced feelings of ambivalence and increased motivation for change in the recovery process (Faris et al. 2009). Motivational Interviewing focuses on the development of the client's motivation to change and resolving the client's ambivalence to the change process working to facilitate growth as the client moves from a place of pre-contemplation to contemplation into action and eventually to the maintenance phase of change (Miller & Rollnick, 2013). As a client moves through the stages of change the awareness of the process and willingness to work increase until the behavioral changes that are seen in the initial phases of change feel like second nature in the final stage of change (Miller & Rollnick, 2013). Motivational interviewing can

work in a brief intervention setting and can complement a variety of other treatment modalities (Faris et al. 2009). This versatility is why it is an effective tool for treating a substance use disorder considering the frequency of comorbidities that are seen in severe substance use disorder.

When a client experiences a lapse or relapse shame, guilt, and a reduction in feelings of self-worth often accompany those feelings and, as a result, negatively impact the continuation of treatment. The use of compassion-focused therapy with clients that are experiencing shame related to eating disorders has been shown to reduce the feelings of shame and increase self-compassion which works to alleviate the impact of shame (Kelly, et al., 2014). Individuals that experience a relapse in substance use disorders experience this same shame, using techniques like CFT, this feeling of shame can be reduced or reversed.

The Diagnostic and Statistical Manual of Mental Disorders shows the comorbidity of substance use, anxiety and depression will exacerbate the presence of the symptoms of each corresponding disorder. (American Psychiatric Association, 2013). Acceptance and commitment therapy has been seen to reduce the impact of depression and anxiety-related symptoms while increasing the strength of the therapeutic alliance in younger and older veterans (Karlin, et al. 2013). By examining the impact that this treatment modality had on individuals with anxiety and depression the information gained can be adapted and applied to a treatment modality that could reduce the impact of comorbid disorders on clients with a substance use disorder through the development of a stronger therapeutic alliance.

To effectively study shame a distinction must be made between shame and guilt. Due to the significant similarities between shame and guilt, the two are often used interchangeably leading to inadequate care for the client due to the often overlooked cognitive, effective, and

motivational differences between these two emotions (Parker, & Thomas, 2009). The core differences between shame and guilt are in the perspective of the negative emotion, shame is more concerned with oneself whereas guilt is more focused on the choices that were made resulting in the negative feelings (Parker, & Thomas, 2009). Using the Test of Self-Conscious Affects the affective differences in shame and guilt are seen with guilt requiring an empathic awareness of something that a person had done, and shame illustrated a more global negative perspective of oneself (Parker, & Thomas, 2009). The distinction between feelings of shame and guilt must be made to prevent significant overlap showing issues that individuals facing sever opiate use disorder encounter in the recovery process.

One of the most important distinctions between shame and guilt is the difference in motivation because shame results in the person withdrawing or retreating and guilt moves toward the issue in the hope to repair the damage (Parker, & Thomas, 2009). This motivational difference is particularly important in this study because during a relapse situation, a person experiencing guilt will reengage in the therapeutic alliance and work to repair the damage that the client feels has been done in recovery but, the client experiencing shame may retreat resulting in a higher likelihood of attrition in treatment. Distinguishing between shame and guilt will allow the therapist to see the significant difference in the client's perspective concerning the negative emotion but will also allow the therapist to employ specific treatment modalities to aid in the treatment of each one of these issues (Parker, Thomas, 2009).

Throughout much of this review shame and guilt are viewed in a similar light however, a growing body of research shows the distinction between shame and guilt with guilt being seen as a failure of action that can be corrected and often serves as motivation for continued change (Lynch, et al., 2012). However, shame is seen to have and positively significant relationship with

psychological distress and in particular the increase in fear of making mistakes and the continued development of more negative emotions and increase psychological distress (Lynch, et al., 2012). This body of work shows the significance of shame and how this shame can cause an increase in the presence of psychological distress by using empathy to reduce these feelings and developing insight to not contribute to the presence of the client's shame then a counselor should be able to increase the effectiveness of care.

Shame and guilt can impact a client's relationships in differing ways where guilt impacts the client because of being judged for behavior that is considered wrong by the group and shame is rooted in the revelation to the group about something embarrassing (Gao, et al., 2010). If a client feels shame about the social group and begins to withdraw from the social circle there could be a negative impact on the client's recovery. The concept of a sense of community in the recovery process is a widely used tool and commonplace in the treatment of substance use disorders. If there is a negative impact on the client's ability to successfully form effective relationships due to shame this would negatively impact the recovery process.

Research shows that associations exist between shame and negative coping mechanisms, decreased empathy, and impaired self-forgiveness following a transgression (William and Jeffrey 2014). This transgression for this research will be the use of illicit substances or misuse of a prescribed substance. As the client's shame increases related to the lapse of empathy will decrease, the opportunity for self-forgiveness will be reduced, and negative coping could be employed which could further increase the frequency of this transgression (William and Jeffrey 2014). The key to the facilitation of this change will be the development of a strong therapeutic alliance. Trusting and accepting that the therapeutic relationship is working and effective increases the effectiveness of treatment (Long, et al., 2016). The perspective that the client has

on their care can directly impact the outcome, this is true of self-injurious behavior but, it can also be true in treating substance use disorders (Long, et al., 2016). The presence of negative coping mechanisms that include self-injurious behavior can be particularly dangerous in substance use disorders because of the possibility of overdose.

Shame is a common occurrence in individuals dealing with substance use disorders, shame-based perfectionism could also be present in individuals that are seeking treatment for substance use disorders while prescribing traditional abstinence-based support programs like Narcotics or Alcoholics Anonymous (Pembroke, 2012). This sense of perfection-based shame would occur in this setting likely due to the accepted principle that when an individual has a lapse then their "clean time" starts over leaving individuals frequently with a sense of loss and waste of time and increased shame. With this sense of perfectionism or a need to make sure that they are never going to "mess up" and lapse again the individual will experience an increased amount of shame and lower effectiveness of treatment (Pembroke, 2012).

Managing interpersonal shame that is experienced following the expression of addictive behavior is imperative for a client to cope (Leeming & Boyle, 2013). The social factors of shame that client experiences are a key point in this research as individuals that are experiencing shame may be less likely to report to health professionals and collateral sources that they are seeking treatment for opioid dependence (Leemin & Boyle, 2013). Understanding how to manage the emotional minefield that comes with interpersonal shame and developing a recovery plan to process the shame can help in overall recovery fostering a stronger alliance (Leemin & Boyle, 2013).

Shame can exacerbate trauma-based disorders including Complex Posttraumatic Stress Disorder and Dissociative Identity Disorder (Dorthy, et al., 2017). It has been experienced that

individuals with elevated levels of shame also have elevated levels of stress and anxiety, exacerbating the symptoms of complex post-traumatic stress disorder and dissociative identity disorder (Dorthy, et al., 2017). There is a level of consistency with the elevation of shame and the presence of pathological symptoms including chronic PTSD, Complex PTSD, DID, anxiety, and depression (Dorthy, et al., 2017).

Guilt and shame are powerful feelings that can greatly impact a client. The perspective of the client, when they are experiencing guilt and shame, can impact the effectiveness of treatment (Yang, et al., 2010). The research suggests that individuals experiencing guilt showed better perspective-taking than individuals experiencing shame (Yang, et al., 2010). This research shows that the guilty effect tends to generate a higher need for affiliation and increases interpersonal interaction and perspective taking while shame exhibited less need for affiliation and interpersonal interaction (Yang, et al., 2010). This article shows that a difference exists between guilt and shame and the perspective that the client has during this experience will impact the effectiveness of treatment. The body of research continues to show the differences between shame and guilt and the impact that these feelings have on substance use disorders (Luoma, et al., 2017). Shame is a greater predictor of continued development of severe alcohol use disorder symptoms than guilt, not indicating a clear increase in use but more problems in recovery. (Luoma, et al., 2017). The study also uncovered that guilt/shame proneness yielded different results than the experience of guilt and shame (Luoma, et al., 2017).

The working alliance inventory that will be used to measure the therapeutic alliance strength in this study was developed to measure treatment efficacy among several varying treatment modalities and is considered reliable, valid, and widely used. (Horvath & Greenberg 1989). The possible flaw in this inventory is the correlation that the components of the working

alliance inventory have with other measures specified in the comparison between bond and empathy measures (Horvath & Greenberg 1989). The three components of this inventory are bond, goal, and task items with the measure indicating that the higher the score on the inventory the stronger the alliance and, more likely, that the client has a feeling of partnership with the therapist (Horvath & Greenberg 1989).

The indication is that, if the client is invested in a partnership with the therapist for a common goal of successfully navigating the treatment journey, then this therapeutic alliance will translate into predicting treatment success. The second difficulty with this measure is the significant correlation between the goal and bond scales. The study found that the components of the working alliance inventory closely correlated with their measure (Horvath & Greenberg 1989). The use of the Working Alliance Inventory is considered reliable in assessing three specific factors: task, goal, and bond in the therapeutic alliance, and one general measure, alliance strength (Tracey, & Kokotovic, 1989).

Therapeutic alliance can increase success in treatment and, by extension, willingness to continue care indicating that clients who do not develop a strong therapeutic alliance will more likely relapse and leave treatment resulting in an unsuccessful treatment outcome. By understanding the client's perspective of why they leave treatment a therapist could develop a practice that lowers the dropout rate and increases success (Palmer, et al., 2009). Research indicates that from the client's perspective, the most frequent reasons they stop seeking treatment are lack of staff connection and social support from their personal support system (Palmer, et al., 2009). This illustrates the importance of the development of a strong therapeutic alliance (Palmer, et al., 2009).

Retention in a treatment program or a study is important for a successful outcome which poses an issue for this study as estimates show that attrition rates can be as high as fifty percent (Bickel & Petry, 1999). The therapeutic alliance strength does little to improve the retention rate among individuals with mild comorbidities however in those with moderate to severe comorbidities clients with a weak therapeutic alliance have a 25 percent completion rate versus those with a strong therapeutic alliance who had a 75 percent completion rate (Bickel & Petry, 1999). This work will build on the research conducted to show the impact of shame which is not directly a mental health disorder but has been documented extensively as an amplifier of poor emotional health which can exacerbate comorbid symptoms. If a strong therapeutic alliance can reduce the impact of this exacerbator then there should be a significant reduction in addictive behavior including attrition.

A strong therapeutic alliance is necessary for successful treatment outcomes and to achieve this goal a therapist should avoid improper or excessive self-disclosure (Audet, 2011). If a therapist uses self-disclosure in a manner that shifts focus from the client or feels less than professional this can change the dynamic of the therapeutic relationship resulting in a negative impact (Audet, 2011). Clients report that when the self-disclosure was viewed positively then the therapeutic relationship was strengthened, and the overall therapeutic experience was viewed positively (Audet, 2011). When this technique is employed effectively the therapist and client will have a stronger therapeutic alliance and a more effective therapeutic experience.

The therapeutic alliance is considered a great predictor of treatment outcome and when working with individuals with a severe substance use disorder the client's ability to cope effectively can have an impact on the threat's alliance and treatment outcome (D'iuso et al., 2009). When examining the use of cognitive behavioral therapy techniques, through the lens of

the therapeutic alliance, it appears that the development of effective coping patterns showed a more significant relationship than cognitive errors, even though cognitive error frequently implied an air of bias in the relationship (D'iuso, et al., 2009).

The behaviors that a therapist displays and modules in session can impact the development of a strong therapeutic alliance. Making encouraging statements to the client, making positive comments to the client, and greeting the client with a smile make up a vast majority of variance in alliance scores indicating that small meaningful behaviors that a tactfully employed can have a significant impact on the client's outcome in treatment (Duff & Bedi, 2009). Continued development of behaviors and skills that can be easily employed by a therapist to strengthen the therapeutic alliance is essential for a positive therapeutic outcome.

The therapeutic alliance is frequently examined in one-on-one counseling relationships and is important in group treatment environments as well. To characterize the importance of this relationship Fasulo, Ball, Jurkovic & Miller (2015) conducted a study in which the first essential phase of treatment would be the development of the therapeutic alliance before continuing to other treatment goals (Fasulo, et al., 2015). The study found that when challenges were made in the atmosphere of acceptance utilizing strategies based on Dialectical Behavioral Therapy the client responded to the treatment with a more effective therapeutic alliance (Fasulo, et al., 2015).

The individuals in the study were incarcerated adolescents that had a long history of being in and out of treatment encounters, which translated into initial resistance to the therapeutic process (Fasulo, et al., 2015). When the client felt heard and the therapeutic alliance strengthened, the resistance to the treatment process was reduced resulting in positive outcomes. (Fasulo, et al., 2015). Specific counselor styles and behaviors in the session can positively impact the therapeutic alliance in the bound subscale from the counselor's perspective (Lee, et

al., 2013). Different therapeutic styles offer differing perspectives on the therapeutic alliance and are concerned with differing subscales (Lee, et al., 2013). In this study, the cognitive behavioral therapy approach will be the most common approach used by the therapist in the study and will likely show higher levels of goal agreement due to this style.

As the therapeutic alliance develops, an atmosphere that is empathetic and non-judgmental is formed. When a client feels that they are in a non-judgmental place, they feel heard and, when trust is built in an accepting therapeutic alliance, then the occurrence and risk of self-injurious behavior is diminished (Long, et al., 2015). The counselor must take a step to look through the behaviors that are being exhibited by the client and meet them where they are to establish rapport and lay the foundation for an alliance that could potentially be lifesaving. Using encouraging statements, reflections, and restatements in counseling sessions has been shown to increase the bond in the therapeutic alliance (Sharpley, et al., 2000). A strong therapeutic alliance fosters an atmosphere of acceptance in the life of a client. Through the strength of the therapeutic alliance, a client with a severe opiate use disorder could result in a reduction in addictive behavior.

One of the largest issues in maintaining effective treatment is the risk of attrition this is a common problem among all mental health treatment facilities however, the attrition rate among substance use treatment programs is the highest (Cournoyer, et al., 2007). The strength of the therapeutic alliance has a significant impact on the dropout rate among individuals in a substance use treatment program (Cournoyer, et al., 2007). The importance of establishing a therapeutic alliance early in therapy is seen to be one of the most important factors for success in a substance use treatment program because therapeutic alliance strength is seen as the greatest predictor of treatment dropout (Meier, et al., 2006). The development of this relationship early on assures the

client that the therapist is a partner in therapy which allows for shared goals and a strong bond that will increase positive treatment outcomes.

People worldwide are diagnosed with, treated for, and succumb to the effects of substance use. Use is commonly used as the principal description of an unsuccessful treatment outcome but, there are several definitions as to what a successful treatment outcome is regarding substance use treatment. One describes successful treatment as recovery which was described as an ongoing daily process that could not be hurried and must grow organically with sobriety being an essential part of the recovery process that shows changes in the individual on a behavioral and cognitive level (Gubi & Marsden-Hughes, 2013). Achieving abstinence and maintaining recovery and a sober lifestyle was an essential descriptor of long-term recovery and this described successful treatment outcome (Gubi & Marsden-Hughes, 2013). This definition of successful treatment and long-term recovery abandons the idea of short-term solutions and works to understand the disorder as a more chronic endeavor that must be treated over a lifetime.

There are many effective tools in the treatment of substance use disorders. Some of the modalities include Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Motivational Interviewing, and Acceptance and Commitment Therapy, to name a few. One study indicates humor can be an effective tool, however, another suggests that from a client's perspective humor could be offensive or delicate when working on addictions (Andersen, 2015). The therapeutic alliance requires mutual trust and respect, and the use of humor may feel benign to the therapist but be received by the client as offensive (Andersen, 2015). This is particularly true in a younger population who are often socially vulnerable and dependent on professionals in the recovery process (Andersen, 2015). The counselor's actions can, directly and indirectly, impact the effectiveness of treatment based on how the client perceives the therapeutic interaction. When a

therapist is aware of this, the use of humor and other techniques will be carefully weighed with its impact on the therapeutic process in mind (Andersen, 2015). The use of DBT emphasizes the skills of mindfulness, which is placing a high regard on observing, describing, and participating in the here-and-now moment without judgment, emotional regulation, which is developing tools to change emotions quickly, and finding ways to respond less emotionally in everyday situations, interpersonal effectiveness, including basic social skills, assertiveness, and goal-oriented problem solving, and distress tolerance, in the short term, reduce impulsive tendency and in the long term radically accept life events. Primarily used for the treatment of borderline personality disorder, these tools can also be used to effectively treat severe use disorders (Neacsiu, et al, 2010).

Another consideration is that family relationships play a recognized role in alcohol use among adolescents (Pizarro, et al., 2017). Family relationships that have higher levels of conflict and associated trauma have higher levels of adolescent problem drinking (Pizarro, et al., 2017). Significant levels of trauma throughout an individual's life result in Posttraumatic Stress Disorder, increasing the presence of shame and guilt and creating difficulty with interpersonal relationships (Dorahy, 2010). Disassociation and lifetime shame have an impact more than current shame, showing an increase in relationship difficulties. Guilt did not show an increase in relationship difficulties (Dorahy, 2010). As disassociation and similar pathologies are seen more frequently there is a reduction in the appearance of shame (Dorahy, 2010). This is significant in this study due to the possibility of comorbidity with dissociative symptoms and severe pathologies that may show an increase in high-risk addictive behavior without the presence of shame.

Substance use disorder is a serious mental health issue that frequently presents with other comorbidities. When working with clients with severe mental health disorders that include Bipolar Disorder, Schizophrenia, and Schizoaffective Disorder, it is believed that tangible goals are the most important factor for the patient when determining the effectiveness of a therapeutic relationship (Easter et al., 2015). Client and treatment providers report that client-focused goals, availability and access to treatment providers, a caring approach, and trust in the relationship were mutually important in determining the effectiveness of the therapeutic relationship (Easter et al., 2015). When clients and therapist feel that they are on the same page and the client feels heard and feels that they have a partner in the treatment process the therapeutic alliance is strengthened and there is an increase in positive treatment outcomes.

Clients that are experiencing the symptoms of substance use disorders frequently experience other comorbid symptoms and have quite a different symptom presentation with shame being present in both (Gutierrez & Hagedorn, 2013). The presentation of shame is difficult to describe, however, the symptoms are clear in the reduction of self-worth that is described by the individuals that are in pain. The development and use of Acceptance and Commitment Therapy work to reduce the overall symptoms of shame and, as a result, effectively treat the diagnosis (Gutierrez & Hagedorn, 2013). The use of Acceptance and Commitment Therapy works to focus on the impact that shame has on the client and helps them to continue to move forward despite the negative feelings that are being experienced (Gutierrez & Hagedorn, 2013). The use of Acceptance and Commitment Therapy to treat shame in people dealing with substance use disorder and the resulting decrease in use behavior illustrates the relationship between shame has with substance abuse. (Gutierrez & Hagedorn, 2013).

The Diagnostic and Statistical Manual of Mental Disorders shows that half of all individuals with Schizophrenia have a Tobacco Use Disorder (American Psychiatric Association, 2013). The rate of comorbidity between Schizophrenia and other substance use disorders is considered high. (American Psychiatric Association, 2013). Shame has a negative impact on the treatment of Schizophrenia due to the client perceiving and experiencing a high level of stigma associated with this disorder which was noted as being separate from increased depression levels (Keen, et al. 2017). Shame results in negative emotions associated with a reduction in feelings of self-worth, helplessness, being overly self-aware, and an intense desire to retreat (Keen, et al. 2017). Individuals with high levels of stigma withdraw from others, including treatment providers. This could also be true in the lives of those dealing with a substance use disorder.

The difficulties of shame are experienced throughout a myriad of mental health disorders and by addressing the shame the individual experiences better treatment outcomes. Individuals who are diagnosed with eating disorders show a higher expression of shame and by working to improve the level of self-compassion experienced in early treatment interventions the impact of shame is mitigated (Kelly et al., 2014). This is achieved by employing the treatment modality of Compassion-focused Therapy which employs techniques from cognitive behavioral therapy, allowing individuals that have a high level of shame proneness, or are self-critical, to develop a kinder and more accepting attitude toward their perceived flaws or inadequacies (Kelly et al., 2014). This use of this technique allowed the clients to foster more positive reactions to both internal and external criticisms (Kelly et al., 2014). Shame acts both as an exacerbator of negative symptoms of mental health disorders, including eating disorders, and acts to maintain the disorder's hold on the individual. By fostering an atmosphere of shelf compassion early in treatment, clients that experience shame can begin to find relief, resulting in more positive

treatment outcomes (Kelly et al., 2014). It is the goal of this study to employ multiple modalities that foster an increase in the therapeutic/working alliance reducing the presence of shame and leading to more positive treatment outcomes.

Individuals that are experiencing shame are not only impacted by the emotional pain that is felt but are also impacted by physiological responses to shame. Individuals who report experiencing feelings of increased shame show increased levels of Cortisol in their saliva, indicating the individuals with increased shame had an increased stress response (Lupis, et al., 2016). A contributing factor to shame's link to stress was the client's body esteem and perception of their physical self. Given the dramatic changes that the body undergoes when individuals participate in opiate use, the client's body esteem could suffer greatly, increasing the potential for increased shame, stress, and additional negative physiological responses (Lupis, et al., 2016)

Shame has been defined in various ways. It is a socially constructed reality that could apply to many different communities (Lee, 2009). Addiction also occurs in all cultures, religions, races, genders, and socioeconomic levels. By viewing shame as a socially constructed reality a researcher can begin to see the stigma that is carried by individuals seeking treatment or are actively symptomatic. This social construction could lead to either hiding treatment, not engaging a support system, or failing to tell medical professionals that the client is in treatment or has a history of a substance use disorder. This increases the chance of relapse which could lead to health complications and death.

Cultural competence is imperative for effective research and for a hypothesis to apply to various cultures. When examining guilt and shame the client's perspective of the action or behavior that perpetuates these feelings results in form a perceived volition of an internalized

conflict or painful experience (Zou, & Wang, 2009). By working to understand shame and guilt through various cultural perspectives this research will grow to be even more effective at reducing shame and increasing the overall effectiveness of care and reliability.

Shame is frequently considered for exacerbating mental health disorders and, with the use of interviews and shame questionnaires, shame is shown to have a significant correlation as a possible predictor of the development of psychopathologies (Andrews, et al., 2002). Shame is broken down into three separate shame categories, behavioral, characterological, and bodily shame, with varying degrees of significance (Andrews, et al., 2002). When shame was present for individuals the depressive symptoms were more significant than when depression and guilt were present using the TOSCA scale (Andrews, et al., 2002). Shame has a significant impact on the intensity and duration of depressive symptoms, however, the study stopped short of claiming that it was a predictor citing the impact of multiple factors including the exacerbation of shame when depressive symptoms were present. As shame can act as a predictor for the presence of depressive symptoms it is hypothesized that shame is a predicting factor for the presence of addictive behavior in clients with a severe opiate use disorder controlled by medication-assisted therapy. The impact of the relationship between mental health disorder symptoms and shame impacts clients throughout their life. Depressive symptoms and paranoia are present because of shame manifesting in two differing ways, as depressive symptoms are highlighted due to internalizing shame from early traumatic experiences with highlighted submissiveness due to perceived threat, whereas paranoia is affected by the same factors as depressive symptoms while also exhibiting external shame (Pinto-Gouveia, et al., 2014). Shame impacts clients in a profoundly negative way and is a well-established predictor for an exacerbation of multiple mental health disorders.

Shame is a complex emotional experience that requires a sense of self-identity and is characterized by a desire to be unseen leading to emotional and physical withdrawal from others (Black, et al., 2013). When shame is experienced, there is a significant risk of a weaker therapeutic alliance (Black, et al., 2013). When shame is not addressed effectively the client may employ withdrawal as a coping tool leading to a retreat from others resulting in a reduction in treatment effectiveness (Black, et al., 2013). Withdrawing from shame as a coping style is seen as effective for reducing shame however this maladaptive coping behavior prevents the therapeutic alliance from taking shape leading to poor treatment effectiveness and fewer therapeutic interactions (Black, et al., 2013). When a client is withdrawing to escape shame, they will frequently refuse to engage with the therapist, preventing the therapeutic process from taking place (Black, et al., 2013). In addition to the impact that shame has on the client's propensity to withdraw from others, shame may also result in the client having a more difficult time relating to or seeing the perspective of others. When compared to neutral individuals, neither experiencing guilt nor shame, individuals who were experiencing guilt were more able to take the perspective of others, and individuals experiencing shame found it more difficult to take the perspective of someone else (Yang, et al., 2010).

Shame and guilt are emotions that are felt in daily life and can have a devastating impact on the effectiveness of task completion (Bynum & Goodie, 2014). Shame is associated with feeling small, worthless, or insignificant, and prolonging feelings of shame can lead to symptoms of depression, anxiety, post-traumatic stress disorder, and addiction, which is characterized by a lack of self-forgiveness (Bynum & Goodie, 2014). Medical students who experience a lack of empathy and self-forgiveness are greatly impacted by the negative effects of guilt and shame which increase the number of errors made in the learning experience (Bynum & Goodie, 2014).

When shame and guilt are present, a medical student has a decrease in adaptive coping, the use of empathy, and the ability to forgive themself when an error is made, all of which lead to burnout, depression, lack of empathy, depression, and lack of self-forgiveness (Bynum & Goodie, 2014). When shame is experienced in medical students, teachers can reduce the impact by adopting a shame-resilient approach to the student by increasing recognition of these emotions, and the use of non-humiliating, action-based empathetic feedback in addressing errors (Bynum & Goodie, 2014). This experience can translate to the therapeutic experience by employing many of these same approaches for clients who experience a lapse during addiction recovery. The use of empathy and helping the client embrace self-forgiveness can reduce the presence of shame mitigating its impact. A decrease in adaptive coping in clients in recovery could lead to an increase in maladaptive coping resulting in addictive behavior and relapse.

A study by Rangganadhan & Todorov(2010) attempted to show predictability in the relationship between shame, guilt, self-forgiveness, perceived forgiveness, empathy, and conciliatory behavior. Shame and personal distress empathy show a significant negative relationship to self-forgiveness. However, there is a lack of evidence to support a significant relationship between perceived forgiveness or conciliatory behavior and shame reduction or an increase in empathy (Rangganadhan &Todorov, 2010). An inference can be made that the development of a strong therapeutic alliance had been a factor in this study and would have been shown to foster an atmosphere of acceptance allowing the client to experience a reduction in shame as well as perceived forgiveness and eventually experience self-forgiveness.

When shame is experienced, it can be difficult to process the negative thoughts and feelings associated with this experience. This would also indicate difficulty in managing and healing from the difficulty that is caused by shame (Leeming & Boyle, 2013). When repairing

shame, two perspectives emerge, the view of self and the perceived judgment from others that impact one's view of self (Leeming & Boyle, 2013). To resist or to repair from shame the client must navigate identified barriers including the impact of judgment from others on one's appearance of self, and "being disabled by shame" (Leeming & Boyle, 2013). The use of tools to reposition a client in their social world to eliminate or reduce shame is a tool that will both manage and lessen the impact of shame on an individual (Leeming & Boyle, 2013).

To effectively treat the impact of shame on a client with a severe opiate use disorder a valid and reliable measure of shame in patients with present severe comorbidity is needed. The Test of Self-Conscious Affect-3 (TOSCA-3) is considered a valid and reliable measure for various measures of shame and guilt. When the Tosca-3 was administered to a sample of clients with Borderline Personality Disorder the findings were that the test showed good validity among all measures except in the area of guilt-proneness, which showed low internal consistency (Rusch, et al., 2006). In addition to the ability to show guilt and shame in clients with Borderline Personality Disorder, the TOSCA-3 also demonstrated a high correlation between the presence of anxiety and state of shame (Rusch, et al., 2006). The presence of anxiety in clients who are exhibiting a high state of shame could result in maladaptive coping, especially in clients with a severe use disorder. The presence of this additional anxiety related to shame could lead to a predictive factor of state shame and the exacerbation of substance use disorder symptoms leading to an eventual relapse (Rusch et al., 20060.

Individuals with non-cancer pain are frequently treated with opiate-based pain medication which can lead to dependence and addiction (Stevenson & Cole, 2015). The prevalence of non-cancer pain and opiate dependence is between 31% and 67%. Using this information, it was hypothesized that individuals with non-cancer pain will have a less successful outcome in

treatment to the significant comorbidity with non-cancer pain, anxiety, depression, and illicit drug use (Stevenson & Cole, 2015). Individuals with higher levels of comorbid depression show significantly higher levels of shame (Andrews, et al., 2002). Research shows that shame could have a significant role in the exacerbation and prediction of addictive behaviors in clients participating in medication-assisted therapy treatment.

One of the primary treatments for opiate use disorder is the use of medication-assisted therapy sometimes called medication maintenance therapy with the use of Buprenorphine or Methadone, in combination with behavioral therapy (Dehghani-Arani, et al., 2013). The effectiveness seen in neurofeedback training illustrates the need for significant treatment protocols beyond the sole use of a pharmacological approach (Dehghani-Arani, et al., 2013). This research illustrates the importance of neurofeedback training. This study will illustrate the importance of adherence to an understanding of the therapeutic relationship and its ability to reduce the impact of shame on the exacerbation of addiction symptoms (Dehghani-Arani, et al., 2013).

Summary

This body of research is continuing to explore ways that a counselor can affect the relationship that a client has with feelings of shame and how reducing the presence of these feelings of shame will increase the effectiveness of the counseling treatment. The development of a strong therapeutic alliance impacts the counselor's ability to help the client positively through the atmosphere of acceptance and feelings of partnership through agreement on tasks in session, as well as goals for treatment and a perceived bond in the relationship. During this study, the predictability of shame to increase the presence of addictive behavior and the factor of a strong therapeutic alliance to negatively impact the presence of shame will be tested.

The supporting research indicates that several examples exist of the impact of shame on the exacerbation or expression of various mental health disorders. The information provided also provides several instances of the impact of the therapeutic alliance on retention and reducing negative feelings during the counseling experience. This study will attempt to build on the body of research to uncover if a causal relationship exists among the variables that are being studied.

Chapter Three: Methods

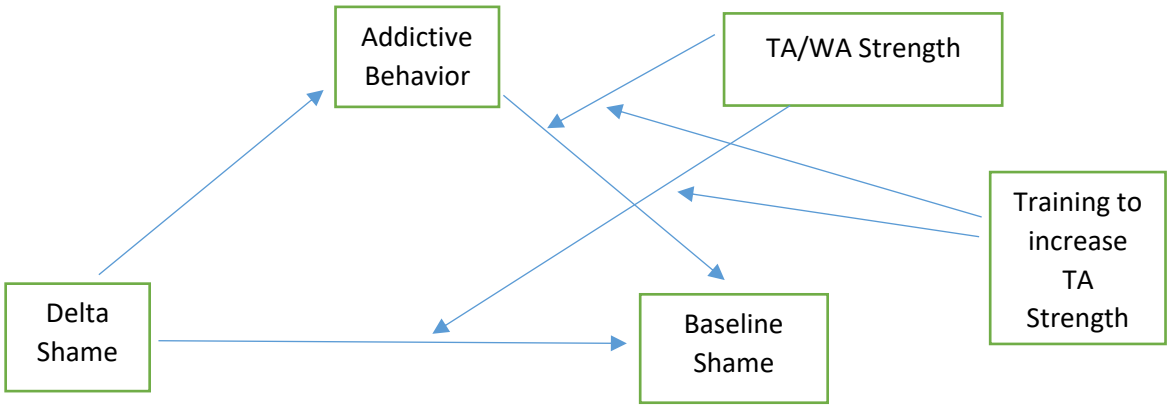
Overview

The body of research indicates that the presence of increased shame is consistent with the exacerbation of symptoms associated with multiple mental health disorders (Bryan, Etal. 2013). In addition to the exacerbation of mental health disorder symptoms other research indicates that the presence of shame can increase the presence of maladaptive coping and socially unacceptable behavior including but not limited to substance use/abuse and self-injurious behavior (Owen & Fox 2011). When increased shame is present in someone with a substance use disorder in remission there is an increase in potential relapse over time, this is seen by an increase in addictive behavior that continues eventually resulting in use and relapse. By reducing shame over time then the result will be a reduction in addictive behavior/relapse behavior and a return to baseline shame. When a counselor can employ methods that increase the strength of the therapeutic alliance then the shame will return to baseline at a faster rate (Munder, et al. 2010).

The methods that are used to achieve this goal will be therapeutic models of counseling that increase the bond between the counselor and client and increase task agreement and agreement on treatment. Dialectic Behavioral Therapy is a treatment modality that has proven to increase the therapeutic alliance with the use of validation strategies (Fasalu et al. 2015). In

addition to DBT, Motivational Interviewing also increases the bond between client and counselor, and due to the non-directed approach to motivational interviewing the client and counselor are frequently in agreement on tasks and goals (Miller, & Rollnick 2013). MI and DBT are two counseling models that increase the strength of a therapeutic alliance through a similar use of techniques that will build rapport, trust, and bond between the client and the counselor which is a key component for increasing the therapeutic alliance.

Design



The Chart above shows that an increase in shame has a predictive factor on addictive behavior and the presence of a strong therapeutic/working alliance will predict a reduction in addictive behavior and a return to baseline shame. Training for the therapist will increase the skills needed to develop and foster a strong therapeutic alliance increasing the effectiveness of the benefit and reducing the time to baseline shame and the presence of addictive behaviors.

Research Questions

RQ1: Does a significant relationship exist between the presence of increased shame and the expression of addictive behavior that is defined as a relapse?

RQ2: If such a relationship exists then what is the level of impact and how can a counselor effectively impact the level of shame to stop the increase and reduce the presence of additive behavior?

Hypothesis

Ha1: The presence of delta shame as indicated by a higher score in shame proneness on TOSCA-3 is positively associated with defined addictive behavior leading to relapse.

Ha2: An increase in the therapeutic alliance, as indicated by the working alliance inventory, is negatively associated with the measures of addictive behavior leading to relapse.

Ha3: The strength of the score on the working alliance inventory is negatively associated with delta shame as indicated by the presence of shame proneness.

Ha4: Training that focuses on modalities that increase bonding, goal agreement, and treatment agreement is positively associated with increased therapeutic alliance strength as indicated by the working alliance inventory.

Ha5: As the scores from the working alliance inventory increase there will be little or no increase in the presence of shame as indicated by the shame proneness scale in the TOSCA-3

Ha6: As the score from the working alliance inventory is increased the presence of addictive behaviors is decreased.

Ha7: Training that focuses on the therapeutic alliance will positively impact the scores on the working alliance inventory. This will reduce the negative impact of shame on the therapeutic alliance's strength.

Participants and Setting

The participants were recruited from a Medication-assisted Therapy program (MAT) with sites located in Columbia and Greenville South Carolina. Achieve Behavioral Health was the agency that provided the site and population for the study. The participants in this study were selected from a population of over 200 individuals. Participation was on a voluntary basis and anyone in the MAT program was eligible for the study. Anyone in the MAT program that was willing to participate in the study was selected for the study.

A physical use cycle presents in clients that have a severe opiate use disorder, to account for the physical impact of the disorder on the participants and the studies outcome all the participants are enrolled and actively participating in a medication-assisted therapy program, using either buprenorphine or buprenorphine-naloxone combination treatment (McCance-Katz, 2004). This medication is a partial opioid agonist that has been in active use in the united states since 2002 and in France as early as 1996 (Pecoraro et al., 2012). By 2007 buprenorphine and its combination product were being used in 44 countries worldwide as a primary treatment for the physical impact of opiate use disorder (Pecoraro et al., 2012). Buprenorphine is widely considered the frontline medication for medication-assisted therapy around the world (Pecoraro et al., 2012). The use of Buprenorphine eliminates withdrawal symptoms experienced by the client during the treatment process. By having the impact of the biological use cycle mitigated the impact of withdrawal on the outcome of the study should be minimal. The clients were asked at each session if they are experiencing any withdrawal symptoms or physical cravings to

account for the biological use cycle's impact. The individuals in the study were under the direction of licensed medical professionals who are certified to prescribe buprenorphine and buprenorphine-naloxone combination treatment.

The participants in this study were all over the age of 18 and signed an informed consent form to take part in the research, along with a release of information, so that the medical records could be shared with the conductor of the study. A counselor was able to provide a release that contained specific instructions to the participants of the study to complete the study.

The principal medical records that were shared were the urine drug screens, missed appointments, self-reported addictive behaviors, and completed scales from each session. Missed appointments, self-reported addictive behaviors opiate use, overuse, or misuse of control medication overtaking medication which served as the definition of addictive behaviors in this study. The participants took part in monthly appointments with a licensed professional counselor and a medical prescriber.

The study's purpose was to build a working alliance and to document shame and addictive behavior while also continuing to provide effective treatment to the participants. The experimentation phase of this study consisted of one therapist receiving additional training to further improve their ability to develop a strong therapeutic alliance. Which did not negatively impact the control group or the experimental group's treatment but, did provide the therapist of the experimental group with a set of skills to strengthen the therapeutic alliance. Following the data collection phase, the professional counselors received extra training to ensure the most effective care is delivered to the participants.

The extra training consisted of using the working alliance inventory as a tool to show the strength of the therapeutic alliance, training in ways to increase the therapeutic alliance, and training on recognizing pitfalls that can damage the therapeutic alliance.

Instrumentation

To successfully conduct this study various scales and measures were employed to gather the required information. The first scale that was used is the Working Alliance Inventory, this inventory was used to the strength of the therapeutic alliance. ("WAI home | Working alliance inventory," n.d.). The author reports that this inventory does not produce a standardized score on "what is a good enough alliance" However, when a baseline alliance is established then this scale shows improvement, and the movement of improvement can be measured against addictive behavior to establish if the therapeutic alliance has the impact on shame and relapse as the study seeks to show ("WAI home | Working alliance inventory," n.d.).

The WAI is a 36-question inventory that measures the client's feelings associated with the strength of the therapeutic alliance ("WAI home | Working alliance inventory," n.d.). There is also a counselor component that has 36 questions to evaluate the counselor's feelings about the strength of the therapeutic alliance. The scoring scale is made up of three sub-scales that measure the strength of the bond between the client and counselor, the agreement on tasks, and the agreement on goals that the client and counselor possess. The answering of the questions produces either a positive or negative score with the more positive marks indicating a stronger therapeutic alliance ("WAI home | Working alliance inventory," n.d.). The scoring is from 1-7 on each question measuring from "never to always". This information will be used to show the therapeutic alliance in motion and establish both baseline and increased shame and addictive behavior.

The second scale that will be employed is the Test of Self-Conscious Affect (TOSCA) this scale is used to measure the development of shame proneness. The (TOSCA)-3 is a 16-item instrument that provides scenarios that the test taker rates. Eleven of the scenarios are negative and five scenarios are positive which produce a measure of shame-proneness, guilt-proneness, externalization, detachment/unconcern, alpha pride, and beta pride (TOSCA: Tangney, J. P., Etal. 2000). The use of shame proneness will assist in the development of baseline shame to conduct this study.

The third measurement that was used in this study was a urine drug screen. These were administered and read by a qualified lab technician and the results of the urine drug screens were a measure of relapse, failed drug screens, the presence of opiates or the absence of the control medication. Indication of tampering with the UDS is also considered a relapse behavior.

The fourth measure was asking the clients a series of questions on withdrawal and cravings to indicate that the biological use cycle is being well controlled. These questions pertained to the presence of withdrawal and craving symptoms in the client. This was measured by the client's use of the control medication. If the client is using the medication as directed then there is no indication of relapse behavior, in contrast, if the client is overusing the medication or misusing the medication then this would be measured as addictive behavior.

The final measure in this study was the measure of attendance, in treatment and UDS. If the clients failed to attend sessions or perform a UDS this was also considered addictive behavior and relapse. As the study continued more addictive behavior was monitored and classified however, only those specifically listed in this section was considered a relapse event.

Procedure

The information to measure the growth of shame was gathered monthly of the Test of Self-Conscious effect. This scale has been widely used to gather information concerning baseline shame and shame proneness this will assist in showing growth to higher levels of shame towards a relapse event and then reducing to a baseline shame measure (TOSCA: Tangney, J. P., Dearing, R., Wagner, P. E., and Gramzow, R., 2000).

Relapse was measured through a pre-session urine drug screen with a positive urine drug screen for opiates or a urine drug screen that is negative for the maintenance medication was considered use/relapse. The urine drug screens took place a minimum of once per month and on occasion increased at a periodic time throughout the sessions. The medical personnel checked the prescription monitoring reports monthly to ensure that the prescriptions are picked up within the prescribed timeframe. If the client was not taking the medication as prescribed, then this behavior was be considered a relapse event.

In addition to the use of opiates or the misuse of the control medication, failure to comply with attendance in treatment will also be considered a relapse event. Failure to attend treatment was considered a relapse event because, if a client failed to attend treatment, then they would be without a control medication that is responsible for halting the biological use cycle, and there was an increased risk for illicit use of opiates. Attendance was measured on a session-by-session basis and “no-showing” for an appointment was considered a relapse event for this study. Finally, if the participant reports the presence of withdrawal symptoms to the medical professional this will be considered a relapse event as all of the participants are well-established in the program. The four types of relapse events will be measured in two ways for occurrences in 3 and 6 month time periods and second in the frequency of occurrence in the three and six-month

time periods. To measure occurrences a binary calculation is used one representing addictive behavior in the month and a zero if the participant had no addictive behavior in the given month. To measure frequency every occurrence of addictive behavior was measured in three and six-month intervals to prevent skewing with addictive behaviors the total number of occurrences were capped at 5 in each month for missed appointments 2 for each scheduled appointment, 1 for each of the remaining categories; withdrawal symptoms, non-complaint UDS and Non-complaint medication use.

The study controlled for use of other illicit substances this is due to the presence of the biological use cycle in other diagnosed substance use disorders. The only substance relationship that is being considered in this study is the relationship between opiates, increased shame, and increased therapeutic alliance. Addictive behavior will be noted as it comes up in session, but only specific behaviors were noted as relapse events for this study.

The therapeutic alliance strength was measured by the administration of the Working Alliance Inventory at the initial session and once a month over the next six months. ("WAI home | Working alliance inventory," n.d.). The working alliance inventory is scaled within a range indicating the strengthening and weakening of the relationship then the client's session experience will vary from the initial testing using three categories Task, Bond, and Goal. By measuring the alliance in a range for baseline and then showing increase and decrease over time the relationship between the therapeutic alliance, increased shame, and relapse could become clear. However, the scores will not be split into separate subcategories rather they will be combined in an overall score to show a combined total score of the working alliance inventory to express a strong or weak therapeutic alliance. All other formats and scoring for the working

alliance inventory are followed exactly as written except for the three categories being combined into one total score for this study.

Data Analysis

In this study, the independent variables are the therapeutic alliance and relapse with the dependent variables being delta shame, baseline shame, and the time from relapse returning to baseline shame. The use of training to strengthen the therapeutic alliance is also considered an independent variable on the dependent variable of the therapeutic alliance.

The correlational analysis used was the Spearman correlation. This correlation is a test that will determine the strength of the relationship of the effect size (Warner, 2013, p 323). Spearman correlation coefficients between .00-.29 show a negligible or almost no association and coefficients over .5 represent a moderate association (Mukaka 2012). The analysis will examine the strength of the relationship between the variables being compared and will deliver a ranked analysis to show the significance of the relationships that are being tested (Warner, 2013, p323).

This study assumed that the relationship between the variables will have a association above .70 or below -.70 indicating a high positive to extremely high positive/negative association (Mukaka, 2012). When evaluating the correlation of the variable they are measured in a scale of +/- 0.00-1.00 any Rs Score that =.7 or higher or -.7 or lower would be considered a highly positive/negative correlation (Mukaka, 2012). This score would then indicate a significant relationship exists between the variables being studied. The Spearman correlation coefficient will be used rather than a Person's Coefficient due to the robust nature of the Spearman correlation coefficient and the possible presence of outliners in this study (Mukaka, 2012). The outliers that

could be present are due to the complexity of the motivation of use that exists within each individual and could result in outliers within this study. The robust nature of the Spearman Correlation Coefficient is on display when conducting this correlation study, as it works to determine the strength of the relationship between the variables of delta shame, baseline, therapeutic alliance strength, and relapse. (Mukaka, 2012).

To properly calculate the correlation the x and y populations of the sample group will have to equal therefore, after recording all the responses to the surveys the means were used to account for any missing data over the 6 months. Using the mean score will allow the correlation calculations to be properly completed without sacrificing any data points of the surveys.

If these relationships are statistically significant then the implication would be that counseling plays a significant role in achieving remission of a severe opioid use disorder and medication therapy alone offers less than optimal treatment. The implications of this could offer a great deal of insight into how to achieve therapeutic goals in the treatment of opioid use disorder and could be used as a tool to help combat the opioid epidemic that is frequently discussed today.

The danger of this statistical study is a type of positive error there is a risk due to the possible presence of comorbid disorders such as other use disorders, mental health disorders, and maladaptive coping skills being present in the clients. This situation fears that the clients' shame increases and the relapse takes place but, the reason for the relapse is less related to the level of shame increase and more related to a pattern of high-risk choices and maladaptive coping skills.

The internal validity within the hypothesis governing the development of increased shame over time causing a relapse may not be strong however, the external validity may prove to

be strong as in retrospect the development of increased shame before relapse may show a strong relationship without a causal relationship. In contrast, the internal validity of the therapeutic alliance reducing the time from relapse to baseline shame should indicate a strong relationship.

Finally, the clinical significance of this study lies in the way that current treatment for opiates is conducted. Currently counseling therapy in conjunction with medication is recommended but is rarely mandated. If this study shows that there is a significant link between the presence of increased therapeutic alliance and the reduction in relapse behavior, then a more holistic approach around the field of study may be adopted and the effectiveness of treatment will increase.

Summary

Many factors exist that impact the severity and presence of additive behavior in an individual diagnosed with a severe opiate use disorder. By controlling for the biological factor with the medication this study worked to show a line of predictability between the presence of shame and addictive behavior. The intention of this study was not to show that shame was the only factor that contributing factor to the presence of addictive behavior however the intended goal was to show that a relationship existed such that when higher levels of shame was present a greater frequency of addictive behavior was also present.

Secondary to the presence of shame predicting the presence of addictive behavior the development of a strong therapeutic alliance was predicted to reduce the impact of shame. Research already exists indicating that the presence of a strong therapeutic alliance would increase the retention and completion rates among individuals with moderate and severe mental health diagnoses (Bickel & Petry, 1999). This study worked to build on previous studies showing

that along with the decreased attrition rates, there could be a significant impact on other addictive behavior including active use of opiates while in treatment.

The therapeutic alliance shows people that they are not alone which is the antithesis of the presence of shame. The impact of shame increases an individual's desire to withdraw which could lead to increased attrition rates in therapy loss of community and familial support eventually leading to relapse. In this study, the clients were in varying stages of therapeutic alliance strength and shame which provided for a broad comparison but could also significantly impact the study.

The clients that are participating in this study are already in a long-term medication-assisted therapy program for the treatment of severe opiate use disorder. The impact on the client's treatment was minimal other than taking repeated measures throughout the study and training the therapist to better understand the impact of the therapeutic alliance and employing an additional treatment technique to increase the strength of the therapeutic alliance. Shame and the therapeutic alliance are both naturally occurring however, the therapeutic alliance can be strengthened and as a result, a reduction in the expression of feelings of shame can be achieved.

Through this study, the participating therapist can gain additional skills to actively continue to build a therapeutic alliance with the clients and make gains with clients that may have been on a decline in treatment due to a weak therapeutic alliance. This use of the scales and model in this study will work to identify and predict the impact of an exacerbation of symptoms that lead to relapse and work to build an environment in the clinical relationship to counteract this issue.

Chapter Four: Findings

Overview

This chapter provides the results from the study measuring the strength of relationship among the strength of therapeutic alliance scores, shame proneness, and addictive behavior in clients that are participating in a medication-assisted therapy program to answer the following questions:

RQ1: Does a significant relationship exist between the presence of increased shame and the expression of addictive behavior that is defined as a relapse?

RQ2: If such a relationship exists then what is the level of impact and how can a counselor effectively impact the level of shame to stop the increase and reduce the presence of additive behavior?

This Chapter also includes a discussion on the methodology used to measure the results of the instruments used in testing and how the analysis of the results provides an answer to the research questions. This chapter will include the demographics of the sample that was used in the study and the tables that were developed to support the results. The process used to measure the therapeutic alliance and shame proneness was administering the Working alliance inventory and the TOCA-3 to 42 clients at least once a month for six months. Not all participants were able to take a test every month and as a result, the means of the tests that were administered were measured. Only the Shame proneness scores were needed for the study and as a result, no other scores from the Tosca-3 were used in the measure. Finally, Addictive behavior was measured in its entirety over the course of the study and compared to the averages.

The Sample consisted of forty-two participants who were measured in this study. The age of participants ranged from 25 years of age to 75 years of age. The office that was the principal

site for the study was in Greenville SC. All participants were enrolled in a medication-assisted therapy program for the treatment of a substance use disorder. The individuals were at varying places in their recovery. The clients were all given at least is opportunity to complete the tests. Not all clients took every opportunity and some clients stopped taking the tests or left the practice in the middle of the study. This information was recorded and averaged with the rest of the data. The total population of the agency is 231 clients, and it was an open invitation to the whole agency to sign up for the study. This generated 49 patients willing to participate of the 49 participants 16 were in the experimental group and 7 dropped out before the study began.

Descriptive Statistics

The participants were given 2 surveys to fill out the first was the Working Alliance Inventory of the 294 potential tests at the beginning of the study the participants completed 177 tests with the highest possible score being 140 and the lowest possible score being -76. The mean total of each participant was calculated the mean score for surveys of the 6 months was 121.29 with a median score of 126.25 and mode of 134. The mean scores were rounded to the nearest tenth before the calculation and the final mean and median were calculated to the nearest hundredth.

The second survey that was administered was the Tosca-3 (the only part of the survey that was used was the Shame Proneness Scale) of 294 potential tests the participants completed 165 tests, the highest possible score was 80 and the lowest possible score was 16. The participant's scores were calculated into monthly means and the mean of these means was 42.01 with a median of 39.6 and a mode of 38.

The final measure was the measures of addictive behavior measured by missed appointments, Non-compliant urine drug screening, Non-compliant medication use and

documentation of the biological use cycle not being well controlled/the presence of withdrawals. These were split into two measures occurrence and frequency for the measure of occurrence this study used a 0-1 binary model, and the occurrence per 3 months cycle was measured. This measure was taken multiple times for months 1-6 whole group, 1-3 whole group, 4-6 whole group, 1-3 experimental group, and 4-6 experimental group. The highest number of numbers of addictive behavior occurrences that could take place in a single month is 1 and the lowest number is 0 of the 42 active participants in months 1-6 the mean of monthly addictive behaviors was .69 with a median and mode both at 1. In months 1-3 for the 42 participants, the mean was .547 the mode and median were 1. In months 4-6 for the 42 participants the mean of occurrences was .5 the median was .5 and the mode was 0. When examining the frequency of occurrences in months 1-3 the participants had a mean of 1.40 a median of 1 and a mode of 0. When examining the months 4-6 the participants as a whole group had a mean of 1.88 a median of .5 and a mode of 0. When examining the whole group for the total 6 months for the frequency of occurrences of addictive behavior the group had a mean of 3.21 a median of 2 and a mode of 0.

The sample size of the experimental group was 16 participants signing up with one dropping out due to completing treatment successfully leaving 15 participants. The participants in the experimental group will have individual statistics for their baseline scores on all the surveys for months 1-3 and months 4-6 as well as addictive behaviors for months 1-3 and months 4-6. The Working Alliance Inventory scores for months 1-3 showed a mean of 123.84, a median of 128, and a mode of 112, and for months 4-6 showed a mean of 125.72 a median of 133.5, and a mode of 138. On the Tosc-3 shame proneness portion for months 1-3 the participants had a mean of 39.07 a median of 37 and a mode of 34.5. In months 4-6, the participants had a mean of 36.66 a median of 31, and a mode of 25.5. When calculating the addictive behavior occurrences

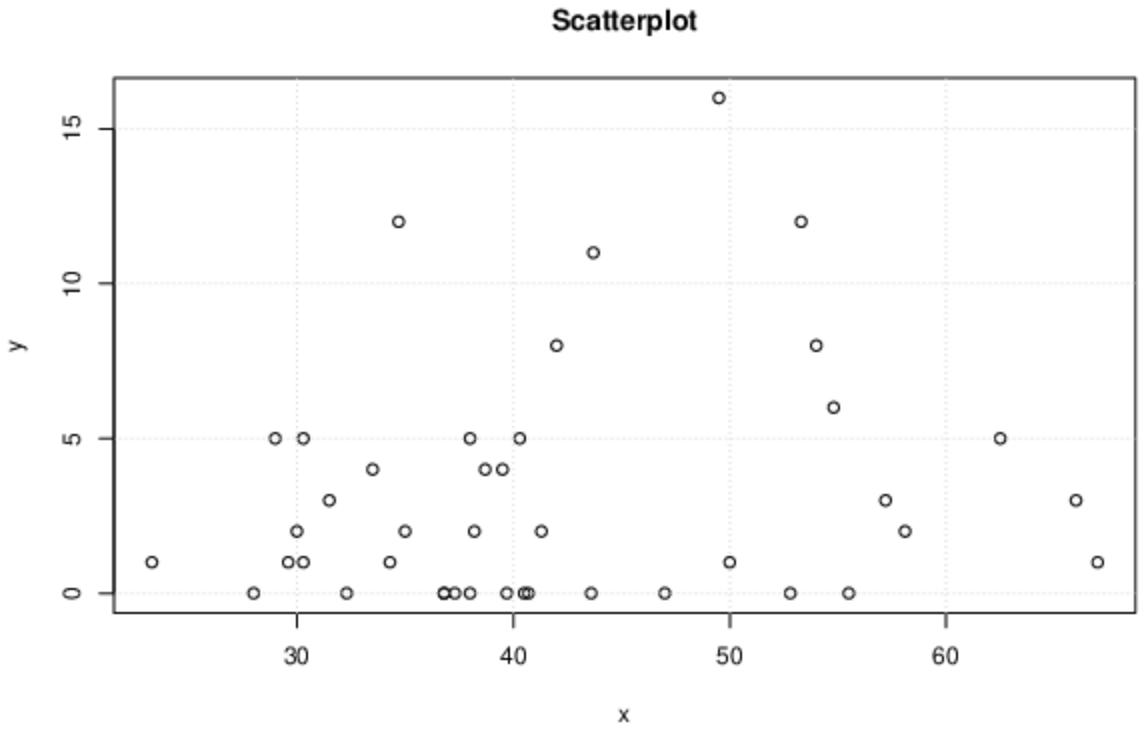
the participants in the experimental group showed a mean of .533 a median and mode of 1 in months 1-3 and in months 4-6 showed a mean of .466 a median and mode of 0. When calculating the frequency of addictive behaviors in months 1-3 the experimental group showed a mean of 1.27 a median of 1 and a mode of 0. In months 4-6 measuring the frequency of addictive behaviors the group showed a mean of 1.4 a median and a mode of zero.

The addictive behavior was well documented and the information that was gathered was compared against the scores from the surveys to determine what impact that therapeutic alliance and the clients' shame proneness score have on the presence of addictive behavior occurrence and frequency.

Results

Hypothesis 1: The presence of delta shame as indicated by a higher score in shame proneness on tosca-3 is positively associated with defined addictive behavior leading to relapse.

Using the Spearman Rho Correlation Coefficient the calculations for the whole group over 6 months show the X ranks have a mean of 21.5 and a standard deviation of 12.27 the Y ranks show a mean of 21.5 with a standard deviation of 12.04 combined covariance= 957.25/41=23.35 R=23.35/(12.27*12.04)=.158 rs=0.15805, p(2tailed)=0.31746 showing that by that the variables shame and addictive behavior over the six months are not statistically significant. Based on this correlation comparison the presence of shame is not a statistically significant relationship to the frequency of addictive behavior for these 42 participants over 6 months.

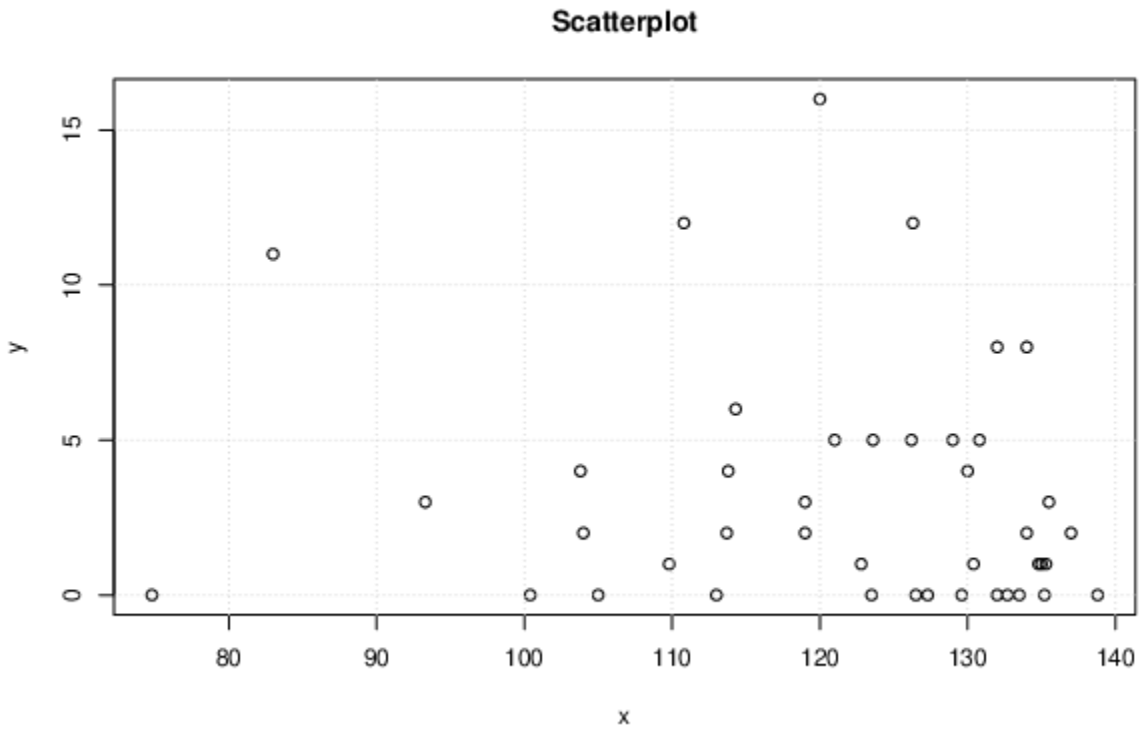


The above Scatter plot shows the results of the Spearman-Rho Correlation for the above Hypothesis. Based on this calculation the relationship is not significant enough to reject the null hypothesis.

Hypothesis 2: An increase in the therapeutic alliance as indicated by the working alliance inventory is negatively associated with the measures of addictive behavior leading to relapse.

When calculating the relationship between the Working Alliance Inventory and the frequency of addictive behavior using the Spearman Rho Correlation Coefficient the results are as follows: X Ranks Mean 21.5 Standard Deviation 12.27 Y Ranks Mean:21.5 and the Standard Deviation is 12.04 with rs = -0.15141, p (2-tailed) = 0.33849. This calculation indicates that the

relationship between the frequency of addictive behavior and the strength of the therapeutic alliance is not statistically significant.

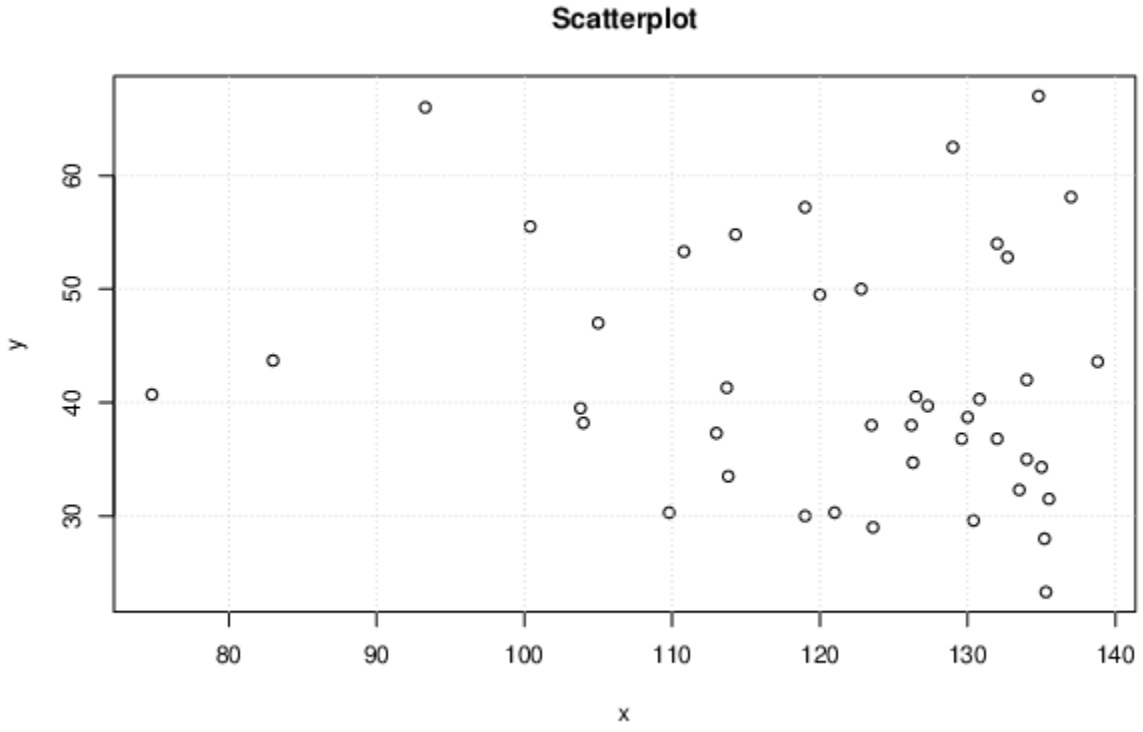


The above scatter plot is a representation of the results of the Spearman-Rho Correlation Coefficient showing the significance of the relationship between the frequency of addictive behaviors and the strength of the therapeutic alliance based on the scores from the Working Alliance Inventory. Based on these results that the relationship is not statistically significant and there is not a strong enough relationship to reject the null hypothesis.

Hypothesis 3: The strength of the score on the working alliance inventory is negatively associated with delta shame as indicated by the presence of shame proneness.

When calculating the significance of the relationship between the Working Alliance Inventory and the presence of Delta Shame as indicated by tosc-3 shame proneness scores using

the Spearman Rho Correlation Coefficient the result indicates there this no significant relationship based on the following information X ranks: Mean 21.5 with a Standard Deviation of 12.27 and Y ranks: Mean 21.5 with a Standard Deviation of 12.27 with combine covariance= -1261.75 / 41 = -30.77 R = -30.77 / (12.27 * 12.27) = -0.205 and rs = -0.20453, p (2-tailed) = 0.19384. This information indicates that the relationship between the strength of the therapeutic alliance as indicated by Working Alliance Inventory Scores and Delta Shame as indicated by Shame Proneness on the Toca-3 is not statistically significant.



The above scatter plot is a representation of the information from the Spearman rho correlation coefficient indicating that there is no statistically significant relationship between delta shame and therapeutic alliance strength. As a result, there is not a strong enough relationship to reject the null hypothesis.

Hypothesis 4: Training that focuses on modalities that increase bounding, goal agreement, and treatment agreement is positively associated with increased therapeutic alliance strength as indicated by the working alliance inventory.

This hypothesis was tested by using a quasi-experimental design indicating that no beneficial experimental tasks will be withheld from the total population after the testing phase. To test this sample a Wilcoxon Signed-Rank test was used to determine the significance of the scores in the experimental group pre and post-test the goal is to determine if the scored pairs changed in a statistically significant manner. The results of the Wilcoxon Signed-Rank test indicated that the result was not statistically significant at $p<.05$ the result of the z value is -.071 The p-value is .47777. The w-value was 47.5 with a mean difference of 3.55, the sum of positive ranks being 47.5, and the sum of negative ranks being 72. The Z-value:-.71 Mean (W):60 with a standard deviation (W) of 17.61 the sample size was N=15.

Though the Wilcoxon Signed-Rank test indicated that there was not a significant relationship pre and post-test for the individual group it should be noted that reduced sample size may impair the reliability of the Wilcoxon Signed-Rank test. The sample was also split into an experimental group and a control group. The means of the WAI were taken at the 1–3-month mark to establish a baseline for the WAI score. Following the establishment of this factor, follow-up emails were sent to the participants in the experimental group to increase their therapeutic alliance by keeping them engaged in the therapeutic process between the sessions. The scores of the experimental group were taken and compared to the scores in the control group in months 4-6. The control group showed a mean of 121.20 as a baseline for months 1-3 and a decrease in therapeutic alliance average with a mean of 116.60 in the 4-6 months. In the experimental group, there were baseline mean scores of 123.84 before the additional follow-ups

and after the additional follow-ups, there was an increase in the therapeutic alliance mean to a score of 125.72 on the WAI for the experimental group. The baseline means in the experimental group started higher and increased in the experiment whereas the control group means did not and reduced in score over the same amount of time. In the experimental group, one subject was eliminated from the means of this test due to not remaining in the experiment through the experimental phase and not being tested. Therefore, the sample size for this hypothesis decreased from 42 to 41. Based on the results gathered in this test the study will fail to reject the null hypothesis.

Control Group M WAI 1-3	Control Group M 4-6 WAI	C Group M 1-3 Tosca	C Group M 4-6 Tosca	Ex Group M 1-3 WAI	Ex Group M 4-6 WAI	Ex Group M 1-3 Tosca-3	Ex Group M 4-6 Tosca-3
115.7		34	33	112	133.5	34.5	25.5
98.6	112	35	40.3	128.5	120.3	36	24.3
126.7	109.3	38.7	40.7	128	123	36.5	31
135	128	63.5	69.3	124	136	44.3	33
121	134.6	36	27.5	139	132	37	26
132.5	121	41.5	39.5	121.3	134	57.3	46
135	120.5	34	35	138.3	135.6	40.3	67
111	135	69.5	62.5	109.5	119	56	53.5
94	75.5	45.5	49	78.3	69.5	37.7	43.7
129	61	62.5		140	138	44	43
134		43.5	30	132.3	138	28	28
119	128	30		127	134.5	38.5	42
137.5		59	56	115	108	29	30.7
119	106.7	38.5	36	130.5	136.5	34	29
136.5	109	27	16	134	128	33	27.3
103	134	51	58				
93.5	118.5	62	49				
119	105	38					
113.7	131	42	40.7				
102.7	113.7	39.7	39.3				
120	105	49.5					
133		38.7	31				
124.5	124.5	37	39				
131.5	122.5	43	41				
132	136.5	54					
134		31	37				
	134						

Hypothesis 5: As the scores from the working alliance inventory increase there will be little or no increase in the presence of shame as indicated by the shame proneness scale in the tosca-3 .

When examining the means from the working alliance inventory and the shame proneness scale the shame proneness scale should remain at baseline or reduce over the same

time frame. It can be seen using the same data from the hypothesis there that when calculating the significance of the relationship between the Working Alliance Inventory and the presence of Delta Shame as indicated by tosc-3 shame proneness scores using the Spearman Rho Correlation Coefficient the result indicates there this no significant relationship based on the following information X ranks: Mean 21.5 with a Standard Deviation of 12.27 and Y ranks: Mean 21.5 with a Standard Deviation of 12.27 with combine covariance= -1261.75 / 41 = -30.77 R = -30.77 / (12.27 * 12.27) = -0.205 and rs = -0.20453, p (2-tailed) = 0.19384. (See Table 3)This information indicates that the relationship between the strength of the therapeutic alliance as indicated by Working Alliance Inventory Scores and Delta Shame as indicated by Shame Proneness on the Toca-3 is not statistically significant. The presence of no significant relationship would indicate that in this hypothesis that the increase of the working alliance inventory would have no impact on the shame score indicating that indeed there would be little or no change in the shame proneness score when the therapeutic alliance score increased however, there is not a high enough significance in the relationship to determine that the presence of increased therapeutic alliance is the cause for a change or in this case a lack of a change in the shame score. In this hypothesis, the study will fail to reject the null hypothesis.

Hypothesis 6: As scores from the working alliance inventory are increased the presence of addictive behaviors is decreased.

When examining the scores from the working alliance inventory and the impact that the relationship of an increase in working alliance inventory scores has on the presence of addictive behaviors examining the data from hypothesis 2 that showed that no significant relationship exists between the score of the working alliance inventory and the presence of additive behavior. Based on the information gathered in hypothesis 2 if there is no significant relationship between

the Working Alliance Inventory and the frequency of addictive behavior using the Spearman Rho Correlation Coefficient as seen in the results that: X Ranks Mean 21.5 Standard Deviation 12.27 Y Ranks Mean:21.5 and the Standard Deviation is 12.04 with rs = -0.15141, p (2-tailed) = 0.33849. It can be inferred that there will also be no corresponding relationship between an increase in the same score as there would be no indication that it was the increase of the therapeutic alliance that resulted in the addictive behavior as opposed to other unknown factors. See Table two to show a representation of the information that indicates that there is no significant relationship between the working alliance inventory and addictive behavior. As a result of the above information and the lack of a significant relationship between the working alliance inventory and the presence of addictive behavior in this hypothesis, the study failed to reject the null hypothesis.

7: Training that focuses on the therapeutic alliance will positively impact the scores on the working alliance inventory. This will reduce the negative impact of shame on the therapeutic alliance's strength.

When examining this hypothesis, the study can use the information gathered from hypotheses 3 and 4. Hypothesis 3 indicates that no significant relationship exists between the baseline shame proneness and the working alliance inventory and because of this information it can be determined that an increase in therapeutic alliance inventory scores does not result in a reduction in the presence of shame.

The result from hypothesis 4 shows no significant relationship at the baseline between the working alliance inventory baseline and an increase in working alliance scores following training and follow-ups. Although there was a presence of an increase of means after training and follow-ups were seen the Though the Wilcoxon Signed-Rank test indicated that there was not a

significant relationship between pre and post-test for the individual group it should be noted that reduced sample size may impair the reliability of the Wilcoxon Signed-Rank test. The sample was also split into an experimental group and a control group. The means of the WAI were taken at the 1–3-month mark to establish a baseline for the WAI score. Following the establishment of this factor, follow-up emails were sent to the participants in the experimental group to increase their therapeutic alliance by keeping them engaged in the therapeutic process between the sessions. The scores of the experimental group were taken and compared to the scores in the control group in months 4-6. The control group showed a mean of 121.20 as a baseline for months 1-3 and a decrease in therapeutic alliance average with a mean of 116.60 in the 4-6 months. In the experimental group, there were baseline mean scores of 123.84 before the additional follow-ups and after the additional follow-ups, there was an increase in the therapeutic alliance mean to a score of 125.72 on the WAI for the experimental group. The baseline means in the experimental group started higher and increased in the experiment whereas the control group means did not and reduced in score over the same amount of time. In the experimental group, one subject was eliminated from the means of this test due to not remaining in the experiment through the experimental phase and not being tested. Therefore, the sample size for this hypothesis decreased from 42 to 41. Based on the results gathered in this test the study will fail to reject the null hypothesis. e increase was not large enough or consistent enough of a change to determine a significant relationship in hypothesis 4. See Tables 3 and 4 to see the results.

Summary

The results of this study show that there was no significant relationship between the variables that were studied. The first four hypotheses in this study determined the testability of the last 3. The first 3 hypotheses focused on the relationship between the working alliance inventory and addictive behavior, shame proneness and addictive behavior, and finally the relationship between the working alliance inventory and shame proneness. No indication was seen that a significant relationship existed between these variables and there was no significant change in the levels of working alliance strength after training in hypothesis 4. This information indicated that if there was a significant change in the relationship between the variables after training then it would be undeterminable if the change came from the variables or an outside unknown factor.

Even though the conclusion was that there was no significant relationship between the variables on a descriptive level there was some change between the variables even when evaluating them using the Wilcoxon Signed-Rank test and Spearman Rho to determine the strength in the relationship. The results from this study are equal on all hypotheses and fail to reject the null hypothesis.

Chapter Five: Conclusions

Overview

The goal of this study was to investigate why individuals who are in a medication-assisted therapy program for the treatment of opiate use disorder still exhibit addictive behavior. The tested hypothesis investigated the relationship between the therapeutic alliance, shame, and

addictive behavior as expressed in four combine categories: attendance, urine drug screen results, observed/reported withdrawal symptoms, and using control medication as directed. The results of this study showed that there was no significant relationship among the variables that were studied and as a result, the study did not fail to adopt the null hypothesis. Despite these results, further implications and questions remain concerning the phenomenon of individuals without an obvious presence of biological triggers for use but still presenting addictive behavior.

Discussion

The purpose of this study was two parts first: to investigate the relationship between shame and addictive behavior in patients that are in a medication-assisted therapy program to reduce the impact of the biological use cycle in the client's decision-making process. The purpose of this part was to investigate if an increased presence of shame contributed to or caused the client to relapse or exhibit significant addictive behavior. The second part of this purpose was to investigate a therapist's impact on the client's shame and subsequently their addictive behavior.

The first of two principal research questions in this study was: "Does a significant relationship exist between the presence of increased shame and the expression of addictive behavior that is defined as a relapse?" The results of the computations that were conducted to determine the significance of this relationship indicated that there was no significant relationship. The research that is conducted regarding the impact of shame in individuals with other use disorders indicates that clients with higher shame scores withdraw for treatment as exhibited by a reduction in affiliation and interpersonal interaction in the therapeutic process (Yang, et al., 2010). Research indicates that shame is a greater predicter than guilt when determining the

predictability of a client with an alcohol use disorder relapsing (Yang, et al., 2010). This research question focused on the thread in this theory that shame could be used as a predictive factor in substance use disorder relapse due to the nature of clients withdrawing from treatment and other helping relationships as exhibited by a reduction in affiliation and interpersonal interactions (Yang, et al., 2010) Further research shows that shame correlates with a clients desire to and execution of isolating themselves from others (Black, et al., 2013). As individuals experience shame they begin to desire to no longer be around other individuals and as a result withdrawal from people and begin to isolate (Black, et al., 2013). Research shows that the presence of shame reduces the presence and effectiveness of individuals coping skills when are diagnosed with substance use disorder (William and Jeffrey 2014). Considering the amount of literature that indicates that shame is a significant impact on behavior particularly through the expression of maladaptive coping skills such as continued use or beginning substance use behaviors, the results of this study were surprising. Several studies cited throughout this paper concluded that the presence of shame exacerbates mental health disorders, maladaptive coping and use behaviors. When examining the results of this study within the scope of the body of research at large a conclusion can be drawn that relapse is a very complex issue and there is not one singular cause for the expression of addictive behavior rather, relapse is a personal issue in which there can be many factors including but not limited to the presence of shame. Even though this study showed that there was no significant relationship between the scores of shame proneness and the presence of addictive behavior an abundance of other evidence exists that suggests that increased shame can negatively impact clients and contribute to the behaviors associated with relapse.

The second research question that was investigated during this study was if a relationship exists between the presence of shame and addictive behavior, then what is the level of impact

and how can a counselor effectively impact the level of shame to stop the increase and reduce the presence of addictive behavior? This question is closely related to the outcome of the first question because the outcome of the second question is partially determined by the existence of the relationship between addictive behavior and shame. The second part of this question focused on the impact that a therapist has on addictive behavior and shame. Can a therapist do anything to impact shame and as a result impact addictive behavior? The results of the study indicate that there was no significant relationship between therapeutic alliance and shame nor was there a significant link between the therapeutic alliance and addictive behaviors. This came as a surprise to the researcher due to the wealth of information that exists that seems to show a link between the presence of shame and the exacerbation of mental health disorders and substance use disorders.

The impact of shame on addictive behavior, relapse, and recovery is seen in research that indicates a client needed to manage interpersonal shame following relapse to learn to effectively cope (Leeming & Boyle, 2013). The indication is that substance use is a maladaptive coping skill and the imperativeness of needing to learn to adaptively cope with shame is required to change the coping skills from maladaptive to adaptive or from active use to recovery. When individuals relapse the shame that is experienced is often a result of the client's belief that they have lost there "clean time" this since of perfectionism is often developed in recovery and contributes to shame when addictive behavior or relapse occurs (Pembroke, 2012). This shame can exacerbate these feelings due to the client feeling as if the time was wasted because they were unable to remain clean (Pembroke, 2012). The research contrasts the results greatly concerning shame and the presence of addictive behavior.

This contrast continues when examining the relationship between therapeutic alliance and shame. Navigating the feelings associated with interpersonal shame and the behaviors that this emotional state drive is imperative for developing and fostering a strong therapeutic alliance (Leemin & Boyle, 2013). The body of research illustrates the importance of the therapeutic alliance when it illustrates that clients report that the most frequent reason given for stopping treatment or stopping seeking treatment was a lack of connection and personal support social support from their personal support system (Palmer, et al., 2009). If the primary reason for a client stopping treatment is due to a lack of support or connection with treatment staff, then the results of a strong therapeutic should have indicated that clients would be less likely to stop treatment (Palmer, et al., 2009). This lies in direct contrast to the results of the study which indicated that there was not a significant relationship between the therapeutic alliance and the presence of addictive behavior. Research also that retention in a program was a great indicator of success in the program and this research reports that among clients with only a mild comorbid condition the therapeutic alliance strength did little to improve retention and by extension reduce addictive behavior but individuals with moderate to severe comorbid conditions should a 50% difference in retention with 75% of clients with a strong therapeutic alliance being retained in treatment as opposed to 25% completion rate among those with a weak therapeutic alliance (Bickel & Petry, 1999).

The results of this study are contrasted by the body of research however, the individual studies that are cited as evidence in this study are focused publications with specific populations and circumstances which could indicate that additional more targeted research could be conducted to determine the influence of negative emotional states on recovery and the role of treatment providers to lend aid in the therapeutic process.

Implications

The results of this study indicated that there was not a significant relationship between therapeutic alliance, shame, and the presence of addictive behavior so why is it important to adopt this theory into the overall body of work moving forward? Several reasons exist why this research should be adopted into the body of research. The most prominent reason is based on a factor a part of the addictive behavior in this study. Addictive behavior was based on 4 factors attendance, relapse (failed UDS), miss use of medication, or withdrawal symptoms. When examining only failed urine drug screens in 41 patients over 6 months and among 262 drug screens there were only 20 occurrences in which the UDS was positive for an opiate which is a failure rate of .076 or 92.4% of urine drug screens that were measured showed that the client did not use opiates. Although the research showed that there was no significant relationship in the variables that were studied seeing urine drug screens come back at such a high rate of success generates a great deal of interest in studying the implications of negative emotional states like shame on individual populations that are diagnosed with an opiate use disorder in medication maintenance therapy. The question arises of how dose the client perceives the shame that is being measured. If the client perceives shame as traditionally expressed there may be a lack of hope and isolation on behalf of the client which could result in an exacerbation of negative symptoms. However, if the client views shame from the perspective of a Christian worldview or sees this as conviction could this perspective affect the client’s behavior while also still answering the questions on the shame measure in the same manner? The principle implication is that with the contrast being seen between the body of research and the results of this study, a client's perspective on shame's spiritual worldview could change the understanding of how shame and guilt are felt and impact individuals expressed behavior.

This study focused on shame as a cause of maladaptive coping in the form of addictive behavior shame being measured with the shame proneness scale from the Toasca-3. This measure is commonly used to measure shame and guilt-proneness. The study showed that shame has no significant effect on the presence of addictive behavior with this standing in contrast to standing research, a very high success rate in urine drug screen and a shame proneness mean of 42.01 the implication being that just because a client is doing well on urine drug screens “not using” does not mean that they are not dealing with a significant amount of shame concerning there recovery journey. This implication is that a greater effort must be made to aid the client from a holistic perspective addressing the client’s mind, body, and spirit from a collaborative effort among different providers on a treatment team or support group.

This study focused on a very specific population, individuals with an opiate use disorder on maintenance therapy. This allowed for a reduction in the impact of the biological use cycle that is often associated with relapse. Focusing on this population and the emotional toll that is paid during the recovery process leads to the implication that the most effective treatment is one that is holistic in nature concentrating solely on alleviating the physical symptoms associated with withdrawal from substance use but also addressing the mental health symptoms that the client is experiencing. Continued focus on this population and the emotional issues that are felt during the recovery process can elevate the understanding of providers, support systems, and family members so that more complete care can be delivered.

The final implication of this study is a discovery of a need to adjust how current substance use treatment is currently focused on. It is commonplace to focus on the symptoms or the addictive behavior and attempt to eliminate or simply curb this behavior and measure success based on the time between instances of addictive behavior. As noted in the research this can lead

to a need for perfectionism and increase the feelings of guilt and shame associated with triggers and addictive behavior (Pembroke, 2012). Even if shame is not an absolute cause of addictive behavior, research such as this moves the perspective from simply reducing the number of relapses and increasing the number of complaint drug screens to a focus that is geared to addressing the root cause of the continued addictive behavior in hopes to aid the client in the healing process. Opiate overdose is a pandemic that is killing thousands of people annually. Medication as helped save individuals following an overdose and eliminate the presence of withdrawal symptoms in the individuals diagnosed with this disorder. This study is a significant step in moving the perspective from treating the symptom of this disorder to working to establish a more effective multifaceted approach in the hope to reduce stigma and increase awareness of how complex this disorder is effective the population and the necessity of addressing the whole person in treatment.

Limitations

The limitations of this study in terms of internal using a p-value of .05 as a measure of the calculations indicated that the relationship was not statistically significant and there was no causal relationship between the variables measured. In terms of external validity and comparing the results of this study to the results of several other studies examining similar variables, the results are different. Other studies showed significant relationships when comparing similar variables. Some limitations include the size of the sample 42 patients in one single practice did not offer a very diverse population in addition to this limitation the clients knowing what the study was about could have influenced the scores on the test, particularly in the working alliance inventory as evidenced by the large number of individuals that chose the highest score for every question or fluctuated between extremes 1 and 7 with little differentiation.

A limitation that could have influenced the study is the lack of available therapists to test the working alliance inventory. The practice used had 3 available therapists' clients from only 2 therapists decided to participate. The lack of a number of participating therapists is a limitation that this study faced. Using multiple therapists and different agencies could have provided a wider array of responses to the questions and would have provided a more reliable and valid response. To compensate for the above limitations, the study used robust calculations and a p: value of <.05 to determine the relationship. This calculation yielded scores that indicated there was not a significant relationship between the values measured: addictive behavior, Shame proneness scores, and the working alliance inventory scores.

A limitation that was significant in this study was the number of tests that were completed in error. A test that was completed in error had questions that were missing, not answered, or answered more than once. If a client completed a test in error the test was thrown out. If this circumstance was noticed prior to the study ending the provider would explain the instructions to the client again prior to the next tests to make sure that the client was filling out the tests properly. This limitation affected the study by reducing the overall sample size in the tests. This limitation led to an additional limitation; if a test was thrown out due to an error often times the corresponding test had to be throughout too because the instruments used for the calculations required that the values be even when comparing them. For example, if an error existed in the tosca-3 but not the working alliance inventory on the same date then both tests may would have been thrown out to make sure that an even number of tosca-3 responses and WOI responses were represented in the calculations. This limitation also further reduced the size of the sample. This limitation was addressed by trying to ensure that the tests that were dropped were from the same day of testing. The limitations in this study that could skew the calculations into a

basis situation that have provided information that indicated that a significant relationship could exist between the variables being studied were thoroughly addressed. This is evidenced by the results of the study's failure to reject the null hypothesis.

Recommendations for Future Research

The future of research in this field of study should focus on substance use disorders in which the biological use cycle is well maintained. This will allow for more effective exploration into a possible causality of addictive behavior. Using the same population but adjusting the type of study could yield a great deal of information. Seeing the discrepancy between the body of research and the results of this quantitative study conducting a new study that is qualitative in nature focuses on a phenomenology of why individuals that are experiencing relapse and corresponding reports in a session that they are also experiencing shame. Additionally focusing on the impact of shame and the feelings that clients associate with the presence of shame and how these feelings impact various aspects of their daily life is vitally important. For instance, if a client is experiencing shame does this result in the client withdrawing from friends, family, and social support, and if they do how does this affect the overall status of their relapse? There is a general acceptance in the recovery community that a lack of social support, coping skills, and treatment increase the chances an individual will relapse. The body of research and clients' testimonials corroborate an indication that withdrawing from these key support systems increases the likelihood that the relapses or lapses.

One issue that may have impacted the results of this study is the possible client basis. Using a double-blind method and running a similar experiment may be helpful as it should reduce the likelihood that the clients have any positive or negative basis in the testing phase. For

instance, if the client has a good relationship with the therapist, then they may over-emphasize the strength of the relationship to “help the therapist”. However in doing so, the client is answering several questions that the client meant for positive but are graded for the negative resulting in a possibility that the results are skewed. By focusing on double-blind experimentation using different variables of addictive behavior individually to uncover the relationships that are taking place. Then a better representation of the measures can be taken. Increasing the size and scope of the study should also be a factor in future research using several practices and differing therapists.

This study focused on addictive behavior by identifying overuse of medication, an absence of a control medication, the presence of an opiate or missing an appointment as addictive behavior. These behaviors can certainly significantly impact the client’s recovery however, future research may modify the behaviors classified as addictive due to variables that could cause some of these behaviors. By replacing the addictive behaviors that were present in this study with DSM-V criteria met for opiate use disorder and continuing to use the UDS and the PDMP for monitoring the clients use of control medication and possible relapse a better description of addictive behavior could be seen.

Future research should also focus on the impact of negative emotions on the exacerbation of symptoms. Examining not only shame but guilt and conviction as well. Working to uncover or develop a scale that can measure conviction would also be valuable for future research. Developing a new measure for conviction or uncovering one could be beneficial in bridging the gap between individuals that report shame but also report that they are entirely unaffected by the shame. Form a Christian world view perspective the questions associated with shame or guilt might mirror conviction but the practical application of the feelings are very different. Shame

and guilt cause the individual to feel a since of worthlessness based on either intrinsic feelings and beliefs or because of an action that the individual feels guilty about. Conviction might follow similar feelings initially, however with the presence of grace these feelings subside due to forgiveness. Furthermore, an exploration of the topic of shame and substance use from a Christian world view perspective would aid in a deeper understanding of this theory. By studying the impact of grace on negative feelings associated with lapses and relapse as well as the feelings of stigma associated with individuals that seek therapy from faith-based programs versus secular programs.

Although the conclusion of the study resulted in a failure to reject the null hypothesis, this study has yielded many questions and potential research studies that continually focus on the impact of shame on the feelings of clients with a substance use disorder and how these negative feelings impact the client's ability to effectively navigate the recovery process. By focusing on the impact of negative emotional states and how there adversely impact the results of recovery. This field can continue to develop a multidisciplinary approach to treating this epidemic that has claimed so many lives.

This was a complex study that was built on the establishment of the impact of shame on the therapeutic alliance and both variables' impact on addictive behavior. The result of this study was a failure to reject the null hypothesis despite the body of research seeming to predict a different outcome. The reason for this outcome could come from several different sources the most evident is the client’s failure to provide an honest assessment of the questions that were presented. This is evidenced by the number of raw scores that showed several clients on multiple tests and retests scored all 7’s on the therapeutic alliance or fluctuated between both extremes on every test with little or no variation. This situation occurred in a significant number of the tests

and could have certainly impacted the overall result of the study. Additional, other variables could have impacted the outcome of the study including the way the questions were asked, the number of times the client took the test, the length of the study, or even the length of time the individuals had been in therapy. Several speculations exist on why the outcome of this study. It would be easy to stop there but, as the total body of evidence is examined including this study, many more questions are able to be asked, most notably why individuals relapse who have the biological use cycle well maintained. Uncovering evidence of what factors correlate to addictive behavior and relapse is a pursuit that should be continued. Working to take the evidence presented in this study and develop new studies which will aid in the development of additional forms of care and techniques for treating opioid use disorder could be life saving for those that are impacted by this disorder.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders. doi:10.1176/appi.books.9780890425596

Andersen, D. (2015). What's so funny? Towards a client perspective on professionals' use of humor in drug treatment. *Drugs: Education, Prevention and Policy*, *22*(3), 263-271. doi:10.3109/09687637.2015.1016399

Andrade-González, N., & Fernández-Liria, A. (2015). Spanish adaptation of the revised helping alliance questionnaire (HAq-II). *Journal of Mental Health*, *24*(3), 155-161. doi:10.3109/09638237.2015.1036975

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41*(1), 29-42. doi:10.1348/014466502163778

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24*(2), 85-100. doi:10.1080/09515070.2011.589602

Barr, P. (2015). Guilt, shame and fear of death predict neonatal intensive care unit-related parental distress. *Journal of Reproductive and Infant Psychology*, *33*(4), 402-413. doi:10.1080/02646838.2015.1043624

Baumann, E. C., & Hill, C. E. (2015). Client concealment and disclosure of secrets in outpatient psychotherapy. *Counselling Psychology Quarterly*, *29*(1), 53-75. doi:10.1080/09515070.2015.1023698

Black, R. S., Curran, D., & Dyer, K. F. (2013). The impact of shame on the therapeutic alliance and intimate relationships. *Journal of Clinical Psychology*, *69*(6), 646-654. doi:10.1002/jclp.21959

Brennan, M. A., Emmerling, M. E., & Whelton, W. J. (2014). Emotion-focused group therapy: Addressing self-criticism in the treatment of eating disorders. *Counselling and Psychotherapy Research, 15*(1), 67-75. doi:10.1002/capr.12012

Britton, P. C., & Conner, K. R. (2007). Reliability of the UCLA loneliness scale in opiate dependent individuals. *Journal of Personality Assessment, 88*(3), 368-371. doi:10.1080/00223890701333605

Bryan, C. J., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2012). Guilt, shame, and suicidal ideation in a military outpatient clinical sample. *Depression and Anxiety, 30*(1), 55-60. doi:10.1002/da.22002

Bynum, W. E., & Goodie, J. L. (2014). Shame, guilt, and the medical learner: Ignored connections and why we should care. *Medical Education*, *48*(11), 1045-1054. doi:10.1111/medu.12521

Carr, S. M., Smith, I. C., & Simm, R. (2013). Solution-focused brief therapy from the perspective of clients with long-term physical health conditions. *Psychology, Health & Medicine*, *19*(4), 384-391. doi:10.1080/13548506.2013.824594

Chao, Y., Cheng, Y., & Chiou, W. (2011). The psychological consequence of experiencing shame: Self-sufficiency and mood-repair. *Motivation and Emotion*, *35*(2), 202-210. doi:10.1007/s11031-011-9208-y

Claesson, K., & Sohlberg, S. (2002). Internalized shame and early interactions characterized by indifference, abandonment and rejection: Replicated findings. *Clinical Psychology & Psychotherapy*, *9*(4), 277-284. doi:10.1002/cpp.331

Cook, D. R. (1994). *Internalized shame scale: Professional manual*.

Cook, S., Heather, N., & McCambridge, J. (2015). The role of the working alliance in treatment for alcohol problems. *Psychology of Addictive Behaviors, 29*(2), 371-381. doi:10.1037/adb0000058

Cournoyer, L., Brochu, S., Landry, M., & Bergeron, J. (2007). Therapeutic alliance, patient behaviour and dropout in a drug rehabilitation programme: The moderating effect of clinical subpopulations. *Addiction, 102*(12), 1960-1970. doi:10.1111/j.1360-0443.2007.02027.x

Day, E., & Mitcheson, L. (2017). Psychosocial interventions in opiate substitution treatment services: Does the evidence provide a case for optimism or nihilism? *Addiction*, *112*(8), 1329-1336. doi:10.1111/add.13644

De France, K., Lanteigne, D., Glozman, J., & Hollenstein, T. (2016). A new measure of the expression of shame: The Shame code. *Journal of Child and Family Studies*, *26*(3), 769-780. doi:10.1007/s10826-016-0589-0

Dehghani-Arani, F., Rostami, R., & Nadali, H. (2013). Neurofeedback training for opiate addiction: Improvement of mental health and craving. *Applied Psychophysiology and Biofeedback*, *38*(2), 133-141. doi:10.1007/s10484-013-9218-5

D'iuso, D., Blake, E., Fitzpatrick, M., & Drapeau, M. (2009). Cognitive errors, coping patterns, and the therapeutic alliance: A pilot study of in-session process. *Counselling and Psychotherapy Research*, *9*(2), 108-114. doi:10.1080/14733140902804276

Dorahy, M. J. (2010). The impact of dissociation, shame, and guilt on interpersonal relationships in chronically traumatized individuals: A pilot study*. *Journal of Traumatic Stress*, *23*(5), 653-656. doi:10.1002/jts.20564

Dorahy, M. J., Corry, M., Black, R., Matheson, L., Coles, H., Curran, D., … Dyer, K. F. (2016). Shame, dissociation, and complex PTSD symptoms in traumatized psychiatric and control groups: Direct and indirect associations with relationship distress. *Journal of Clinical Psychology*, *73*(4), 439-448. doi:10.1002/jclp.22339

Dorahy, M. J., Gorgas, J., Hanna, D., & Wiingaard, S. U. (2014). Perceptions of therapist responses to shame disclosures by clients: A quasi-experimental investigation with non-clinical participants. *Counselling and Psychotherapy Research*, *15*(1), 58-66. doi:10.1002/capr.12004

Duff, C. T., & Bedi, R. P. (2010). Counsellor behaviours that predict therapeutic alliance: From the client's perspective. *Counselling Psychology Quarterly*, *23*(1), 91-110. doi:10.1080/09515071003688165

Easter, A., Pollock, M., Pope, L. G., Wisdom, J. P., & Smith, T. E. (2015). Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships. *The Journal of Behavioral Health Services & Research*, *43*(3), 341-353. doi:10.1007/s11414-015-9492-5

Faris, A. S., Cavell, T. A., Fishburne, J. W., & Britton, P. C. (2009). Examining motivational interviewing from a client agency perspective. *Journal of Clinical Psychology*, *65*(9), 955-970. doi:10.1002/jclp.20599

Fasulo, S. J., Ball, J. M., Jurkovic, G. J., & Miller, A. L. (2015). Towards the development of an effective working alliance: The application of DBT validation and stylistic strategies in the adaptation of a manualized complex trauma group treatment program for adolescents in long-term detention. *American Journal of Psychotherapy*, *69*(2), 219-239. doi:10.1176/appi.psychotherapy.2015.69.2.219

Gao, J., Wang, A., & Qian, M. (2010). Differentiating shame and guilt from a relational perspective: A cross-cultural study. *Social Behavior and Personality: an international journal*, *38*(10), 1401-1407. doi:10.2224/sbp.2010.38.10.1401

Gubi, P. M., & Marsden-Hughes, H. (2013). Exploring the processes involved in long-term recovery from chronic alcohol addiction within an abstinence-based model: Implications for practice. *Counselling and Psychotherapy Research*, *13*(3), 201-209. doi:10.1080/14733145.2012.733716

Gutierrez, D., & Hagedorn, W. (2013). The toxicity of shame applications for acceptance and commitment therapy. *Journal of Mental Health Counseling*, *35*(1), 43-59. doi:10.17744/mehc.35.1.5n16p4x782601253

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology*, *36*(2), 223-233. doi:10.1037/0022-0167.36.2.223

Karlin, B. E., Walser, R. D., Yesavage, J., Zhang, A., Trockel, M., & Taylor, C. B. (2013). Effectiveness of acceptance and commitment therapy for depression: Comparison among older and younger veterans. *Aging & Mental Health*, *17*(5), 555-563. doi:10.1080/13607863.2013.789002

Keen, N., George, D., Scragg, P., & Peters, E. (2017). The role of shame in people with a diagnosis of schizophrenia. *British Journal of Clinical Psychology*, *56*(2), 115-129. doi:10.1111/bjc.12125

Kelly, A. C., Carter, J. C., & Borairi, S. (2013). Are improvements in shame and self-compassion early in eating disorders treatment associated with better patient outcomes? *International Journal of Eating Disorders*, *47*(1), 54-64. doi:10.1002/eat.22196

Klingemann, H., Schläfli, K., & Steiner, M. (2013). “What do you mean by spirituality? Please draw me a picture!” complementary faith-based addiction treatment in Switzerland from the client's perspective. *Substance Use & Misuse*, *48*(12), 1187-1202. doi:10.3109/10826084.2013.803875

Lee, J. A., Neimeyer, G. J., & Rice, K. G. (2013). The relationship between therapist epistemology, therapy style, working alliance, and interventions use. *American Journal of Psychotherapy, 67*(4), 323-345. doi:10.1176/appi.psychotherapy.2013.67.4.323

Lee, J. H. (2008). Shame and pastoral care: Implications from an Asian theological perspective. *Pastoral Psychology, 57*(5-6), 253-262. doi:10.1007/s11089-008-0138-x

Leeming, D., & Boyle, M. (2011). Managing shame: An interpersonal perspective. *British Journal of Social Psychology, 52*(1), 140-160. doi:10.1111/j.2044-8309.2011.02061.x

Long, M., Manktelow, R., & Tracey, A. (2015). "Knowing that I'm not alone": Client perspectives on counselling for self-injury. *Journal of Mental Health, 25*(1), 41-46. doi:10.3109/09638237.2015.1101426

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., Bunting, K., & Rye, A. K. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development, and pilot outcomes. *Addiction Research & Theory, 16*(2), 149-165. doi:10.1080/16066350701850295

Luoma, J. B., Kulesza, M., Hayes, S. C., Kohlenberg, B., & Larimer, M. (2014). Stigma predicts residential treatment length for substance use disorder. *The American Journal of Drug and Alcohol Abuse, 40*(3), 206-212. doi:10.3109/00952990.2014.901337

Luoma, J., Guinther, P., Potter, J., & Cheslock, M. (2017). Experienced-based versus scenario-based assessments of shame and guilt and their relationship to alcohol consumption and problems. *Substance Use & Misuse, 52*(13), 1692-1700. doi:10.1080/10826084.2017.1305416

Lupis, S. B., Sabik, N. J., & Wolf, J. M. (2015). Role of shame and body esteem in cortisol stress responses. *Journal of Behavioral Medicine, 39*(2), 262-275. doi:10.1007/s10865-015-9695-5

LYNCH, J. S., HILL, E. D., NAGOSHI, J. L., & NAGOSHI, C. T. (2012). Mediators of the shame-guilt-psychological adjustment relationship. *Scandinavian Journal of Psychology, 53*(5), 437-443. doi:10.1111/j.1467-9450.2012.00967.x

Maffina, L., Deane, F. P., Lyons, G. C., Crowe, T. P., & Kelly, P. J. (2013). Relative importance of abstinence in clients' and clinicians' perspectives of recovery from drug and alcohol abuse. *Substance Use & Misuse, 48*(9), 683-690. doi:10.3109/10826084.2013.782045

Matos, M., Pinto-Gouveia, J., & Duarte, C. (2012). Above and beyond emotional valence: The unique contribution of central and traumatic shame memories to psychopathology vulnerability. *Memory, 20*(5), 461-477. doi:10.1080/09658211.2012.680962

McCabe, B. E., Santisteban, D. A., Mena, M. P., Duchene, D. M., McLean, C., & Monroe, M. (2013). Engagement, retention, and abstinence for three types of opioid users in Florida. *Substance Use & Misuse, 48*(8), 623-634. doi:10.3109/10826084.2013.800112

McCance-Katz, E. F. (2004). Office-based buprenorphine treatment for opioid-dependent patients. *Harvard Review of Psychiatry, 12*(6), 321-338. doi:10.1080/10673220490905688

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction, 100*(3), 304-316. doi:10.1111/j.1360-0443.2004.00935.x

Meier, P. S., Donmall, M. C., Barrowclough, C., McElduff, P., & Heller, R. F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, *100*(4), 500-511. doi:10.1111/j.1360-0443.2005.01031.x

Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, *83*(1), 57-64. doi:10.1016/j.drugalcdep.2005.10.010

Moritz, S., & Jelinek, L. (2011). Further evidence for the efficacy of association splitting as a self-help technique for reducing obsessive thoughts. *Depression and Anxiety*, *28*(7), 574-581. doi:10.1002/da.20843

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2009). Working alliance inventory-short revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy*, n/a-n/a. doi:10.1002/cpp.658

Mukaka MM. Statistics corner: A guide to appropriate use of correlation coefficient in medical research. Malawi Med J. 2012 Sep;24(3):69-71. PMID: 23638278; PMCID: PMC3576830.

Neacsiu, A. D., Rizvi, S. L., Vitaliano, P. P., Lynch, T. R., & Linehan, M. M. (2010). The dialectical behavior therapy ways of coping checklist: Development and psychometric properties. *Journal of Clinical Psychology*, n/a-n/a. doi:10.1002/jclp.20685

Owen, T., & Fox, S. (2011). Experiences of shame and empathy in violent and non-violent young offenders. *Journal of Forensic Psychiatry & Psychology*, *22*(4), 551-563. doi:10.1080/14789949.2011.602096

Oliveira, A., Sousa, D., & Pires, A. P. (2012). Significant Events in Existential Psychotherapy:

The Client's Perspective. Existential Analysis: *Journal of the Society for Existential Analysis*, 23(2), 288–304. Retrieved from http://ezproxy.liberty.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=82404661&site=ehost-live&scope=site

Paap, D., Schrier, E., & Dijkstra, P. U. (2018). Development and validation of the working alliance inventory Dutch version for use in rehabilitation setting. *Physiotherapy Theory and Practice*, *35*(12), 1292-1303. doi:10.1080/09593985.2018.1471112

Palmer, R. S., Murphy, M. K., Piselli, A., & Ball, S. A. (2009). Substance user treatment dropout from client and clinician perspectives: A pilot study. *Substance Use & Misuse*, *44*(7), 1021-1038. doi:10.1080/10826080802495237

Parker, S., & Thomas, R. (2009). Psychological differences in shame vs. guilt: Implications for mental health counselors. *Journal of Mental Health Counseling*, *31*(3), 213-224. doi:10.17744/mehc.31.3.f405217281988832

Pecoraro, A., Ma, M., & Woody, G. E. (2012). The science and practice of medication-assisted treatments for opioid dependence. *Substance Use & Misuse*, *47*(8-9), 1026-1040. doi:10.3109/10826084.2012.663292

Pembroke, N. (2012). Pastoral care for shame-based perfectionism. *Pastoral Psychology*, *61*(2), 245-258. doi:10.1007/s11089-011-0414-z

Petry, N. M., & Bickel, W. K. (1999). Therapeutic alliance and psychiatric severity as predictors of completion of treatment for opioid dependence. *Psychiatric Services*, *50*(2), 219-227. doi:10.1176/ps.50.2.219

Pinto-Gouveia, J., Matos, M., Castilho, P., & Xavier, A. (2012). Differences between depression and paranoia: The role of emotional memories, shame and subordination. *Clinical Psychology & Psychotherapy*, *21*(1), 49-61. doi:10.1002/cpp.1818

Pizarro, K. W., Bustamante, I. V., & Surkan, P. J. (2016). Family factors and adolescent problem drinking in a high-risk urban Peruvian neighborhood. *Substance Use & Misuse*, *52*(2), 194-202. doi:10.1080/10826084.2016.1223137

Prosek, E. A., Giordano, A. L., Holm, J. M., Bevly, C. M., Sender, K. M., Ramsey, Z. B., & Abernathy, M. R. (2017). Experiencing shame: Collegiate alcohol abuse, religiosity, and spirituality. *Journal of College Counseling*, *20*(2), 126-138. doi:10.1002/jocc.12065

Rangganadhan, A. R., & Todorov, N. (2010). Personality and self-forgiveness: The roles of shame, guilt, empathy and conciliatory behavior. *Journal of Social and Clinical Psychology*, *29*(1), 1-22. doi:10.1521/jscp.2010.29.1.1

Rollnick, S., Miller, W. R., & Butler, C. C. (2012). *Motivational interviewing in health care: Helping patients change behavior*. Guilford Press.

Roussos, A., Braun, M., & Olivera, J. (2016). "*For me it was a key moment of Therapy*": Corrective experience from the client's perspective. *Journal of Clinical Psychology*, *73*(2), 153-167. doi:10.1002/jclp.22429

Ruckstaetter, J., Sells, J., Newmeyer, M. D., & Zink, D. (2017). Parental apologies, empathy, shame, guilt, and attachment: A path analysis. *Journal of Counseling & Development*, *95*(4), 389-400. doi:10.1002/jcad.12154

Rüsch, N., Corrigan, P. W., Bohus, M., Jacob, G. A., Brueck, R., & Lieb, K. (2007). Measuring shame and guilt by self-report questionnaires: A validation study. *Psychiatry Research*, *150*(3), 313-325. doi:10.1016/j.psychres.2006.04.018

Sarno. (n.d.). *A Phenomenological Study of Clinicians Treating Traumagentic Compulsions Resulting from Childhood Sexual Abuse* (Unpublished doctoral dissertation). Capella University.

Sarno, A., (2014). Treating Veterans with Complex Traumagenic Disorders: When Childhood Traumas and Current Traumas Collide. *Journal of Military and Government Counseling*, 2(1) 48-61. Retrieved from http://acegonline.org/wp-content/uploads/2013/02/ JMGC-Vol-2-Is-1.pdf

Schalkwijk, F., Stams, G. J., Dekker, J., Peen, J., & Elison, J. (2016). Measuring shame regulation: Validation of the compass of shame scale. *Social Behavior and Personality: an international journal*, *44*(11), 1775-1791. doi:10.2224/sbp.2016.44.11.1775

Sharpley, C. F., Fairnie, E., Tabary-Collins, E., Bates, R., & Lee, P. (2000). The use of counsellor verbal response modes and client-perceived rapport. *Counselling Psychology Quarterly*, *13*(1), 99-116. doi:10.1080/09515070050011097

Silfver, M., Helkama, K., Lönnqvist, J., & Verkasalo, M. (2008). The relation between value priorities and proneness to guilt, shame, and empathy. *Motivation and Emotion*, *32*(2), 69-80. doi:10.1007/s11031-008-9084-2

Stevenson, E., & Cole, J. (2015). Associations between chronic non-cancer pain and medication assisted treatment outcomes for opiate addiction. *The American Journal on Addictions*, *24*(2), 138-143. doi:10.1111/ajad.12151

Stuewig, J., Tangney, J. P., Kendall, S., Folk, J. B., Meyer, C. R., & Dearing, R. L. (2014). Children's proneness to shame and guilt predicts risky and illegal behaviors in young adulthood. *Child Psychiatry & Human Development*, *46*(2), 217-227. doi:10.1007/s10578-014-0467-1

Tangney, J. P., Dearing, R. L., Wagner, P. E., & Gramzow, R. (2000). Test of self-conscious affect–3. *PsycTESTS Dataset*. doi:10.1037/t06464-000

Thomaes, S., Stegge, H., & Olthof, T. (2007). Externalizing shame responses in children: The role of fragile-positive self-esteem. *British Journal of Developmental Psychology*, *25*(4), 559-577. doi:10.1348/026151007x173827

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(3), 207-210. doi:10.1037/1040-3590.1.3.207

WAI home | Working alliance inventory. (n.d.). https://wai.profhorvath.com/

Wallhed Finn, S., Bakshi, A., & Andréasson, S. (2014). Alcohol consumption, dependence, and treatment barriers: Perceptions among Nontreatment seekers with alcohol dependence. *Substance Use & Misuse*, *49*(6), 762-769. doi:10.3109/10826084.2014.891616

Wallhed Finn, S., Bakshi, A., & Andréasson, S. (2014). Alcohol consumption, dependence, and treatment barriers: Perceptions among Nontreatment seekers with alcohol dependence. *Substance Use & Misuse*, *49*(6), 762-769. doi:10.3109/10826084.2014.891616

Warner, R. M. (2013). Applied statistics: From bivariate through multivariate techniques: From bivariate through multivariate techniques. SAGE.

Watson, J. B. (2017). Behaviorism. Routledge.

Wood, L., & Irons, C. (2017). Experienced stigma and its impacts in psychosis: The role of social rank and external shame. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(3), 419-431. doi:10.1111/papt.12127

Yang, M., Yang, C., & Chiou, W. (2010). When guilt leads to other orientation and shame leads to egocentric self-focus: Effects of differential priming of negative affects on perspective

taking. *Social Behavior and Personality: an international journal*, *38*(5), 605-614. doi:10.2224/sbp.2010.38.5.605

Zou, Z., & Wang, D. (2009). Guilt versus shame: Distinguishing the two emotions from a Chinese perspective. *Social Behavior and Personality: an international journal*, *37*(5), 601-604. doi:10.2224/sbp.2009.37.5.601

Appendices

Appendix A

Dear Cameron McClure, Gary Probst,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu<mailto:irb@liberty.edu>.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B

Greetings,

You are more than welcome to use our measures. I am attaching the TOSCA-3 as well as the TOSCA-4 (our most recent measure of shame and guilt proneness for adults) along with scoring information. If you need another version (for children or adolescents), please let us know. I've also attached a couple articles providing information on the reliability and validity of the TOSCA-4.

You can find a comprehensive summary of our earlier research and information on reliability and validity of the TOSCA-3 in:

Tangney, JP & Dearing, RL (2002). Shame and Guilt. NY: Guilford Press.

The book is available through www.guilford.com, www.amazon.com, and in some university libraries.

Please do keep in touch and let us know how your research develops. I would be grateful for a summary of the results whenever they become available.

Best Wishes,

June T.

June Tangney, Ph.D.
University Professor
and Professor of Psychology

George Mason University
Department of Psychology
MSN 3F5
Fairfax VA 22030
703 993 1365 (Office)
703 993 1335 (Fax)
jtangney@gmu.edu

Appendix C

SOCIETY FOR PSYCHOTHERAPY RESEARCH

January 24, 2021

Cameron McClure
Liberty University
Lynchburg, VA

Dear Cameron McClure:

You have our permission to use the Working Alliance Inventory in your study on the impact of the working alliance on shame and addictive behavior on individuals with severe opiate use disorders. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

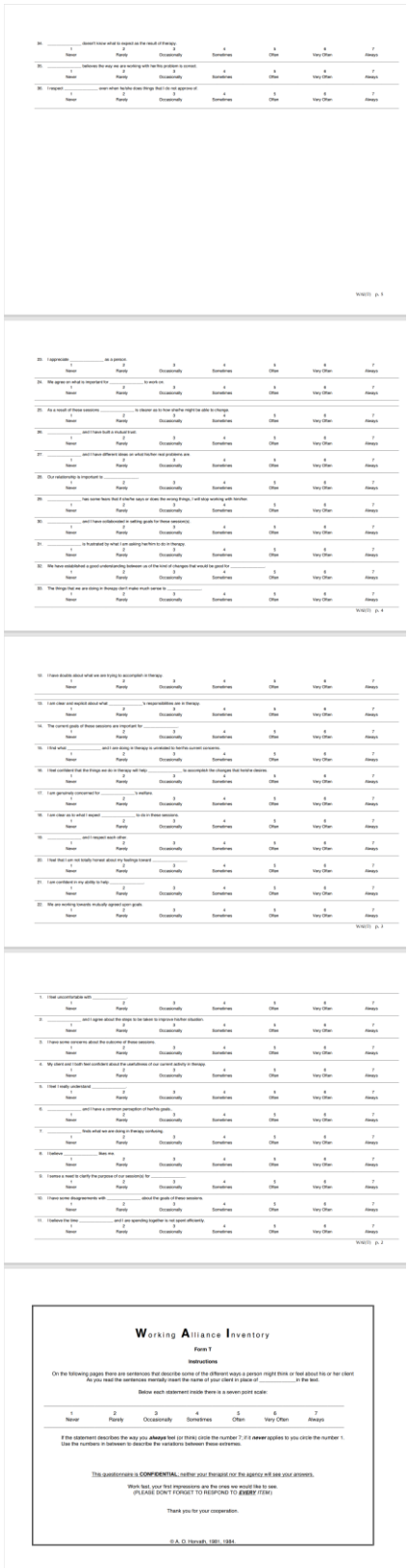
We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

[redacted]

Bernadette Walter, Ph.D.
Interim Executive Director
Society for Psychotherapy Research
sprexecutive@gmail.com

Appendix D



34. _____ doesn't know what to expect as the result of therapy.
35. _____ believes the way we are working with her/his problem is correct.
36. I respect _____ even when he/she does things that I do not approve of.

WAIIT5 p. 5

39. I appreciate _____ as a person.
34. We agree on what is important for _____ to work on.
35. As a result of these sessions _____ is clearer as to how she/he might be able to change.
36. _____ and I have built a mutual trust.
37. _____ and I have different ideas on what his/her real problems are.
38. Our relationship is important to _____.
39. _____ has some fears that if he/her says or does the wrong things, I will stop working with him/her.
30. _____ and I have collaborated in setting goals for these sessions(s).
31. _____ is frustrated by what I am asking her/him to do in therapy.
32. We have established a good understanding between us of the kind of changes that would be good for _____.
33. The things that we are doing in therapy don't make much sense to _____.

WAIIT5 p. 4

10. I have doubts about what we are trying to accomplish in therapy.
19. I am clear and explicit about what _____'s responsibilities are in therapy.
14. The current goals of these sessions are important for _____.
15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.
16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.
17. I am genuinely concerned for _____'s welfare.
18. I am clear as to what I expect _____ to do in these sessions.
19. _____ and I respect each other.
20. I feel that I am not totally honest about my feelings toward _____.
21. I am confident in my ability to help _____.
22. We are working towards mutually agreed upon goals.

WAIIT5 p. 3

1. I feel uncomfortable with _____.
2. _____ and I agree about the steps to be taken to improve his/her situation.
3. I have some concerns about the outcome of these sessions.
4. My client and I both feel confident about the usefulness of our current activity in therapy.
5. I feel I really understand _____.
6. I feel I really understand _____.
7. _____ and I have a common perception of her/his goals.
8. _____ finds what we are doing in therapy confusing.
9. I believe _____ likes me.
10. I sense a need to clarify the purpose of our session(s) for _____.
11. I have some disagreements with _____ about the goals of these sessions.
12. I believe the time _____ and I are spending together is not spent efficiently.

WAIIT5 p. 2

Working **A**lliance **I**nventory

Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client
As you read the sentences mentally insert the name of your client in place of _____ in the text.

Below each statement inside there is a seven point scale:

1 Never 2 Rarely 3 Occasionally 4 Sometimes 5 Often 6 Very Often 7 Always

If the statement describes the way you **always** feel (or think) circle the number 7. If it **never** applies to you circle the number 1.
Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL**, neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO ***EVERY*** ITEM)

Thank you for your cooperation.

Appendix E

Consent Template: General

To provide the information necessary for potential subjects or their legally authorized representatives (LARs) to make a decision about participating in research, consent is required.

Information in the consent document must be organized to facilitate comprehension. **Consent documents should be written in plain language, generally at an 8th-grade reading level.** The reading level can be higher if the target population tends to have a higher literacy rate than the general population.

We recommend the use of this template to create the consent document(s) for your study. Please note the following:

1. Text in [brackets] represents information about your study that you must add. Your study information should be written in plain language.
2. A backslash (/) indicates that you must make a selection depending on your study procedures (e.g., "will/will not" or "I/we").
3. Additional instructions or sample text are provided in boxes.
4. Before you submit your consent document to the IRB, delete this cover page, brackets, and boxes. The finished document should reflect what you will give to the subject.
5. Please follow the **instructions in blue** below, revising or providing the information in **red**. You will need to remove the instructions as you go, including these instructions. The font color of your completed document should be **black**.
6. If your study will involve multiple types of participants requiring different consent forms, save each file using a file name specific to each consent document, clearly identifying the type of consent and the intended audience (e.g., parental consent, survey consent, etc.).

For questions about consent, please contact the IRB at irb@liberty.edu.

For more information on plain language, go to http://www.plainlanguage.gov/.

Appendix F
Consent

Title of the Project: Predicting positive and negative treatment outcomes in medication assisted opiate treatment programs as indicated by the presence of shame and therapeutic alliance strength.
Principal Investigator: Cameron McClure M.A. LPC., Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be at least 18 years old and currently enrolled in a medication assisted therapy program treating opiate use disorder with a buprenorphine product. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to complete the necessary requirements of a doctoral dissertation for the principal investigator and to study the impact of shame and therapeutic alliance on the outcome of therapy in medication assisted therapy programs .

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete a Working alliance inventory once a month during the study. This will taking place during your counseling sessions and should not take more than a five minutes to complete. The results of this survey will be scored, and no personally identifiable information will be used in the result of the study.
2. Complete a Test of Self-Conscious Affect-3 once a month during the study. This will be taking place during your counseling sessions and should not take more than five minutes to complete. The results of this survey will be scored, and no personally identifiable information will be used in the result of the study.
3. The study will be requesting access to your monthly urine drug screen, pills counts and attendance to your regularly scheduled treatment programs.
4. Some participants will be randomly selected to have a slight modification in the counseling procedure that may result in the participant being contacted by the therapist.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are the strengthening of the therapeutic alliance within the therapeutic process. A reduction in addictive behaviors and reduction in the measurable presence of shame. The purpose of this study is identification and reduction of things that make treatment more difficult for success.

Participants should not expect to receive a direct benefit from taking part in this study to include an elimination of addictive behavior or shame.

Benefits to society include a perspective change in the way that medication assisted therapy is approached and a greater infuses to be placed on the counseling experience. This study will also show the need for long term maintenance therapies in order to continue to treat individuals with this chronic condition.

What risks might you experience from being in this study?

The risks involved in this study include because you currently participate in a medication assisted therapy program, the risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- A statement describing procedures taken to protect the privacy of the participant(s) and the confidentiality of their data: Participant responses will be anonymous. Participant responses will be kept confidential using codes. Interviews will be conducted in a location where others will not easily overhear the conversation. During regularly scheduled counseling sessions where increased confidentiality already applies.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Hard copy information will be stored in a locked building, in a code locked office in a locked filling cabinet. Hard copy data will be retained for three years at which time it will be shredded and properly disposed of.
- Theses surveys and the information will be taking place during a professional counseling session as such the following limits to confidentiality apply: threats to ones self or others, and reported abuse to a child or vulnerable adult.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

What are the costs to you to be part of the study?

To participate in the research, you will need to pay for your current medication assisted therapy treatment and medication. There is no additional cost incurred to participate in the study but in order to participate you must be in the program.

Does the researcher have any conflicts of interest?

The researcher serves as a Clinical Counselor and the Program Director at Achieve Behavioral Health. This disclosure is made so that you can decide if this relationship will affect your

willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate in this study will not affect your current or future relations with :Liberty University, Achieve Behavioral Health or Participating Researchers. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please inform the researcher that you wish to discontinue your participation, and do not submit your study materials. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Cameron McClure. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted]. You may also contact the researcher's faculty sponsor, Dr. Gary Probst, at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You will be given a copy of this document for your records/you can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher/study team using the information provided above.

_____

Printed Subject Name

_____

Signature & Date

Appendix G

Debriefing Template

You may need to debrief participants after they have completed your study ***to inform them about any deceptive study procedures or element(s)***. Whether or not you choose to debrief participants depends on the nature of your research, whether your data collection was anonymous, and if debriefing would cause more harm than good. If your data collection was anonymous and it will not be possible for you to remove data from individual participants should they choose to withdraw, you should evaluate whether debriefing is necessary and potentially choose not to do so.

Information in the debriefing document must be organized to facilitate comprehension. **Debriefing should be written in plain language, generally at an 8th-grade reading level.** The reading level can be higher if the target population tends to have a higher literacy rate than the general population.

We recommend the use of this template to create the debriefing document(s) for your study. Please note the following:

7. Text in [brackets] represents information about your study that you must add. Your study information should be written in plain language.
8. A backslash indicates that you must make a selection depending on your study procedures (e.g., "will/will not" or "I/we").
9. Additional instructions or sample text are provided in boxes.
10. Before you submit your consent document to the IRB, delete this cover page, brackets, and boxes. The finished document should reflect what you will give to the subject.
11. Please follow the **instructions in blue** below, revising or providing the information in **red**. You will need to remove the instructions as you go, including these instructions. The font color of your completed document should be **black**.
12. If your study will involve multiple types of participants requiring different debriefing forms, use a file name for each debriefing document that clearly identifies the intended audience (e.g., teacher debriefing, student debriefing, etc.).

For questions about debriefing, please contact the IRB at irb@liberty.edu.

For more information on plain language, go to http://www.plainlanguage.gov/.

Debriefing Statement

Title of the Project: Predicting positive and negative treatment outcomes in medication assisted opiate treatment programs as indicated by the presence of shame and therapeutic alliance strength.
Principal Investigator: Cameron McClure LPC Liberty University

Thank you for being part of a research study.

You recently participated in a research study. You were selected as a participant because you. Participation in this research project was voluntary.

Please take time to read this entire form and ask any questions you may have.

What was the study about and why was it being done?

The purpose of the study was to explore the impact of shame on recovery and the importance of therapeutic alliance in order to reduce addictive behavior in clients that are participating in medication assisted therapy treatment for a severe opiate use disorder.

Why am I receiving a debriefing statement?

The purpose of this debriefing statement is to inform you that the true nature of the study or an aspect of the study was not previously disclosed to you.

You were originally told that the study was to show your progress in therapy and the impact that the shame experience has on progress. You were not told that the intent of the study was to illustrate that a strong therapeutic alliance is being study to show if it results in a reduction of addictive behavior. You were not told that the shame that was being studied also resulted in a possible increase in addictive behavior .

Why was deception necessary?

Deception was necessary because, if you knew the impact of the questions being asked and the intent of the study it may have impacted your answers and skewed the study resulting in a less than accurate response.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researchers will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of [pseudonyms/codes]./ Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Cameron McClure. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted]. You may also contact the researcher's faculty sponsor, Gary Probst at [redacted].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd, Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Appendix G

TOSCA-3

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news. (1)---2---3---4---5
not likely very likely

b) You would take the extra time to read the paper. 1---2---3---4---(5)
not likely very likely

c) You would feel disappointed that it's raining. 1---2---(3)---4---5
not likely very likely

d) You would wonder why you woke up so early. 1---2---3---(4)---5
not likely very likely

In the above example, I've rated ALL of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on a Saturday morning -- so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't -- it would depend on what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items -- rate all responses.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

a) You would think: "I'm inconsiderate." 1---2---3---4---5 not likely very likely

b) You would think: "Well, they'll understand." 1---2---3---4---5 not likely very likely

c) You'd think you should make it up to him as soon as possible. 1---2---3---4---5 not likely very likely

d) You would think: "My boss distracted me just before lunch." 1---2---3---4---5 not likely very likely

2. You break something at work and then hide it.

a) You would think: "This is making me anxious. I need to either fix it or get someone else to." 1---2---3---4---5 not likely very likely

b) You would think about quitting. 1---2---3---4---5 not likely very likely

c) You would think: "A lot of things aren't made very well these days." 1---2---3---4---5 not likely very likely

d) You would think: "It was only an accident." 1---2---3---4---5 not likely very likely

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

a) You would think: "I should have been aware of what my best friend is feeling." 1---2---3---4---5 not likely very likely

b) You would feel happy with your appearance and personality. 1---2---3---4---5 not likely very likely

c) You would feel pleased to have made such a good 1---2---3---4---5

impression. not likely very likely

d) You would think your best friend should pay attention to his/her spouse. 1---2---3---4---5 not likely very likely

e) You would probably avoid eye-contact for a long time. 1---2---3---4---5 not likely very likely

4. At work, you wait until the last minute to plan a project, and it turns out badly.

a) You would feel incompetent. 1---2---3---4---5 not likely very likely

b) You would think: "There are never enough hours in the day." 1---2---3---4---5 not likely very likely

c) You would feel: "I deserve to be reprimanded for mismanaging the project." 1---2---3---4---5 not likely very likely

d) You would think: "What's done is done." 1---2---3---4---5 not likely very likely

5. You make a mistake at work and find out a co-worker is blamed for the error.

a) You would think the company did not like the co-worker. 1---2---3---4---5 not likely very likely

b) You would think: "Life is not fair." 1---2---3---4---5 not likely very likely

c) You would keep quiet and avoid the co-worker. 1---2---3---4---5 not likely very likely

d) You would feel unhappy and eager to correct the situation. 1---2---3---4---5 not likely very likely

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

a) You would think: "I guess I'm more persuasive than I thought." 1---2---3---4---5 not likely very likely

b) You would regret that you put it off. 1---2---3---4---5

not likely very likely

c) You would feel like a coward. 1---2---3---4---5
not likely very likely

d) You would think: "I did a good job." 1---2---3---4---5
not likely very likely

e) You would think you shouldn't have to make calls you feel pressured into. 1---2---3---4---5
not likely very likely

7. While playing around, you throw a ball and it hits your friend in the face.

a) You would feel inadequate that you can't even throw a ball. 1---2---3---4---5 not likely very likely

b) You would think maybe your friend needs more practice at catching. 1---2---3---4---5 not likely very likely

c) You would think: "It was just an accident." 1---2---3---4---5 not likely very likely

d) You would apologize and make sure your friend feels better. 1---2---3---4---5 not likely very likely

8. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

a) You would feel immature. 1---2---3---4---5 not likely very likely

b) You would think: "I sure ran into some bad luck." 1---2---3---4---5 not likely very likely

c) You would return the favor as quickly as you could. 1---2---3---4---5 not likely very likely

d) You would think: "I am a trustworthy person." 1---2---3---4---5 not likely very likely

e) You would be proud that you repaid your debts. 1---2---3---4---5 not likely very likely

9. You are driving down the road, and you hit a small animal.

a) You would think the animal shouldn't have been on the road. 1---2---3---4---5 not likely very likely

b) You would think: "I'm terrible." 1---2---3---4---5

not likely very likely

c) You would feel: "Well, it was an accident." 1---2---3---4---5
not likely very likely

d) You'd feel bad you hadn't been more alert driving down the road. 1---2---3---4---5
not likely very likely

10. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

a) You would think: "Well, it's just a test." 1---2---3---4---5
not likely very likely

b) You would think: "The instructor doesn't like me." 1---2---3---4---5
not likely very likely

c) You would think: "I should have studied harder." 1---2---3---4---5
not likely very likely

d) You would feel stupid. 1---2---3---4---5
not likely very likely

11. You and a group of co-workers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

a) You would feel the boss is rather short-sighted. 1---2---3---4---5
not likely very likely

b) You would feel alone and apart from your colleagues. 1---2---3---4---5
not likely very likely

c) You would feel your hard work had paid off. 1---2---3---4---5
not likely very likely

d) You would feel competent and proud of yourself. 1---2---3---4---5
not likely very likely

e) You would feel you should not accept it. 1---2---3---4---5
not likely very likely

12. While out with a group of friends, you make fun of a friend who's not there.

a) You would think: "It was all in fun; it's harmless." 1---2---3---4---5
not likely very likely

b) You would feel small...like a rat. 1---2---3---4---5
not likely very likely

c) You would think that perhaps that friend should have been there to defend himself/herself. 1---2---3---4---5
not likely very likely

d) You would apologize and talk about that person's good points. 1---2---3---4---5
not likely very likely

13. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

a) You would think your boss should have been more clear about what was expected of you. 1---2---3---4---5 not likely very likely

b) You would feel like you wanted to hide. 1---2---3---4---5 not likely very likely

c) You would think: "I should have recognized the problem and done a better job." 1---2---3---4---5 not likely very likely

d) You would think: "Well, nobody's perfect." 1---2---3---4---5 not likely very likely

14. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

a) You would feel selfish and you'd think you are basically lazy. 1---2---3---4---5 not likely very likely

b) You would feel you were forced into doing something you did not want to do. 1---2---3---4---5 not likely very likely

c) You would think: "I should be more concerned about people who are less fortunate." 1---2---3---4---5 not likely very likely

d) You would feel great that you had helped others. 1---2---3---4---5 not likely very likely

e) You would feel very satisfied with yourself. 1---2---3---4---5 not likely very likely

15. You are taking care of your friend's dog while they are on vacation and the dog runs away.

a) You would think, "I am irresponsible and incompetent." 1---2---3---4---5 not likely very likely

b) You would think your friend must not take very 1---2---3---4---5

good care of their dog or it wouldn't have run away. not likely very likely

c) You would vow to be more careful next time. 1---2---3---4---5 not likely very likely

d) You would think your friend could just get a new dog. 1---2---3---4---5 not likely very likely

16. You attend your co-worker's housewarming party and you spill red wine on their new cream-colored carpet, but you think no one notices.

a) You think your co-worker should have expected some accidents at such a big party. 1---2---3---4---5 not likely very likely

b) You would stay late to help clean up the stain after the party. 1---2---3---4---5 not likely very likely

c) You would wish you were anywhere but at the party. 1---2---3---4---5 not likely very likely

d) You would wonder why your co-worker chose to serve red wine with the new light carpet. 1---2---3---4---5 not likely very likely