

**Professional Counselors' Perceptions of the Role of Alcoholics Anonymous (AA) in
Substance Abuse Treatment: A Qualitative Narrative**

by

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Abstract

Participation in Alcoholics Anonymous (AA) is an accepted, widely used practice in substance abuse treatment as a stand-alone method and as an adjunct to more traditional therapeutic models. The absence of overwhelming support for the AA model as a successful or curative approach in the treatment of substance abuse coupled with the far ranging use of this approach by professional counselors and treatment centers appears counterintuitive. The present study examines professional counselors' perceptions of the perceived benefits of AA, how and under what circumstances they would identify participation in AA as the best treatment option, and their assessment of the circumstances under which AA should be used. Results may contribute to the development of protocols for determining which clients might be referred by professionals to AA, which might be treated solely with more counseling-based models, and which might benefit most from some combination of the two approaches. Findings may also have implications for alcohol and drug treatment programs.

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CHAPTER I. INTRODUCTION

Substance abuse ranks as one of the major public health issues in today's society. At any given time in the United States, substance abuse is either directly or indirectly related to up to 50% of emergency room admissions and 25% of completed suicides (Stevens & Smith, 2001). As well, half of all homicides, one-third of psychiatric emergencies, 25% of completed suicide attempts of people addicted to alcohol, adolescents' psychiatric conditions, more than half of all domestic violence cases, and ischemic stroke primarily due to illicit drug use (Cohen, 1995; Evans & Sullivan, 1990; Gentilelo, Donovan, Dunn & Rivera, 1995; Hyman & Cassem, 1995; Martin, Enevoldson, & Humphrey, 1997; National Foundation for Brain Research, 1992). Regardless of their area of expertise, counseling professionals will certainly be faced with clients who present with substance use disorders (Polcin, 2000). Numerous studies suggest a lifetime prevalence rate of 8%–14% for alcohol dependence (American Psychiatric Association, 1994), and it appears that at least 19% of clients who present with a current mental health problem are also plagued with a history of substance use disorder, and in such populations such as clients with a diagnosis of schizophrenia, for example, there is a 47% lifetime history of substance abuse or dependence (Regier et al., 1990).

Substance abuse almost always occurs within the context of other problems. Common presenting problems that are related to substance abuse are marital and family conflicts, child abuse, unemployment, financial problems, depression, suicide, multiple medical problems, as well as problems with aggression and violence. In assessing the role of substance abuse within

the context of other problems, the clinician needs to understand the dynamics of other behavioral problems and how they may be exacerbated by substance abuse (Stevens, 2001).

Unfortunately, the literature indicates that mental health professionals have not performed well in their treatment of substance abuse disorders (Brown, 1985; Khantzian, 1985; Vaillant, 1995). According to Shaffer (1986), although addictions professionals choose from an array of treatment models, including professional and self-help approaches, no single method appears to demonstrate a high degree of effectiveness. Some reviews of the history of the treatment of substance abuse have argued that the traditional psychodynamic approach to treating individuals with substance abuse issues as a symptom of an underlying psychiatric disorder have been especially ineffective (Polcin, 1997). Vellerman (1989) indicates that there is no single approach or one agency that can help those individuals who suffer with substance abuse problems. He indicates that accurate assessment of individuals is essential in order to match the client with the best possible service. Beck, Wright, Newman and Liese (1993) stated that there is no conclusive evidence about the most effective treatment for all people with alcohol problems. They concluded that treatment outcomes for individuals with alcohol problems are determined by a number of aspects that include the process of treatment, post-treatment adjustment, the characteristics of those individuals seeking treatment, the nature of the presenting problem, and the interactions between these variables. Professionals have speculated that the popularity of self-help groups such as Alcoholics Anonymous (AA) occurred because of the ineffective response by mental health professionals to substance abuse problems (Khantzian, 1985).

AA is described as a self-help program based on the attraction of its members to the program's philosophy rather than on program promotion (Alcoholics Anonymous World Services [AAWS], 1990). The relationship between AA and professionally directed addiction

treatment is an enduring theme in the modern history of alcoholism treatment. AA is viewed by many professionals and recovering individuals as the single most important component of maintaining a clean and healthy lifestyle (White, 1998). Proponents of AA quickly point out that participation provides the individual with an environment in which experiences can be shared and trust can be established. AA's philosophy has changed how many people view themselves, their substance use and abuse, and the roles played by the people around them. AA meetings are accessible, open to all prospective members, and free with no time limit for participation (Le, Ingarson, & Page, 1995). The broad influence of AA is reflected in slogans AA has made famous. "It's the first drink that gets you drunk"; this slogan tells members to aim for abstinence. "One day at a time" warns members not to be discouraged by relapses. "Think through the drink" encourages members to consider the long-term consequences of their actions. As in behavior therapy, individuals are warned to stay away from "people, places, and things" associated with alcohol, and to be especially conscious of the risk when they are "angry, hungry, tired, or lonely" (Harvard Mental Health Letter, July 2007). There is also a strong reliance on spirituality. AA professes to be spiritual rather than religious. Bill Wilson, AA's founder, explains the distinction in a chapter of *Alcoholics Anonymous* entitled, "We Agnostics":

As soon as we were able to lay aside prejudice and express even a willingness to believe in a Power greater than ourselves, we commenced to get results, even though it was impossible for any of us to fully define or comprehend that Power, which is God. Much to our relief, we discovered we did not need to consider another's conception of God. Our own conception, however inadequate, was sufficient to make the approach and to affect a contact with Him. As soon as we admitted the possible existence of a Creative Intelligence, a Spirit of the Universe underlying the totality of things, we began to be

possessed of a new sense of power and direction.... [L]ay aside prejudice, even against organized religion. We have learned that whatever the human frailties of various faiths may be; those faiths have given purpose and direction to millions.

Some counselors are uncomfortable with the spiritual qualities of AA (Bristow-Braitman, 1995), and prefer to use cognitive-behavioral or humanistic approaches to treatment. Rational emotive behavior therapy (REBT) has led the way in setting up recovery groups that are non-spiritual in nature. In a comprehensive review of research on alcoholism treatment outcomes Miller and Hester (1986) identified social skills training, stress management, and the community reinforcement approach as receiving sound support from controlled studies that have been replicated. The Institute of Medicine (1990) cited social skills training, marital and family therapy, stress management training, and the community reinforcement approach as showing “promise for promoting and prolonging sobriety” (p. 538). If a healthy relationship between AA and professional counseling is to be achieved, then a clarification of boundaries is needed. These boundaries must be solid enough that both clients and counselors are aware of the important differences between AA philosophy and other substance abuse treatment programs, and flexible enough that clients may be referred to AA if desired.

The use of the AA model of recovery as an adjunct, or, in some instances, as a replacement for therapy models bears further investigation. The focus of the present study is on the perceptions of professional counselors about the treatment of substance abuse disorders and the role of AA in the treatment of such disorders. Further understanding of the reasons counselors integrate AA philosophy into counseling treatment will be explored. The study attempts to identify and examine professional counselors’ perceptions regarding the effectiveness

of the AA model of recovery as both a stand- alone model for the treatment of substance abuse and as part of a counseling-based approach to treatment.

Statement of the Problem

Most people, whether or not they have used or abused substances themselves, have an abuser in the family, or have a close friend who has abused, or at least know someone or heard of someone in their community who uses alcohol or other drugs inappropriately. According to Stevens (2001), alcoholism continues to be a major problem among adolescents and is a major contributor to fatal automobile accidents and domestic violence situations. Smoking has increased in children ages 12 to 13. The United States has waged a “war on drugs,” and carried out hundreds and possibly thousands of drug busts to stop the explosion of substance use, but to no avail. For helping professionals, drug abuse and dependence continue to be a major mental health challenge. Anecdotally, counseling professionals believe that substance use/abuse is intertwined with the majority of other problems that clients present in therapy; statistics support that belief.

Purpose of the Study

Participation in AA is a well-accepted and widely used practice in substance abuse treatment as an adjunct to more traditional therapeutic models and as a stand-alone treatment. The absence of overwhelming support for the AA model as a successful, or curative, approach in the treatment of substance abuse coupled with the far-ranging use of this approach by professional counselors and treatment centers seems counterintuitive. Therefore, an in-depth examination of professional counselors’ perceptions of the perceived benefits of AA, how and under what circumstances participation in AA is identified as the best treatment option, and the circumstances under which AA is not used may aid in the development of protocols for

determining which clients might be referred to AA, which might be treated with more counseling-based models, and which might benefit most from some combination of the two approaches. Also, these findings may suggest additional content and instructional strategies for alcohol-related treatment intervention courses.

This qualitative case study was designed to generate a description of substance abuse counselors' perceptions of the role of AA in treatment. . In the following chapters, a review of the literature regarding the current status of substance treatment and AA will be presented, an explanation of the qualitative design for the present study, and finally the results, analyses, and conclusions of the study.

Definition of Terms

Alcoholics Anonymous (AA) – Alcoholics Anonymous describes itself as a mutual self-help group and a fellowship of recovering individuals, not as a treatment modality. Membership is based on attraction rather than promotion. It is free of charge. It does not have any opinion on any outside issues. It makes no effort to study its effectiveness to justify its existence other than periodic surveys to see what percentage of its members remain abstinent (Alcoholic Anonymous, 1976).

Counseling-Based Interventions – The term, Counseling-Based interventions, refers to the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies that address wellness, personal growth, career development, or pathology. Counseling-based interventions may range from a few brief interventions, such as classroom discussions, or longer-term one-on-one or small group counseling interventions for individuals with more substantial needs. Counseling may be delivered by a single counselor, two counselors working collaboratively, or a single counselor

with brief assistance from another counselor who has specialized expertise that is needed by the client (Gladding, 2004).

Professional Counselor – Individuals who wish to practice counseling or who wish to use the title, professional counselor, must be licensed as a professional counselor or hold a temporary license or professional counselor training certificate. According to the American Counseling Association (ACA), professional counselors apply mental health, psychological or human development principles, through cognitive affective, behavioral or systemic interventions, strategies that address wellness, personal growth or career development, as well as pathology.

Self-Help Model – Since the 1970s, self-help groups have grown in prominence. Self-help groups usually develop spontaneously on a single topic, and are typically led by a layperson with little, if any, formal group training; however, the individual usually has experience in the stressful event that brought the group together. Over 10 million people are involved in approximately 500,000 such groups in the United States, and the number continues to increase (Gladding, 2004). Self-help groups aim to fill some of the needs of populations who can best be served through groups, and those who might otherwise not receive services. Groups meet in churches, recreation centers, schools, and other community buildings, as well as in mental health facilities. Lieberman (1994) sees self-help and support groups as healthy for the general public, and Corey (2001) thinks such groups are complementary to other mental health services. Like other group experiences, however, “cohesion is always a vital characteristic for success,” and proper guidelines must be set up to ensure the group will be a positive, not a destructive, event (Riordan & Beggs, 1987).

Substance Abuse (Diagnosis) – One of the primary difficulties encountered in diagnosing alcohol and drug problems may lie in the inadequate definitions commonly used. In an attempt to

provide more comprehensive, specific, symptom-related criteria for diagnosis, the American Psychiatric Association (1994) developed categories for “Substance-Related Disorders” in the Diagnostic and Statistic Manual IV (DSM-IV). The term substance is used to refer to a drug of abuse, a medication, or a toxin. Substances are grouped into 11 classes: alcohol; amphetamines; caffeine; cannabis; cocaine; hallucinogens, inhalants; nicotine; opioids; phencyclidine (PCP); and sedatives, hypnotics, or anxiolytics (anti-anxiety drugs). The Substance-Related Disorders are divided into two basic groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and Substance-Induced Disorders (including Substance Intoxication and Substance Withdrawal) (Chamberlain & Jew, 2001).

CHAPTER II. LITERATURE REVIEW

The review of the literature examines the differences between Alcoholics Anonymous (AA) and substance abuse treatment. Also, this review will examine the differences between treatment programs based on the 12-step model of recovery and counseling-based treatment programs.

Substance Abuse Treatment

Substance misuse, abuse, and addiction are multifaceted problems that vary across cultures and families as well as with individuals. Each problem is an issue that affects everyone, and the costs are staggering. The complexity of the problem has resulted in no single treatment method evolving as most effective for health-distressed individuals experiencing the consequences of substance abuse; however, current research does find that some approaches are more effective than others. Counselors, whether they work in the field of substance abuse counseling or in the general field of psychotherapy, encounter issues of substance abuse with many of their clients. Therefore, it is essential that all mental health professionals understand the process of abuse and addiction, the etiology of addiction, the individual, family, and societal costs, and available treatment modalities such as Alcoholics Anonymous (AA) and counseling-based interventions (Stevens, 2009).

Alcoholics Anonymous (AA)

Alcoholics Anonymous (AA) was founded late in the spring of 1935 when two middle-aged, middle-class men met in Akron, Ohio and formed an alliance to obtain and maintain

sobriety. Both men, known now to AA as Bill W. and Dr. Bob, had been through years of compulsive, heavy drinking and had tried to stay sober with the aid of the Oxford Group, an evangelical non-denominational Christian organization. From those beginnings, AA has grown into a worldwide social organization consisting of autonomous local groups. An unusual institution, the only membership requirement is a desire to stop drinking. AA charges no dues or fees from members and keeps no membership lists. AA exists in and through local meetings and the interpersonal relationship between members. AA in the United States and Canada has a formal organizational structure based in New York City, but that structure has a minimal relationship with AA at large (Swora, 2004).

Since its conception in 1935, AA has grown to be the most widely used organization for the treatment of alcoholism and substance abuse. Currently consisting of an estimated 1,800,000 members in 134 countries and more than 87,000 local groups, AA has become a major force in shaping the views of addiction (Alcoholics Anonymous World Services [AAWS], 1990). AA's treatment philosophy has changed how many people view themselves, their substance use and abuse, and the roles played by the people around them. The influence of AA is seen not only in the treatment of alcoholics, but also in the range of support groups for varying concerns of eating disorders, drug addiction, and gambling (Browne, 1991; Gifford, 1989; Yearly, 1987). AA can provide the individual with an environment in which experiences can be shared and trust can be established (Flores, 1988).

Brief History of Alcoholics Anonymous

By 1934 alcoholic Bill Wilson had ruined a promising Wall Street career with his persistent drunkenness. He was introduced to the idea of a spiritual cure by an old drinking buddy, Ebby Thacher, who had become a member of a Christian movement called the Oxford

Group. The Oxford Group believed in the practice of meditation, a belief in God of the believers' understanding, and following the six tenets: 1. Men are sinners; 2. Men can be changed; 3. Confession is a prerequisite of change; 4. The changed soul had direct access to God; 5. The age of miracles has returned; and 6. Those who have been changed must change others. At some point, Wilson was treated at Charles B. Towns Hospital by Dr. William Silkworth who promoted a disease concept of alcoholism. While in the hospital, Wilson underwent what he believed to be a spiritual experience and, convinced of the existence of a healing higher power, he was able to stop drinking (White, 1998).

On a 1935 business trip to Akron, Ohio, Wilson felt the urge to drink again and in an effort to stay sober, he sought another alcoholic to help. Wilson was introduced to Dr. Bob Smith. Wilson and Smith co-founded AA with a word-of-mouth program to help alcoholics. Bob Smith took his last drink on June 10, 1935, and this date is considered by members to be the founding date of AA. By 1937, Wilson and Smith determined that they had helped 40 alcoholics get sober, and two years later, with the first 100 members, Wilson expanded the program by writing a book entitled, *Alcoholics Anonymous*, which the organization also adopted as its name. The book, informally referred to by members as "The Big Book," described a twelve-step program involving admission of powerlessness, a moral inventory, and asking for help from a higher power. In 1944, book sales and membership increased after radio interviews and favorable articles in national magazines, particularly by Jack Alexander in *The Saturday Evening Post*.

According to White (1998), there were a wide range of ways in which AA as an institution and AA members related to alcoholism in the years between 1935 and 1960. AA made plans and then abandoned their plans to create "AA hospitals" and "AA Rest Homes" as well as

plans to send out “field missionaries” to carry the AA message to the far corners of the earth. AA members served as advocates for the creation of local alcoholism treatment programs, and served on national, state, and local alcoholism treatment advisory boards. Many states and national alcoholism efforts were pioneered almost exclusively by AA members.

By 1946, as membership grew, confusion and disputes within groups over practices, finances, and publicity led Wilson to write the guidelines for non-coercive group management that eventually became known as the Twelve Traditions. AA came of age at the 1955 St. Louis convention when Wilson turned over the stewardship of AA to the General Service Board. In this era, AA also began its international expansion, and by 2006 there were a reported 1,867,212 AA members in 106,202 AA groups worldwide. The Twelve Traditions informally guide how AA groups function, and the *Twelve Concepts for World Service* guide how AA is structured globally. AA groups are self-supporting and are not charities, and they have no dues or membership fees. Groups rely on member donations, typically \$1 collected per meeting in America, to pay for expenses like room rental, refreshments, and literature. No one is turned away for lack of funds. AA receives proceeds from books and literature that constitute more than 50% of the income for the General Service Office (GSO), which unlike individual groups, is not self-supporting and also maintains a small salaried staff. Additionally, it also maintains service centers which coordinate activities like printing literature, responding to public inquiries, and organizing conferences. They are funded by local members and responsible to the AA groups they represent.

The AA-suggested program of recovery for alcoholics includes abstaining from alcohol one day at a time and having a spiritual awakening through following the Twelve Steps, helping with duties and service work in AA, and regular AA meeting attendance or contact with AA

members. Members are encouraged to find an experienced fellow alcoholic called a sponsor to help them follow the AA program. The program of action has the goal of producing an identity change sufficient to recover from alcoholism. AA promotes the idea that recovery from alcoholism entails more than not drinking. Most AA meetings begin with socializing. Formats vary between meetings; for example, a beginner's meeting might include a talk by a long-time sober member about his or her personal experience of drinking, coming to AA and what was learned there about sobriety. A group discussion on topics related to alcoholism and the AA program might follow.

A survey conducted by AA in 2004 indicates that over 7500 members in Canada and the United States concluded that AA is composed of 89.1% White, 65% male, and 35% female members. Average member sobriety is eight years with 36% sober more than ten years, 14% sober from five to ten years, 14% sober from one to five years, and 26% sober less than one year. Before coming to AA, 64% of members received some type of treatment or counseling, such as medical, psychological, or spiritual. After coming to AA, 65% received outside treatment or counseling and 84% of those members said that outside help played an important part in their recovery. A survey conducted in 2004 showed that AA received 11% of its membership from court ordered attendance (AA World Services, 2004).

AA in the Context of Substance Abuse Treatment

Since 1949, when the Hazelden Treatment Center was founded by members of Alcoholics Anonymous, some alcoholic rehabilitation clinics have frequently incorporated precepts of the AA program into their own treatment programs. A reciprocal influence has also occurred with AA receiving 31% of its membership from treatment center referrals. Alcoholics

Anonymous, however, does not endorse and is not allied with any rehabilitation center or outside facility.

With the passing of many years, AA emerged as a primary source of referral of alcoholics to treatment programs. There were also many alcoholism treatment programs in the 40s and early 50s in which AA sponsorship was a requirement for admission. AA members served as volunteers within alcoholism treatment programs — often in education and co-therapist roles. AA members transported patients from hospitals, asylums, sanitariums, rest homes and prisons to AA meetings, and facilitated AA meetings inside these institutions. In the 40s, AA members — acting as individuals rather than as representatives of AA — began organizing and working as paid staff within alcoholism education and treatment programs, a practice that forced AA and treatment institutions to begin a dialogue about the distinctions between AA and treatment. As treatment programs developed formal patient-education programs, AA members were increasingly called upon to speak to patients about alcoholism, recovery, and AA.

The Basic Text of AA regards alcoholism as an illness. While discussing the term “disease,” Bill Wilson once stated that alcoholism was more comparable to an illness or malady, and uses the concept to challenge the belief of chronic, compulsive drinkers that they can stay sober by willpower alone. Dr. Silkworth introduced to Wilson and to AA the idea that alcoholism is an illness consisting of an obsession to drink alcohol and an “allergy” which was the compulsion to continue drinking once the first drink had even been taken.

What is perhaps most significant is that AA became the primary sobriety-based support structure to which most alcoholic patients were referred upon their discharge from treatment. What has been called the “modern alcoholism movement” rose in the 1940s to redefine America’s view of alcoholism and the alcoholic. One of the legacies of this movement was a

professionally directed model of alcoholism treatment that integrated AA's philosophy and professionalized AA members within the new role of alcoholism counselor. Beginning with this movement, and ending with a model that, more than any preceding it makes the boundary between mutual-aid and alcoholism treatment extremely difficult to draw (White, 1998).

Philosophy of Alcoholics Anonymous (AA). Kurtz (1979) describes AA as both a fellowship of alcoholics and a program of recovery from alcoholism. Participation and its principles are considered an effective treatment for alcoholism; however, AA itself is not considered therapy. AA's program for recovery as outlined in the Twelve Steps is a set of spiritual concepts and practices that have the purpose not of curing alcoholism, but of transforming the alcoholic, and the key term here is spiritual. The AA model of recovery explains alcoholism as incurable and a progressive disease of the body, mind and spirit. The fellowship and program focus on the spiritual aspect.

Miller and Kurtz (1994) suggest that the cornerstone of the AA model of recovery is the paradoxical belief that to gain control of one's life, the individual must give up control to a Higher Power. Although God is spoken about in AA, members believe that one's Higher Power can be many things or beings. AA does distinguish between spirituality and religion. Addiction is believed to be a spiritual disease as well as a physical one. By embracing spirituality and not a specific religious dogma, AA allows all individuals to embrace a Higher Power of their own choosing. AA is described as a "spiritual program of living."

As emphasized by Marion and Coleman (1991), the belief that abstinence from substance use is not enough is fundamental in AA philosophy. Individuals must be willing to make fundamental changes in their lifestyle with respect to attitudes and behaviors. The model is designed to allow individuals to address every aspect of their lives to include the physical,

emotional, social and spiritual aspects and to make positive changes in each of these areas. Once these changes are implemented by an individual, the individual will then be expected to reach out to others in an effort to offer assistance to others who are recovering from a substance using life style. The Twelve Traditions are also an important component of AA; they govern the operation of AA.

AA considers five aspects of recovery as the most important in the program: (a) learning to give up control to gain control; (b) self-examination and discussion of this examination; (c) making amends; (d) group participation; and (e) daily reminders. Hoffman and Gressard (1994) point out that these factors work best when combined in a non-coercive environment of participation that is present in AA. A 12-step program is a set of guiding principles for recovery from addiction, compulsion, or other behavioral problems. Originally proposed by AA as a method of recovery from alcoholism, The Twelve Steps were first published in the book, *Alcoholics Anonymous* in 1939. The method was then adopted and became the foundation of other twelve-step programs. Below are the original Twelve Steps (Alcoholics Anonymous World Services [AAWS], 1976): We

1. Admitted we were powerless over alcohol — that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and lives over to the care of God as *we* understood *Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

AA provides the individual with an environment where experiences can be shared and trust can be established. In the AA environment, members can exchange stories and encourage and support each other (Flores, 1988). Feelings of isolation can be reduced through the AA group process (Talbot, 1990). Kurtz (1988) highlights a particular strength of AA and that is its ability to help members in times of crisis. This idea of assisting others originated with AA's founding members Bill W. and Bob S. Out of their friendship and mutual support came the philosophy of AA that one member can be of aid to another during periods of stress.

Kurtz (1988) points out that AA has been instrumental in bringing about the acceptance of the disease model of alcoholism. This model supports the idea that some people may be "allergic" to alcohol and unable to use it in any form (AAWS, 1976), and presents alcoholism as a progressive illness that can be arrested but not cured (AAWS, 1984). Although the explanation

of alcoholism as a disease is supported by the American Medical Association (AMA), its validity continues to be debated in the literature (Miller & Mahler, 1991; Peele, 1990, 1992). It should be noted, however, that for many individuals, AA's view has reduced feelings of guilt and shame. AA's views have clarified the cause of the desire to drink, and has helped to remove much of the stigma associated with treatment. Although AA believes in a medical cause for alcoholism, the treatment program is non-medical in that it also includes both social and emotional elements (Le, Ingvarson, & Page, 1995). Critics of AA suggest that the principles of the AA program contrast with the interpretation of counseling theory. AA's steps revolve around themes of powerlessness, dependency, and humility. The steps emphasize removing character defects and personal shortcomings, rather than developing individual abilities and strengths. In contrast, counselors often work to promote responsibility for self and use of their strengths to overcome their problems.

AA and substance abuse treatment. The differences between AA and substance abuse treatment could easily be drawn if the boundaries of both of these separate units were clearly defined. White (1988) explains that while AA's boundaries are defined by the Twelve Steps and the Twelve Traditions, the professional boundaries of what makes up "treatment" are much less clearly codified.

In a review of self-help and support groups, Kurtz (1997) highlights the distinctions between treatment and mutual-aid groups. Kurtz points out that self-help and support groups focus on the mobilization of resources within the self, within the family, and the wider community. These groups are personal, egalitarian, anti-bureaucratic, and shun expert advice in lieu of personal and collective experience. According to Kurtz, many practitioners in the field have some difficulty in distinguishing among self-help, support, or psychotherapy groups. She

explains that the most distinct difference between self-help and support groups is that self-help groups aim at effecting change. Both self-help groups and psychotherapy groups help their members achieve personal change; however, the difference is a psychotherapy group is a collection of two or more individuals who meet interdependently, in a face-to-face interaction, with the realization that each is suitable to the group, and are meeting for the purpose of achieving mutually agreed-on objectives (Johnson & Johnson, 2000).

White (1998) offers elaborations on the points made by Kurtz (1997) and adds additional reflections on the differences between AA and professional treatment. According to White (1998), professional treatment services take place within the context of a business environment; AA-directed recovery takes place within a voluntary social and spiritual community. The field of professional treatment is tied together by professional and institutional self-interest; AA is bound together by what Bill has called a “kinship of common suffering.” Theories underlying alcoholism treatment begin with different conceptions of the etiology of alcoholism and proceed from these conceptions to numerous derived treatment strategies; AA simply says to the alcoholic, “Stop drinking and here is how to avoid taking the next drink.” Professional treatment asserts that it is rooted in psychology and medicine, while AA claims to come from medicine and religion. The focus of traditional therapeutic treatment is characterized as a process of “getting into oneself,” self-exploration and self-healing. AA is about the individual getting outside oneself and focusing on resources and relationships beyond the self. Treatment involves self-development; AA is about self-transcendence. Treatment involves discovery or initiating sobriety while the goal of AA is recovery or sustaining sobriety. White further states that with respect to locus of control in addiction treatment, it is often difficult for the client to have control over the degree of intimacy in the client/therapist relationship, because of the inherent inequality

of this relationship; in contrast, AA members, every day, decide if, when, where, how long, and at what level of intensity contact with AA will occur.

Additionally, according to White (1998), significant amounts of money are paid for professional treatment services; thus, treatment involves an exchange of money for services. These fees paid by the addict or someone else help to reinforce the non-reciprocal character of the client/therapist relationship and the inequality of power within the relationship. AA involvement calls for voluntary financial contributions, in small amounts, to help support the group. These contributions are optional for membership. Addiction treatment involves addiction-specific intervention technologies that target the cravings and compulsions that drive addictive behavior, to include the consequences of addiction. Treatment focuses on the core of addiction to include its antecedents, consequences, co-morbidities and obstacles to recovery. AA has one focus: the achievement of sobriety one day at a time through a spiritual program of daily living.

With respect to the ethical and legal guidelines associated with treatment, relationships are guided by professional codes of ethics to which each individual practitioner is bound, as well as licensing and accreditation standards to which treatment institutions are bound. These legal standards were conceived and exist in order to govern the delivery of addiction treatment services, because harm to the public might result from the delivery of fraudulent or incompetently delivered services. Disclosures in treatment are confidential as well as legally protected. There are no legal regulations governing AA because the public perceives no similar threat resulting from involvement in mutual-aid activity, and disclosures in AA are sacred and spiritually protected. Additionally, it is the practice of institutions and treatment programs to maintain extensive records on those who seek their services. There are no individual records in AA (White, 1998).

White (1998) suggests that in comparing AA (mutual-aid) to professional treatment, we are not comparing two types of treatment; we are comparing treatment and something else. White argues that AA is not a treatment for alcoholism but rather AA is a spiritual community of individuals that share similar experiences. AA is a way of living and being, and putting AA and alcoholism treatment in the same basket misunderstands them both. This is not an error of mistaking “apples for oranges”, two objects from the same family; it is similar to comparing “apples and automobiles.”

White (1998) insists that personal safety of individuals requires an understanding of, and adherence to the code of ethics, and the principles and boundaries that govern professional and personal relationships. If alcoholism treatment becomes nothing more than an undeclared AA meeting, it stops being treatment; to call twelve-step work alcoholism counseling violates the AA traditions and the discipline of addiction counseling. White states that these reflections are about the differences between AA and professional treatment and are offered as opening observations in what will be a continuous discussion of the historical depictions of AA and professional addiction treatment.

According to Lemanski (2000), the AA model of recovery characterizes addiction as a progressive, chronic and ultimately fatal disease. AA also leaves the addict powerless, experiencing a loss of control in the ability to refrain from a drug of choice. The model requires a commitment to total abstinence, the embrace of spirituality, and life-long participation in AA or another twelve-step program, because addiction is defined as treatable but never entirely curable.

Wheeler and Turner (1997) investigated counselors’ attitudes and experiences in working with people with drinking problems and counselors’ understanding of AA as a helping agent. They summarized that, in general, counselors do not feel competent in working with people with

a drinking problem, and that some counselors decline to work with such clients. This study also points out that counselors become more confident with experience, that attitudes towards working with problem drinkers may be colored by the counselor's own drinking habits, and that AA is seen as a potentially helpful adjunct of therapy, although detailed knowledge of the way AA works is sparse. Wheeler and Turner further concluded that given the high incidence of alcohol abuse and the likelihood that all counselors will meet clients with alcohol problems whether this is the presenting problem or not, there is a case for more space being given to alcohol counseling in training courses, and for more support and encouragement being offered to counselors who undertake substance abuse counseling.

Research on 12-Step programs. As reported in the 1990s, there are over 94,000 Alcoholics Anonymous groups, 11,000 Narcotics Anonymous groups, more than 32,000 AI-Anon groups, as well as thousands of other related groups across the country and, because of their widespread availability, the 12-step programs have been seen by many as the best hope in stopping the continued growth of substance abuse. Although scant, outcome studies on the effectiveness of AA have been conducted (Dorsman, 1996; Humphreys & Moos, 1996; Watson et al., 1997). Ninety-five percent of inpatient addiction treatment programs in the United States incorporate AA and Narcotics Anonymous (NA) at some level (Brown, Peterson & Cunningham, 1988). Brown (1985) found that 77% of the AA participants in their research had experienced some form of psychotherapy before abstinence, and 45% after abstinence. In another survey of AA members, Maxwell (1976) reported that 31.5% seek additional professional help after entering AA. Studies designed to evaluate/review AA groups and their effectiveness has been burdened with scientific design problems. Most of these studies did not include control groups. The two controlled AA studies included in the Miller et al. (1995) meta-analysis both revealed

no beneficial effect of this modality. However, this conclusion is contradictory to earlier findings, with their limitations, that have generally shown positive results (Bebbington, 1976; Leach & Norris, 1977; Madsen, 1974). Leach (1973) reports four studies involving AA treatment in New York, London, Finland, the United States and Canada. The results from United States and Canada report 38% of the sample were abstinent from 1 to 5 years.

Smith (2001) states that findings concerning AA's effectiveness are still mixed, owing to a wide range of uncontrolled variables: inability to use control groups, questions of mandatory versus voluntary participation, and the wide variance found among the ways AA meetings are conducted across the country. Emerick, Tonigan, Montgomery and Little (1993) found that individuals most likely to affiliate with AA had a history of the following: (a) using external supports to stop drinking, (b) losing control of drinking and of behavior when drinking, (c) consuming a high quantity of alcohol, (d) expressing distress about their drinking, (e) being obsessively/compulsively involved with alcohol, (f) believing that drinking enhances mental functioning, and (g) engaging in religious/spiritual activities (Montgomery, Miller, & Tonigan, 1995). Emerick et al. (1993) also found participation in AA prior to treatment not to be a significant factor when predicting treatment outcome. However, AA attendance during treatment and/or after treatment was found to be positively associated with successful outcomes (Emerick, 1989; Emerick et al., 1993). Montgomery et al. (1995), supported in part by grants from the National Institute on Alcohol Abuse and Alcoholism, studied whether AA involvement would predict treatment outcome. Their findings, supported by previous research (Emerick et al., 1993), suggest that it is the extent of involvement or active participation in the AA process, rather than mere attendance at AA meetings, that predicts more favorable outcomes after treatment. These findings are also consistent with discussions centered on mandated versus voluntary AA

meetings. When attendance by members is voluntary and when such members actively participate in AA meetings, there is strong evidence of successful outcomes. However, Humphreys and Moos (1996) found that a group of patients who entered into outpatient counseling-based treatment had the same percentage of abstinent members as did subjects from the group that joined. Doweiko (1999) suggests that these studies point to some powerful aspects of AA, as well as ongoing questions concerning its overall effectiveness.

Research on counseling-based interventions. In a review of alcoholism treatment, Miller and Brown (1997) made a strong case for psychologists to treat clients with alcohol use disorders rather than refer them to specialty treatment programs. The authors pointed out that the training psychologists receive is relevant to substance abuse treatment, and that fundamental therapy skills such as empathy and cognitive-behavioral treatment have been associated with positive treatment outcomes. Current studies suggest that professional outpatient therapy is sufficient for most clients who present with substance abuse problems. However, it must be stated that many studies supporting professional treatment have been conducted with populations presenting “less severe” substance abuse profiles.

Another recent study documenting the effectiveness of professional treatment was the multi-site study conducted by the Project MATCH Research Group (1997). Project MATCH was originally designed to match clients with alcohol problems to different types of professional alcohol treatment. Clients were randomly assigned to one of three different types of individual treatment: cognitive-behavioral, motivational interviewing, or 12-step facilitation. Cognitive-behavioral treatment was designed to teach clients cognitive and behavioral skills to cope with situations that precipitate drinking (Kadden et al., 1992). Motivational-interviewing strategies were designed to facilitate internally motivated change through the use of a stage model of

alcoholism as well as the use of techniques such as promoting empathy, eliciting self-motivating statements, providing objective feedback, and supporting self-efficacy (Miller, Zwegben, DiClemente & Rychtarik, 1992). The twelve-step facilitation efforts were designed to help clients learn about AA, attend AA meetings, and begin working on the steps of AA (Nowinski, Baker, & Carroll, 1992). Although Project MATCH was not able to demonstrate that particular subtypes of clients with alcohol problems responded differently to these approaches (which was the primary aim of the study), it did demonstrate significant and sustained improvements in drinking at 1-year follow-up for all three treatments (Project MATCH Research Group, 1997).

The general findings of Project MATCH are consistent with other large-scale studies and recent reviews of the literature, in that, all found both cognitive-behavioral treatments and AA to be effective in terms of reducing substance use and improving most areas of life functioning. For example, Ouimette, Finney, and Moos, (1997) conducted a large multi-site study in Veterans Affairs Centers and found both cognitive-behavioral treatments and AA to be effective in terms of reducing substance use and improving most areas of life functioning.

Additional support for motivational interviewing can be found in a meta-analysis conducted by Miller et al. (1995). Consistent with other outcome reviews in the field, these researchers found support for motivational-interviewing and cognitive-behavioral therapies but little support for psychodynamic approaches to treating substance use disorders.

Individual counseling programs remain a viable option for many addicted patients. The outpatient-counseling model offers the individual a chance to live at home and in most cases continue working. There is a belief that for many patients, individual outpatient drug addiction counseling is as effective as inpatient chemically dependent programs (Doweiko, 1999).

Individual counseling approaches for drug use are viewed as heterogeneous in nature (Institute of

Medicine, 1990) and often serve clients who have less severe drug-related problems. The goals of individual outpatient substance abuse counseling programs include abstinence from alcohol and other drugs. In addition, counseling focuses on (a) social relational stabilization (e.g., marital/family), (b) employment stabilization, (c) physical health, (d) emotional health, (e) legal problem resolution, and (f) spiritual strengthening (Lewis, Dana & Blevins, 1994). Counseling, listed as one of the four most common forms of drug abuse treatment, was most recently seen as effective in reducing drug use (National Institute on Drug Abuse [NIDA], 1994). The Drug Abuse Treatment Outcome Study (DATOS) tracked 10,010 drug abusers in nearly 100 treatment programs in 11 cities who entered treatment between 1991 and 1993. Results showed that counseling was effective in reducing the use of substances for clients who remained in treatment. Support for both client-centered counseling and behavioral contracting was recently reported through a methodological analysis of the alcohol treatment outcome literature (Miller et al., 1995).

Interpersonal relationships and social interactions are major factors affecting substance abuse clients. Because of this phenomenon, the group counseling process has been historically considered as a viable approach to use with substance abusers either alone or in conjunction with other treatment methods. Group programs attempt to help substance abuse clients alter distorted concepts of self, learn from others, regain hope and reduce isolation. Despite the generally stated advantages of using group counseling approaches with substance-abusing clients, these programs have been sparsely researched. Miller and Hester (1986), after reviewing studies on the efficacy of group counseling programs with substance abuse clients, concluded that we have yet to consistently demonstrate measurable effective outcomes. Yet the general view has been that group therapy programs are effective with adolescent substance abusers.

Family therapy has been viewed over the years as a promising treatment approach for substance abusers (Kaufman, 1979). When therapy includes family members, it is believed that it can impact change significantly when working with alcoholic patients (Liepmann, Nirenberg & Begiw, 1989). Despite few controlled studies to validate this belief, Stanton and Todd (1982) report family therapy to be effective when compared to certain individual approaches used by themselves with clients. Todd and Selekman (1991) found that when family therapy was used with substance abuse cases, individuals tended to stay longer in treatment, and maintain sobriety for longer periods of time.

In summary, a certain amount of evidence suggests substance abuse treatments can be effective in reducing substance use and in bringing about improvement in the areas of employment, criminal activity, social adjustment, and use of health care activities (Anglin & Hser, 1990; Ball & Ross 1991; Doweiko, 1999; Institute of Medicine, 1990; McClellan et al., 1994). Both inpatient and outpatient programs have reported success in dealing with alcohol abuse, and cocaine abuse patients. As a result, some very clear guidelines and program recommendations for substance abuse treatment have evolved (Washton, 1992). There have been reports that individual counseling and certain types of group counseling, when used alone, are effective with substance abuse clients. However, only a few studies of this nature have been done and currently most treatment programs combine these modalities with other methods of treatment. More information is being obtained on the successful use of AA programs, particularly as related to mandated versus voluntary attendance. Level of participation, rather than simply the number of meetings attended, becomes a significant variable in predicting abstinence (Smith 2001). Many of the contemporary issues involving substance abuse counseling, directly or indirectly relate to research as to what works with specific presenting

problems, substance abuse etiology, predictability of substance abuse, adolescent substance abuse, gender differences, and programs for minorities.

The present study was designed to study the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and also to explore the perceptions of professional counselors who ascribe to the AA model, even in the absence of empirical support. This study also looks at the potential for developing protocols for determining those clients who might be referred to AA, those clients that might be treated with more counseling-based models, and those particular clients that might benefit most from some combination of the two approaches.

CHAPTER III. DESIGN AND METHODS

Theoretical Foundations

Two perspectives, counseling theory and critical theory, formed the theoretical foundations for this research study. The role that theory plays in the process and outcome of counseling has been a subject of discussion, and sometimes heated debate, for almost as long as counseling has been a profession. Critical theory examines and critiques society and culture, drawing from knowledge across the social sciences and humanities.

Counseling Theory

Counseling theory provides a structure or framework from which counselors can work in a systematic fashion. Professional counselors cannot function in a meaningful manner without being able to place events in some order. Peterson and Nisenholz (1999) argue that even though some counselors may hold an anti-theoretical position, they are usually basing their behavior on vaguely defined but implicit theory. A case can be made for and against the use of theory in counseling, as arguments can be provided for both sides. Arguments for theory include: creates order; provides a therapeutic road map; helps counselors use a consistent framework for developing an understanding of human behavior; provides knowledge from which to make choices and predictions; influences what the counselors do and how they do it; generates new ideas and approaches for testing; may cause counselors to miss valuable data in counseling if not guided by theory; may develop a reputation as a professional counselor more readily if you are identified with a given theory; may be impossible not to have a theory; having no theory is itself a theory. Arguments against theory include: creates a false sense of certainty; confuses

counselors because there are too many theories, many of which differ greatly and even conflict; can lock counselors into a rigid format; forces counselors to be mechanical; cannot guarantee success by having a strong theoretical approach; and can counsel, successfully, without adhering to a specific theory (Peterson & Nisenholz, 1999).

Counseling theory provides a framework upon which to base counseling interventions. When used properly and efficiently (theoretical strategies are used that best “fit” the individual client and ensuring the counselor does not attempt to fit the client into a theoretical framework that is not appropriate for that individual), theories can bring organization out of chaos and deepen one’s understanding of human behavior (Peterson & Nisenholz, 1999).

Critical Theory

Recently, a number of scholars have begun to question whether theory and research can really contribute to an understanding of human behavior. These scholars usually referred to as postmodernists, criticize the relevance of traditional research; they deny the existence of underlying structures (e.g., meaning, laws) in the domain of social behavior. They argue that all knowledge and truth are products of history, power, and social interests, and cannot be “discovered,” as positivists believe. They also argue that all naturally occurring languages are made up of ambiguous terms that change over time and that all statements that use these languages cannot be verified. The postmodern perspective has found application in qualitative research through “solutions” (Bloland, 1995). One of those perspectives is critical theory. According to Creswell (1998), this approach can form a conceptual lens for designing a qualitative study. Through the use of critical theory, the investigator can begin a process of bringing about planned change. Variations of critical theory are in all of the social science disciplines, but central themes that a critical researcher might explore include the study of social

institutions and their transformations through the interpretation of the meanings of social life; the historical problems of domination, alienation, and social struggles; and a critique of society and the envisioning of new possibilities.

Qualitative Research Design

The literature review highlights some distinctions between AA and treatment for substance abuse disorders. However, there was little in the literature to describe positive outcomes associated with combining the AA model with other treatment approaches.

Qualitative research designs hold greater promise for answering certain research questions than quantitative methodology. The methodologies used in qualitative studies enable a richer and potentially deeper investigation of such variables as the quality of relationships, the formative assessment of activities, situations, or materials with greater emphasis on using holistic description. This type of research describes in detail all of what goes on in a particular activity or situation rather than comparing the effects of a particular treatment as in experimental research, or describing the attitudes or behaviors of people as in survey research (Fraenkel & Wallen, 2003).

The present study adopted the methodology of the qualitative case. The use of qualitative methods is justified on the basis that this study's intent is, according to Merriam (1998), to "build abstractions, concepts and hypothesis, or theories rather than test existing theory" (p. 7). The lack of well-defined theory as it relates to the perceptions of the professional counselors' role of AA in substance abuse treatment justifies, and even suggests, the use of qualitative methods (Merriam, 1998). Specifically, this study adopted the methodology of the qualitative case study for two reasons: First, the topic deals with the factors counselors consider in substance abuse treatment, and a deeper understanding of the perceived benefits of the use of the AA model and

how counselors view and use AA in substance abuse treatment is needed to be explored in a more open manner than closed-ended questions. Also, the variables associated with the topic were sufficiently constructivist and open to multiple perspectives and responses, that existing theories would have potentially restricted responses and not been fully descriptive of interviewees' views. Secondly, according to Merriam, postmodern non-constrictive invitations to share observations and assessments offered the most promising vehicle for investigating professionals' identification of preferred strategies in understanding and impacting in substance abuse treatment outcomes. This study was not designed to confirm previous concepts and theories, but to stimulate new understandings related to the use of AA in the context of substance abuse treatment.

According to Yin (1994), the case study is preferred when “the investigator has little control over events, and when the focus is on a contemporary phenomenon with some real-life context” (p. 1). Furthermore, Yin articulates that a case study is, “...an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p. 13). The case study is also appropriate in this study because the approach “benefits from the prior development of theoretical propositions to guide data collection and analysis” (Yin, 1994. p. 13). The interest of the present case study is the phenomenon of the integration of AA, a twelve-step philosophy, into counseling treatment, and therapists' perceptions about the effectiveness of this method as both a “stand-alone” model, and as a part of a counseling-based approach

When using case study methodology, the research must define the case. The case, according to Stake (1995), is a bounded system, or the object of study. It might be an event, a process, a program, or several people. The bounded system, the case selected for study has

boundaries, often bounded by time and place. It also has interrelated parts that form a whole, and, therefore, the proper case to be studied is both bounded and a system.

According to Marshall and Rossman (2006), for qualitative studies, context matters. Studies should be conducted in the setting where the complexity of treating individuals with substance use and abuse issues operate over time, and where data on the multiple versions of reality can be collected. Human actions cannot be understood unless the meaning that humans assign to them is understood. The thoughts, feelings, beliefs, values, and worldviews of the individuals are involved. There is a need to understand the deeper perspectives that can only be captured through face-to-face interaction (Marshall & Rossman, 2006). For this study, multiple sources of information in the data collection were used to provide a detailed, in-depth picture of the responses of the counselors interviewed (Creswell, 1998). This research study was conducted in two counseling centers where treatment for substance abuse is provided because the actions of the human beings involved are significantly influenced by the setting in which they occur. One should study behavior in real-life situations.

Furthermore, the objective scientist in experimental research using codes according to operational variables risks destroying valuable data by imposing a limited worldview on the subjects, and policymakers and practitioners are sometimes unable to derive meaning and useful findings from the experimental research. In some instances the research techniques in quantitative studies themselves have affected the findings. The strengths of qualitative studies are the emphases that are placed on context, setting, and the participants' frames of reference. It is vital to have the counselor's perspectives when trying to identify the processes involved in the treatment of problematic substance abuse (Marshall & Rossman, 2006).

Naturalistic Observation

This qualitative research study utilized a *naturalistic observation* design that involved observing individuals in their natural settings. The researcher made no effort whatsoever to manipulate variables or to control the activities of individuals, but simply observed and recorded what was said and what happened as things naturally occurred (Fraenkel & Wallen, 2003).

Role of the researcher and observer bias. This qualitative research design was a nonparticipant observation study; the researcher did not participate in the activities being observed; the researcher was not directly involved in the situation being observed (Fraenkel & Wallen, 2003).

According to Fraenkel and Wallen (2003), observer bias refers to the possibility that certain characteristics of observers may bias what they view. Qualitative researchers have continually had to deal with the charges that it is very easy for their prejudices to bias their data. Observer bias is something all researchers have to deal with. Nevertheless, all researchers do their best to become aware of, and try to control their biases. The researcher attempts to study subjective factors objectively.

In order to control observer bias, the researcher in this study spent a considerable amount of time at the two counseling center sites, getting to know the subjects and the environment (both physical and culturally) in which they live and work. The researcher was aware that most situations and settings are very complex, and the researcher did her best to collect data from a variety of perspectives, using a variety of formats. To guard against inadvertent bias, the researcher consistently reflected on her own subjectivity using a reflexive journal. In maintaining a journal, the researcher prepared extremely detailed field notes that bracketed perceptions and opinions separating the observer comments from the descriptions of the site. After each site visit,

the researcher presented the reflexive journal to her major professor for review to help in identifying possible biases. Researchers are aware that biases can never be completely eliminated from one's observations, but it is extremely important to continuously reflect and document on how one's attitudes may influence what one perceives (Creswell, 1998).

Interpretive Case Study

This study was more specifically an interpretative case study. According to Merriam (1998), interpretive case studies not only contain “rich, thick description, but also “are descriptive data...and are used to develop conceptual categories or illustrate, support, or challenge theoretical assumptions held prior to the data gathering” (p. 38). This type of case study allows the researcher, according to Merriam (1998), to “gather as much information about the problem as possible with the intent of analyzing, interpreting, or theorizing about the phenomenon” (p. 38). Furthermore, rather than merely describing what has been observed or reported in an interview, in an interpretative case study, “the investigator might take all the data and develop a typology, a continuum, or categories that conceptualize different approaches to the task” (Merriam, 1998, p. 38).

The interpretive case study is fitting for this study because, according to Merriam (1998), “the level of abstraction and conceptualization...may range from suggesting relationships among variables to constructing theory” (p. 39). The interpretative case study is an appropriate method of inquiry because the study is not only interested in the phenomenon of perceived benefits of AA to the counseling profession in the treatment of substance abuse, but also in exploring the perceptions of those counselors who ascribe to the AA model, even in the absence of empirical support for it.

The preferred model of data analysis for this study is inductive. It is an interpretive case study that allows not only rich description of the phenomenon under study, but also permits the “complexity, depth, and theoretical orientation” (p. 39), of the case under investigation to emerge.

Multi-site case design. This qualitative study used a multi-site case design, an approach that is designed to gain an in-depth knowledge of an organizational phenomenon that has barely been researched. It involves the observation and analysis of two sites in this case using cross-case comparisons and explanation building techniques to analyze data. This report primarily explains the perceptions of professional counselors about the role of AA in substance abuse treatment. The advantage of using a multi-site case design is that the results are often considered more compelling, and they are more likely to lend themselves to valid generalization when more than a single source is observed and utilized. However, the disadvantage of using a multi-site case design is that such studies require extensive resources and time (Creswell, 1998). The cases in this study are two community agency counseling centers serving clients with substance abuse issues.

Site selection. In this multi-site qualitative study, the researcher collected and analyzed data from two counseling center sites in the Montgomery, Alabama metropolitan area. Although there are several sites serving clients with substance abuse issues in this area, these particular sites were chosen because Site I for this study is the oldest site in the area, and also is one that incorporates AA in their treatment strategies and interventions. The other site chosen, Site II, is the largest community counseling center in the metropolitan area serving clients with substance abuse issues, and also is a site that incorporates AA in their treatment strategies and interventions.

Site I was founded in 1971 with meager resources and has managed not only to survive, but to grow into a very needed and useful organization in Montgomery, Alabama and the surrounding communities. It was established as a gap agency to provide services to youth and adolescents who were experiencing substance abuse and other related problems. Fully licensed by the Alabama Department of Mental Health and Mental Retardation, they maintain complete compliance with the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Housing and Urban Development (HUD), and the Alabama Department of Education and Community Affairs. The center now provides chemical dependency recovery services, rape counseling, prevention education and permanent housing services to individuals from all walks of life in need. Intensive outpatient services are available to adults at various times throughout the day. Specialty services are offered to women who are pregnant or have dependent children as well as those who suffer with co-occurring disorders.

Site II is the largest center in the metropolitan area dealing with clients with substance abuse issues incorporating AA in their treatment approaches, and was formed from the merger of four alcohol treatment centers in 1979. The center operates as the only adult short term crisis residential program for treatment of drug and/or alcohol addiction, and it also operates as the only adolescent outpatient and intensive outpatient substance abuse/dependency treatment program. The site is certified by the Department of Mental Health and Mental Retardation Substance Abuse Services Division.

Site II was the first substance abuse treatment program in the state of Alabama to require all of its therapists to hold a master's degree from an accredited college or university. Twenty-seven of their employees hold a master's degree or higher in a clinical area with a clinical practicum.

These sites were selected in part due to an expectation that they were homogeneous, thereby, enabling comparisons and integration. For both sites, the same interview protocol was used and the researcher did not deviate from asking the same questions in the same order. Some of the themes generated by professionals in each site are similar for both sites, and yet some are not similar at all. The themes that are presented are based on observations and the three in-depth interviews conducted at the sites.

Upon receiving approval from executive directors of both selected sites to conduct research on-site, and approval from the Auburn University Institutional Review Board, licensed professional counselors (LPC) who worked at the two selected sites were recruited in regular staff meetings. At these meetings, the information letter notice was disseminated, informing the staff at each site that participation in the study was voluntary, that the information provided would have no identifying information, and that the absence of personal identification data would protect their identities in any retention or use of interview data. The researcher arrived at the facility at least 45 minutes prior to the scheduled interviews to gather field notes by observing the physical structure as an outsider; then moved into the setting and observed as an insider. The researcher gathered other non-interview data including such items as: DVDs, books, pamphlets and other multimedia available to the clients at the sites. Some of the material gathered was AA oriented, some of it was not. The research activities were finished at a predetermined date and a copy of the transcript of the taped interview was provided to participants no later than seven days after the actual interview. The investigator agreed not to interfere with the flow of work as counselors conducted their business assisting clients. Each interview lasted no longer than 90 minutes. The researcher promised to provide a copy of any aggregate results.

Sample. Purposeful sampling was used for this multi-site qualitative study, e.g., selecting a sample from which the maximum can be learned. According to Yin (1994), sample selection should be dictated by a type of replication logic, instead of a statistical one. More precisely, each site (or case) should be considered as an experiment in itself.

Participants in this study were solicited from the two counseling centers. Three professional counselors from each counseling center volunteered to participate in the study.

Participation selection was based on the following criteria:

1. Participants must have a master's degree in counseling.
2. Participants must use the title of professional counselor, e.g., are licensed professional counselors (LPC).
3. Participants must be working with clients with substance abuse problems.
4. Participants must use the AA model in their treatment strategy when dealing with clients who present with substance abuse problems.

Summary of experiences of participants. For this study, there were three interviewees selected from each counseling center site. From Site I, interviewee #1 is a 48-year-old African American professional counselor, who prior to working at Site I as a substance abuse counselor for the past five years, spent fifteen years working in the mental health arena. She has an undergraduate degree in psychology and a master's degree in counseling. Interviewee #2 is a 39-year-old African American woman. She has worked at Site I for the last thirteen years as a substance abuse counselor. She attended a historically black college and has a master's degree in general counseling. Interviewee #3 is a 32-year-old Caucasian male who has worked at Site I for 5 years as a substance abuse counselor. His undergraduate degree is in social science. He has a

master's degree in counseling and human development and has recently started a doctoral program in the field.

From Site II, interviewee #4 is a professional counselor who is a 52-year-old Caucasian woman. She has spent the last 22 years working in the field of substance abuse counseling, and the last ten years working at Site II. She holds a master's degree in community agency counseling. Interviewee #5 is a professional counselor who is 37-year-old Caucasian woman. She has an undergraduate degree in psychology and a master's degree in community agency counseling. She has been working in the field of substance abuse for the past ten years, and joined the staff at Site II two years ago. Interviewee #6 is a professional counselor who is a 57-year-old Caucasian male. His undergraduate degree is in social science. He holds a master's degree in agency counseling. He has been working in the community dealing with substance abuse issues for over 25 years.

In this multi-site qualitative study, the researcher collected and analyzed data from two counseling center sites where persons diagnosed with substance abuse disorders receive treatment. There were multiple phases in collecting data that extended beyond conducting interviews or making observations. Important steps in the process included identifying individuals to interview, gaining access to the sites, and establishing rapport with volunteers. It was also important to determine a strategy for the purposeful sampling of individuals.

Observations as data sources. According to Marshall and Rossman (2006), observation involves the systematic noting and recording of events, behaviors, and objects in the social setting chosen for the study. The observational record is frequently referred to as *field notes* which are detailed, nonjudgmental, concrete descriptions of what was observed.

The types of data for this multi-case study came from observations of the settings, documents collected at the sites (examples – brochures, handouts and other artifacts located in the waiting areas), and from one-on-one in-depth interviews. The purpose of observation at each site was to get a sense of what it might be like to work in the particular environment. A special effort was made to ascertain what the counselors who work at the sites see every day, and to observe what types of resources the counselors used and promoted. Once arrangements of interviews were initiated, the researcher arrived at least 45 minutes before the scheduled interview times to conduct observations. The goals were to record observations of the physical layout of the counseling centers, including the reception areas, bulletin boards, counseling offices; break rooms, snack areas, and outside break areas in the observation protocol before the interview. Environmental assessments are typically completed before interviews in these kinds of case studies to prevent observer bias due to the process and outcome of the interviews. According to Hammersley and Atkinson (1995), observation in a setting requires management of specific issues such as the potential deception of the people being interviewed as well as impression management. An observational protocol was used for recording notes of experiences, hunches, portraits of the informant, the physical setting, as well as the researcher's reactions (Bogdan & Biklen, 1989) (Appendix A).

Interviews as data sources. The primary source of data for this study came from one-on-one, in-depth interviews (Appendix B). Pre-interview observations were performed and recorded not only for the purpose of facilitating the site selection process, and the volunteer recruitment process, but also to verify that the selected participants met the pre-determined selection criteria listed above. Two counseling centers in Montgomery, Alabama were identified that treat clients with substance abuse problems, and use in some way as a part of their treatment strategy, the

Alcoholics Anonymous (AA) model of recovery. This bounding of the study is consistent with accepted exploratory qualitative case study design methodology, which was chosen because models and variables were not available for assessing the perceptions of professional counselors about the role of AA in substance abuse treatment.

The semi-structured interview used in the study was constructed in such a way that therapists could provide data relative to their perceptions of AA and their perceptions of substance abuse treatment programs. Resulting perceptions were used to generate identifiable themes. Other data included multimedia routinely used by the therapists; multimedia available to the clients such as: DVDs, books, pamphlets that are AA oriented and some material that is not. Prior to the interview, a demographic sheet for the participants to complete was provided (Appendix C), partly to assure volunteers in writing that: All data obtained in connection with this study will remain anonymous; to protect your privacy and the data you provide, prior to the taped interview, participants will be asked to provide a pseudonym to use in the study. The pseudonym you use will not be connected to your real name in any file or data.

The questions during the semi-structured interview were determined in advance and all interviewees at the sites were asked the same basic questions in the same order. Questions were worded in a completely open format, with follow-up questions and prompts, developed on-the-spot to amplify or to clarify responses. One weakness of this interview process is that there is little flexibility in relating the interview to the particular individuals and circumstances, and standardized wording of questions may constrain and limit naturalness and relevance of questions and answers (Fraenkel & Wallen, 2003, p. 462).

For both observing and interviewing, data collection forms were used. These were organizational sheets where information learned during the observations or interviews were

logged in. These protocols helped the investigator to take notes and assisted in helping the researcher to organize thoughts (Creswell, 1998). An audiotape recorder was used in this qualitative study. "Tape recorders do not 'tune out' conversations, nor do they change what has been said because of interpretation either conscious or unconscious. Tape recorders do not, however, eliminate the need for taking notes" (Fraenkel & Wallen, 2003). Interview transcripts were then produced with margins available on both sides of the transcribed material for writing notes, as well as pertinent information and passages. All data collected were maintained in a locked filing cabinet at the residence of the researcher; however, it should be reiterated that all data was anonymous and participants were not linked to specific data.

Interview questions. This study explored the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and also explored the perceptions of those counselors who ascribe to the AA model. This study also looked at the potential for developing protocols for determining those clients who might be referred to AA, those clients that might be treated with more counseling-based models, and those particular clients that might benefit most from some combination of the two approaches. Additionally, these findings suggest a possibility for identifying areas related to additional training for alcohol-related training courses. The first set of questions was intended for ascertaining those factors counselors consider as they make decisions about interventions to use in substance abuse treatment.

- 1) What are your thoughts about why people engage in substance use and why some people become addicted? What are your thoughts about substance abuse and addiction, especially alcoholism, being labeled a disease?
- 2) How do you assess and diagnose substance abuse problems? What are the common factors and problems associated with substance abuse?

- 3) What is your understanding about the dynamics of denial, tolerance, loss of control and medical consequences associated with different drugs of abuse?
- 4) How do you assess and treat individuals with a primary diagnosis of substance abuse who have additional psychological disorders?

The second set of questions asked was intended to highlight the counseling-based interventions that appear to be most effective with counselors' clients who present with substance abuse issues.

- 5) Do you believe the term "hitting bottom" plays a significant role in treating substance abuse problems?
- 6) What aspects of an individual's life do you integrate into a substance abuse treatment program?
- 7) Is your treatment program grounded in a theoretical base? How does the theoretical base of your program influence the treatment of the clients?
- 8) Do you have a particular treatment approach or approaches you use to treat clients? How effective do you feel individual therapy is in treating clients with substance abuse issues? How effective is group therapy in substance abuse treatment? What are your thoughts about family therapy in substance abuse treatment? What counselor characteristics do you believe to be important in substance abuse therapy? Do you choose treatment approaches that take into account the gender and cultural differences of clients who present with substance abuse problems?

- 9) What are your thoughts about the effectiveness of counseling-based interventions in the treatment of substance abuse? In your experience, what type of client benefits from counseling-based strategies?

The third set of questions considered the counselors' views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems.

- 10) What common factors do you find to be present in clients who relapse?
- 11) What is your definition of relapse? In your experience, how common is relapse in the recovery process? Do you believe relapse to be a common treatment outcome?
- 12) With respect to the people who join AA (gender and minority status/ culture) and remain members, how representative are they of the overall substance-abusing population?
- 13) How does AA fit into your practice? What are your views about AA as a component of recovery? Have you observed any differences between clients who adopt the AA philosophy from those who do not? Have you ever referred an individual to AA in lieu of counseling-based treatment? If not, would you? What is your view of a stand-alone counseling method for treating individuals with substance abuse issues?
- 14) What are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA?

The fourth set of questions were intended to highlight counselors' views of the need for research in substance abuse counseling in determining "what works" under which circumstances with substance abuse clients?

- 15) As a practitioner, what do you need from researchers to help you do you work more effectively?
- 16) What are your thoughts about suggestions from researchers in the field that AA meetings need to be more closely examined?
- 17) What are your thoughts concerning the need for research related to gender-specific and culture-specific treatment programs in studying best methods of treatment sensitive to gender and cultural differences?

CHAPTER IV. RESULTS AND DATA ANALYSIS

Introduction

This study was a qualitative multi-site case study that explored the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and also explored the perceptions of those counselors who ascribe to the AA model of recovery in the absence of empirical support. This chapter presents the results of the study. Observation and the course of the in-depth interviews dictated the later direction of this study, and the subsequent data analysis, consistent with the nature of qualitative study. The results are divided into areas that are supported by the data as well as supported by the literature. After a short description of the community agency counseling sites, the participants, and the process of data collection used in this study, this chapter organizes the outcome of the data analysis into three sections.

The first section provides a within-case analysis of Site I and outlines the themes generated within the case. In the second section a within-case analysis is provided for Site II. The third section of data analysis provides a thematic analysis across the cases called a cross-case analysis as well as provides assertions or interpretations of the meanings of the themes generated by the cases in the study. The final interpretive phase provides a summary and discussion of the findings and explores the lessons learned from the cases. The purpose of the structure outlined provides continuity and context for the reader in understanding the perceptions of those counselors towards the AA model of recovery in the treatment of substance abuse.

Exploratory Qualitative Case Design

For this interpretive qualitative case study (Merriam, 1998), an inductive method was used that allows a number of themes to emerge within a case and across cases. The themes that emerged within each case, Site I and Site II, appear to exhibit consistency across the cases with some variations from the two counseling sites. The similarity in experiences of the counselors interviewed at both mental health centers was evident in the interviews. The results of the in-depth interviews suggested that AA provided the language and the framework that permitted the counselors to integrate AA philosophy into their work.

While analyzing the data, the researcher was influenced by what was observed at the sites. The data were analyzed according to the procedures described in Chapter Three. The data that emerged from the interviews, in addition to observation and the literature, contributed to the process of data analysis as well as the organization of the data.

The first step involved was listening to the interviews and then reading the interviews in their entirety after they were transcribed. The transcribed interviews were separated and read at least twice, and the individual interviews were divided into different sections. The sections included factors counselors consider as they make decisions about interventions to use in substance abuse treatment, counseling-based interventions that appear to be most effective in treating substance abuse, counselor's views regarding the use of the AA model of recovery in treating substance abuse problems, and counselor's views of the need for research in substance abuse counseling in determining what works with substance abuse clients. After separating the data in this format, pertinent aspects were highlighted of the experiences of the counselors in the context of repeated themes that were observed at the sites, the interviews themselves, and previous literature. A special effort was made to remain mindful of the central focus of the study,

namely, to explore the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and the perceptions of counselors who ascribe to the AA model.

Participants and Data Collection

The first step was to draft a research protocol for approval by the Auburn University Institutional Review Board (IRB). Upon obtaining approval from the IRB, the study was conducted at two counseling centers in the Montgomery, Alabama area in which clients with substance abuse problems are treated, and where their treatment programs use the AA model of recovery. One site is the oldest community agency site in the metropolitan area dealing with clients who present with substance abuse issues. The second site is the largest site in the area that reaches a broad spectrum of the substance abusing population. This bounding of the study is consistent with an exploratory qualitative case study design, which was chosen because previously developed models and variables are not available for assessing the perceptions of professional counselors about the role of AA in substance abuse treatment. Also, consistent with case study design, as a part of the recruiting strategy, the executive directors for both centers were telephoned to schedule a meeting at a set time and date. During each meeting with the directors of the centers the intentions of the study and the particulars of the study were explained. The researcher asked their permission to conduct the study at their sites. Once that permission was obtained from each director, a request was made to make a group presentation at one of their staff meetings to identify possible participants for the study. Each center director was informed that participation selection would be based on the following criteria: (a) participants must have a master's degree in counseling, (b) participants must use the title of professional counselor, e.g., are licensed professional counselors (LPC), (c) participants must be working with clients with substance abuse problems, and (d) participants must use the Alcoholics Anonymous (AA) model

in their treatment strategy when dealing with clients who present with substance abuse problems. An agreement was acquired from both of the directors of the sites to solicit participants for the study at one of their scheduled meetings. At Site I, an invitation was given to the counseling professionals present at the meeting to participate in a qualitative research study designed to explore the perceived benefits of Alcoholics Anonymous (AA). A copy of the information letter was given to all counselors present. At this site, three qualified counselors volunteered at the conclusion of the presentation. On a break at the meeting, the researcher met with each counselor and exchanged information necessary to set up a date and time for the one-on-one interview. These actions were repeated at Site II at a weekly clinical staff meeting. One person volunteered at the meeting. Three other individuals indicated they would get back with the researcher. After the meeting, the director provided a list with the names of counselors he thought would be eligible to participate so that a follow-up could be conducted. During the next week, dates and times were scheduled for the six participants in the study, three participants from each site. The interviews would take place over the course of a two week period. Consistent with earlier established criteria, the six participants in the study were self-identified as licensed professional counselors. It was made explicit that there were no known risks and/or discomforts associated with this project. The participants were also assured that all information obtained in connection with this research project would be anonymous, because there would be no way to connect the data with specific individuals. Volunteers included two African-American and one Caucasian from Site I and three Caucasians from Site II. These participants hold masters degrees in counseling and all reside in Montgomery, Alabama and the surrounding communities. Each of the counselors has been licensed at least five years. The length of time working with the substance abuse population ranged from six years to nineteen years. They have acquired

numerous hours in continuing education (CEUs), as well as continuing education in the field of mental health. One participant holds the Master Addiction Certification (MAC). The participants who volunteered for the study use AA as a part of their treatment strategy. The data for the project was collected at three points. First, the researcher arrived at least 45 minutes prior to the scheduled interview to make observations of the physical site, and to record these observations. Field notes were taken of the reception areas at the sites, the bulletin boards, counseling offices, break rooms, snack areas, and outside break areas, and the researcher observed the use made of these areas and facilities before and after the interviews. The six interviews were scheduled at the two sites on different days. Fortunately, the researcher arrived at the sites for each interview early on all occasions of the site visits. The observations of the physical site were enhanced by visiting each site three times for three separate interviews with the participants.

One-on-one, in-depth interviews with the participants were conducted. The primary source of data for this study was the in-depth interviews, and each interview was audio-taped. While taping the interviews, notes were taken using an interview protocol as a backup. All the interviews were conducted in the offices of the counselors. The interviews were transcribed, and later the researcher provided a copy of the interview to each participant for review of accuracy and content.

The semi-structured, literature-based interview was designed to facilitate an open discussion about the volunteers' experiences and perceptions of substance abuse treatment programs, and about AA. Responses were used to generate themes. The participants were asked the same basic questions in the same order. The questions were worded in a completely open format with follow-up questions used to expand on or clarify responses. Prior to each interview, participants were asked to complete a demographic sheet. It was explained again that the data

being collected would remain anonymous. To ensure anonymity each person was asked to provide a pseudonym for use in the study. It was indicated to the participants in the study that the pseudonym provided would not be connected to the real name in any file or data base. The total commitment time for each participant was approximately 90 minutes. Finally, other data were gathered such as: DVDs, books, pamphlets and other multimedia available to the clients from each site; the majority of which is AA oriented.

Within-Case Analysis (Site One)

Site I was founded in 1971. The community agency is fully licensed by the Alabama Department of Mental Health and Mental Retardation, and maintains complete compliance with the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Housing and Urban Development (HUD), and the Alabama Department of Education and Community Affairs. The semi-structured themes presented below are based on observations and the three in-depth interviews conducted at Site I.

Semi-Structured Interview Themes

Substance abuse is a disease; it is genetically based; it is learned behavior. This theme is based on responses to the first set of questions posed to the interviewees at Site I which were intended to ascertain those factors counselors consider as they make decisions about interventions to use in substance abuse treatment. The process began with questions asked the interviewee about his/her thoughts regarding the practice of labeling substance abuse and addiction, especially alcoholism, a disease. The concept that alcoholism is a disease gained in popularity in the mid-20th century. The founders of AA followed this theme in 1935 when they began a self-help movement that does not blame the alcoholic for having the condition, but only for not seeking help.

Interviewee #1 articulating how she viewed alcoholism being labeled a disease said the following regarding the disease model,

No, I think for the most part I do not subscribe to the disease model. I think it is a disease that is genetically passed on from one person to another. I can say that because my mom was an alcoholic. So I don't subscribe to the disease model, but I can see where that model might have an impact in the minds of some, in the minds of some researchers, where you realize that a heavy drinker created some dysfunction or some disease within their own body to the point that now it can be passed on. You know, like diabetes, nobody in my family had diabetes and then somebody did something to their body and destroyed it to the point that it became an issue and then it was passed on.

So, for this interviewee, substance abuse is not a disease with signs and symptoms. This prompted me to ask her if she subscribed to any other models regarding the etiology of substance abuse.

I believe learned behavior is the way people pick up things, conditioned by television, conditioned by other media exposures that get us to the point where we say it is OK to do drugs; it's OK to do a little heroin. Like right now, the media is really pushing that it is OK to do marijuana. I got to do blunt, got to hit this and that, and so the children are being conditioned, in essence, that it is OK to do that. And as a result of excessive and long term usage, it could develop into medical disease that is passed on genetically. But from the issue of onset, I think the origin of substance abuse is related to learned behavior.

Interviewee #1 clearly feels learned behavior is the root of substance abuse, and the interviewee also touches on the fact that a genetic influence is also present in clients with substance abuse problems. Alcoholism runs in families. A review of the literature reveals a consensus that children of alcoholics run a higher risk of developing alcoholism than children in the general population. Influence is one of degree rather than solely determinant with environmental influences playing an important role.

Interviewee #2 is a firm proponent of the disease model,

It does have a medical format to it, it progresses over time—um—it's, how do you put it? OK, it is a diagnosed problem that has specific symptoms and criteria to it. And over time it becomes chronic; it can go into remission, but there is no cure for it. So, it has all three criteria for a medical format.

When I asked Interviewee #2 about substance abuse and addiction, especially alcoholism being labeled a disease the response was,

Well—um—I know it is really not in vogue to be calling it a disease anymore. It is like you are labeling yourself an alcoholic; you are labeling yourself an addict. In the research I have read, it is moving towards the idea of not labeling, and it is a good idea. When someone has cancer and you don't have cancer anymore, you say they are in remission. So why can't we say when someone is in recovery, why can't you say he is in recovery. He is not an addict or alcoholic anymore, he is in recovery; that makes more sense to me.

In summary, each of the theories has strengths in explaining the origins of substance abuse, but none are complete in their explanation. According to the professional literature, research is particularly difficult because the factors involved in substance abuse behavior are so complex. Erickson (2001) states that recent trends in the treatment of substance abuse reflect this complexity and lean toward the use of combined theories to address the interactive aspects of the myriad of factors associated with substance abuse.

Assessment and diagnosis of substance abuse is not an exact science. This theme deals with the accurate assessment and diagnosis in treating substance abuse. A counselor's awareness of common factors and problems related to substance abuse is of great importance. An understanding of the dynamics of denial, tolerance, loss of control, and the diverse medical consequences associated with different drugs of abuse is an essential prerequisite for accurate diagnosis.

The interviewees were asked how they assessed and diagnosed substance abuse problems and what were some common factors associated with substance abuse. Interviewee #1 stated,

Well, we use the DSM IV standard for diagnosing a person. And, once you determine what it is, then you determine what the client wants to do in terms of treatment and planning. So, in the initial stage of having a diagnosis on hand, you can determine what kind of treatment plan and process you want to proceed with as it is structured through the DSM IV. As far as common factors and problems, I have found that the individuals who have very low self-esteem as children--very low self-confidence as children have substance abuse issues. Highly impressionable as children and so when they were in the

presence of other people that learned behavior took hold and became their identity. What I am saying is that a child who was ostracized or picked on and couldn't process that in a positive manner, is the one who wants to please others. So, he will take on using drugs and alcohol to be in the in crowd and to fit in. Once they become enmeshed in that environment, then they don't know how to come out of it as readily and easily as anyone else who has their own self identity, pretty good self confidence, and self esteem.

The most important aspect of any assessment of substance abuse is the diagnostic interview. A carefully planned and conducted interview is the cornerstone of the diagnostic process. With respect to assessment, diagnosis and common factors Interviewee #2 said,

Um—I look at the difference between abuse and dependency. If there is control over use but unmanageability. I might say there is abuse there. If there is loss of control and unmanageability then you're looking more toward dependency as the client defines it. Yes, the DSM IV may consider loss of control, but the client doesn't. He may see it as just maladaptive behavior. So you have to sort of wait and see.

With respect to the common factors and problems associated with substance abuse issues, Interviewee #2 responded,

It has changed over time with respect to the traditional view of a single drug addict or alcoholic. Now it is more of a family or sub-family type of a format. You know, you get aunts, uncles, cousins all using so, when you don't treat the whole family, but just one individual it makes it even 3 or 4 times more difficult. When, just 10 years ago, it was still just single people. So now it is whole families, now there is a family component to it. Substance abuse is generational now, and it has become part of our culture. So, I believe there are two components of it now that makes treatment harder than it used to be 10, 20 years ago. So, the problem has gotten worse, if you look back there, you've got third generation back there.

Interviewee #2 brings up the point of how professionals who have to make decisions about the presence or absence of addiction for their clients must make a series of complex judgments. An adequate conceptualization of substance abuse and addiction emphasizes the interaction among the individual user, the physiological effects, and the social context in which the user functions. Establishing a standard set of rigid diagnostic criteria for addiction is not only improbable, but is also not likely to be beneficial to clients.

Regarding assessment and diagnosis, Interviewee #3 responded to this question by saying,

Well, the first thing of course is to use the DSM IV criteria. The seven criteria we use are straight by DSM IV to be considered substance dependent. So, we use it almost exactly-- and so we don't go off that, so everything is self-report for the person, so they can choose what they want to tell you and I find they always minimize in the beginning. The state of Alabama has been trying to—um—come up with a new assessment which I do prefer over the one we have now. The new assessment tool allows for more of a collaborative approach that I think would be better, because I have found that if you have a stake in your own sobriety it appears you care about it more.

With respect to common factors and problems associated with substance abuse, Interviewee #3 expressed it this way,

I think there is a commonality. The history of that would probably be true. For most of them, relationship issues with their spouse or girlfriend, boyfriend, whichever is the case, I would say somewhere along the line, somebody either wished they would be closer to somebody, and the person always pushed them away, parent-wise, or maybe sibling-wise. Maybe that's the reason they turned to drugs and alcohol and I believe another factor would be to deal with emotional and abuse issues. I find these to be very common. I would venture to say that at least one in four individuals who present with substance abuse issues have been abused in some way.

The next responses from the interviewees were related to their understanding of the dynamics of denial, tolerance, loss of control and medical consequences associated with different drugs of abuse as it relates to assessment and diagnosis. Interviewee #1 said,

Um—I believe that to a degree that we do have limited insight into our own problems and so as a result of that limited insight, clients will say that “I don't have a problem”. We want to minimize what is going on with us. We don't want to admit to ourselves that there is a problem. Once you admit to yourself that there is a problem, and others see that you have a problem, and then you begin to admit to yourself that it is a problem. So, yes the denial is there. It is a protector more than anything else. It is a means of protecting oneself.

Interviewee #2 had this to say on the subject,

Denial is a symptom of the disease, the chronic medical problem. All of these are symptoms of the disease and the disease process. None of them get better over time.

Interviewee # 3 indicated,

The tolerance thing, I think tolerance really sneaks up on people. They don't realize that—man—it takes way more to get drunk than it used to, but everybody is cheering you know. You know somebody's cheering for me, and I'm meeting new men or new women, and the fact that my tolerance has just went up, totally went by me, and I just didn't see it. When they actually look at it on paper, it's like they didn't even know. You start out drinking 2 beers once a week maybe, and on Friday night, no big deal, and now you're 24 and you drink a case. They're like, wow, I didn't realize it was that much.

Interviewee # 3 further elaborated on his understanding of loss of control and his understanding of the medical consequences associated with substance abuse and the implications for treatment and said,

Loss of control is kind of like the tolerance thing—um—research is still out about nature/nurture and all that, but at some point it kicks in where you lose control. You tell yourself just 2 beers or I'm just going to smoke one over here, or I'm just going to do \$10 worth of cocaine, but you find yourself going to the ATM to get more money. And there are all kinds of medical consequences. As you know, methamphetamine, it just amazes me to see what that does to people. I've had some teenage clients, and these are the smallest little girls, and you talk to them and find out they have been arrested for resisting arrest and beating up on police officers. They are 100 lbs. Some of them think they have bugs because they have been picking their skin. And you wonder, in your rational mind, of course, how in the world could you let that happen to yourself, and then, once you talk to them you begin to understand how the drug takes over. And some of the reasons people get into drugs is that sex thing. You know, you haven't really had sex until you have had sex on this. Why not, it is one of those hooks that get a lot of people, unfortunately. Not only have they had sex with someone they have just met and didn't know what was going on, now they are hooked on the drug too. Now they have HIV. Well, it's pretty scary!

What these three counselors realize is that the process of diagnosing substance abuse is perhaps most complicated by the phenomenon of denial. Denial and minimization of the severity of a drug abuse problem are often an essential part of how substance abusers learn to function in their world, and without the mechanism of denial, users could not continue their pattern of substance abuse.

The interviewees were also asked a question regarding how they assess and treat individuals with a primary diagnosis of substance abuse who have additional psychological disorders. Interviewee #1 said,

In the face of substance usage plus psychiatric symptoms the only way you can make a valid decision of whether or not this person is actually experiencing psychiatric issues that are not secondary to substance usage, the individual has to come off drugs and alcohol and be off a substantial amount of time before you can say this is substance abuse or just a matter of mental illness, and you've got to have a good psychosocial assessment of family history as well because we know that the history of mental illness has been genetically passed on. So a good psychosocial assessment is necessary.

Interviewee #2 kept her answer short and to the point, she said,

Um—the psychological disorders are referred out to Mental Health, where they are treated by a mental health counselor, a psychiatrist. All I do is maintenance. Are you taking your medications? Are you keeping your appointments with mental health? That type of thing. I do not dwell much into the psychological side, simply education. My role is education and maintenance.

Interviewee #3 responded to this question as indicated,

Well, I believe you have to treat both as equal. Treat the substance abuse side as well as the mental health side. Let's say they have depression which is very, very common. You know it seems like every other person who comes in here is bipolar. The doctor just says, "Where is my bipolar stamp." I think that many of them might have major depression or seasonal depression, but they just stamp it bipolar disorder. I really wonder if some of these doctors are diagnosing bipolar disorder because some of these doctors have a relationship with these pharmaceutical company reps which pay them dividends for diagnosing bipolar. It makes you wonder if this is going on.

An eclectic approach appears to be most effective in treating substance misuse/abuse.

This theme is associated with counseling-based interventions in the treatment of substance abuse issues. In the second set of interview questions posed to the interviewees at Site I, the intention was to highlight the counseling-based interventions that were used by the counselors and the ones that appear to be most effective with counselors' clients who present with substance abuse issues. The programs that are offered at Site I are grounded in 12-step philosophy as the theoretical base, and the researcher was curious as to whether or not other treatment approaches were used in the treatment of the clients. One question asked was what aspects of an individual's life they integrated into a substance abuse treatment program? Do the counselors have a particular treatment approach or approaches they use to treat clients other than the 12-step

approach? How effective did they believe individual and group therapy to be in substance abuse treatment? What were their thoughts regarding family therapy, and counselor characteristics they believed to be important in substance abuse therapy? Another question asked the interviewees was whether or not they chose treatment approaches that take into account the gender and cultural differences of clients who present with substance abuse problems?

Interviewee #1 answered some of the questions posed regarding counseling-based interventions in this way, she said,

I see it as the whole person approach. You have to look at the whole person's life. Whenever they come into a substance abuse facility, you deal with the whole person. You have got to look into the history of that individual to see what got them where they are and deal with those issues that are not yet resolved and so when a person comes in and they have psychiatric issues, we do not dismiss psychiatric issues, but incorporate them into the treatment plan so you can deal with the whole person.

Interviewee #2 responded in this way,

I will usually try to refer them to a marriage counselor but bringing the family in on interventions is a different story. If there is an intervention needed regarding this substance abuser then I will bring the family in but, other than that, I try to refer family members out to Al-Anon or marriage counseling for those issues.

Interviewee #3 responded this way when asked the question regarding those aspects of an individual's life do you integrate into a substance abuse program,

We try to integrate skills for them to be better parents, so the generation they are raising up won't have to go through what they are going through. All counselors here try to integrate things like GED classes, a more holistic approach, and other agencies in town have things we can get clients into. And this is systems theory we are talking now.

Here are some of the responses that were encountered from the interviewees when the researcher asked about the theoretical base that grounded their treatment program, and counseling approaches they used other than the 12-step approach to counseling; Interviewee #1 responded in this way,

No matter what we do, we incorporate a lot of theories, but I feel we should maintain the AA and NA. And the reason is, it has been proven—it is an evidence-based practice, it has been proven. It is good; it has worked for many, many years. And then on top of that all of our referrals are made to AA and NA agencies once clients leave us and it would not be effective for the clients that we serve if we never taught it to them—if we just used cognitive-behavioral therapy and they never understood the 12-step process, and then we make that final referral and connect them to that community resource and they never know what that is. Regarding individual therapy, I don't think you can perform good therapy unless you do it...doing individual therapy allows you to explore those issues you just surface in group therapy. Group therapy allows you to have that support among your peers. It challenges you on issues you don't want to deal with at that particular time and group allows it be done in a way that is effective and you can begin to see in group that others are going through similar problems such as yourself so that you realize that you are not alone. We have the family therapy piece in place; the biggest problem is family non-compliance. Families complain about the issues and problems, but families have been dealing with this problem for quite a long time and they are pretty much probably tired and exhausted and probably don't know what to do. They never know what to do once the family member is in treatment; they probably think that's enough.

Interviewee #1's response regarding counselor characteristics said,

Acceptance of all people, no matter what, is the most important counselor characteristic to me in substance abuse treatment. Being able to relate to all types of people culturally is also important. I've learned that as a counselor you've got to know yourself; you've got to be respectful at all times; you've got to show empathy. You have to treat that person with respect and dignity no matter what. You've got to have a willingness to help or you are going to miss the mark. A counselor must be caring.

Interviewee #2 articulated her responses to the same questions and said,

I am using the scientific-based books put out by Hazelden. These books are based on Reality and Cognitive-Behavioral theories. I got a letter from the publisher saying they are considered to be scientifically based. If Hazelden doesn't prove that they are scientifically based the government won't fund these program in the future. It has been mandated by the federal government. We all have to change. It is about money and we are changing it. I try to stick to Reality therapy. Um—it works and you have to keep the clients in the here and now for you to see effective change. And, once they see the benefits of change, then you can go back and pick up other types of change and other types of treatment, such as dealing with the past, but you have got to get them sober first and commit to staying sober. I think individual therapy can be very effective for some clients if they are open to it to really deal with those inner core issues. But it is not effective if you attempt to try to push the client or don't understand where the client is...in the point of their recovery. So, it can be detrimental or very effective; it can be very positive if the client is ready to deal with those issues. Group therapy is extremely effective because it is dealing with the client's peers. Um—and they can be motivated to help each other. So, I think that is one of the key points. Family therapy can be effective

when you have a good facilitator. When you have someone who is going to follow along with the family for a certain period when facilitating a family group, then I think it can be effective. A lot of it has to do with the facilitator.

Interviewee was asked her thoughts about counselor characteristics and does she take into account gender and cultural differences when choosing treatment approaches, and did she believe counseling-based interventions in treating substance abuse to be effective. Interviewee #2 said the following,

With respect to counselor characteristics, um—being able to have good common sense and—um—the ability to read people effectively, because they are highly manipulative and cunning group of folks. I think common sense is a “biggey.” You have to be able to hear and read people. If you have good common sense, you can read people. If you don’t have good common sense, it is a struggle, and you tend to take people on face value, and this is not an area where you can take people on face value. And, yes, you have to take into account gender and cultural differences. You have too. I think counseling-based interventions are quite effective in dealing with the type of population we receive in substance abuse treatment...more so than others. Especially with those clients who use stimulants like cocaine. You have to do something that is going to be thought-based because their thinking is distorted. So, I believe going back and looking at past history is not going to help the crack addict. Counseling-based strategies work with people who are on stimulants, especially people who have had chronic, long-term drug use with minimal intervention. Those are the types of people I have to do something like that.

The interviewee was asked what his thoughts were about the effectiveness of counseling-based interventions in the treatment of substance abuse and what type of client benefits from counseling-based strategies, the interviewee responded,

Everything I’ve seen research-wise says yes, that it is a lot better than just medication alone. And that...I don’t know who is smoking what doing these surveys but um—I really wonder about that because talk therapy would be my first line of defense. If I come to you for something, I would want you to at least talk to me. The first thing I would want you to do is say, “let me talk to you about it before I decide to give you medication,” rather than see me and give me medication. One of the biggest complaints I hear of is that...like the people at the VA...they say, “well what have you got?” “Well that sounds like depression, here is a bunch of pills, now go home.” You know I’m like...you really didn’t even talk to me. I mean, I have a soft spot...I want to talk to the person and do whatever I can; I am breathing air, and I am not speaking German or Japanese or Chinese yet—um—because of our veterans, and I appreciate what they do, and I do come from an Army family.

Regarding the question of what type of client benefits from counseling-based strategies, Interviewee #3 said,

Well—um—it depends on how...it is good to have a theory because you have a framework, but I think the important thing is to be able to help clients to establish a collaborative, helping relationship with that client. If you can't do that...and if they see you...I tell you the worst thing is “experts.” And in school, we're trained that we are “experts” and everyone comes to us for answers. No, we are collaborators. I'm in this journey called life and I may have some more answers than you do, but that doesn't make me an expert, that just means I know the path...let's go with this together.

Participation in AA will aid the client in remaining clean and sober. This theme was chosen in response to the questions I asked the interviewees regarding AA at Site I. AA is viewed by many professionals in the field and recovering individuals as the single most important component of recovery. In the third set of questions to the interviewees, the questions consider the counselors' views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems. The questions included: a) what is your definition of relapse?; b) with respect to the people who join AA (gender and minority status/culture) and remain members, how representative are they of the overall substance-abusing population?; c) how does AA fit into your practice and your views about AA as a component of recovery?; d) is there a difference between clients who adopt 12-step philosophy and those who do not?, and d) what are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA?

Interviewee #2 elaborated on the definition of relapse and said,

I base my relapse definition on the 12 steps—um—if you use it one time, just one drink or one hit...if you have been clean and sober and working a recovery plan for a period of time, you cannot relapse unless you have been in recovery, and that is something that people get confused about. You have to be in recovery first, not only clean and sober, but making steps towards remaining that way. So then you relapse. But if you are just clean and sober and not taking any steps towards keeping it up, then you weren't in recovery to begin with...so you cannot relapse. AA calls it suggestions. These are suggestions for remaining sober. You have sobriety and then suggestions for remaining sober. Now if

you are staying sober and you are following the suggestions, then you are in recovery. So, then if you relapse, that means you “lapse” back into use. But if you are not in recovery then you just simply went back to using. Relapse is a common treatment outcome.

One powerful component of AA is the group support provided by the involvement in AA meetings and sees AA involvement as a commitment to recovery.

With respect to the question regarding people who join AA (gender and minority status/culture) and remain members, how representative are they of the overall substance-abusing population, Interviewee #3 responded this way,

In my experience, the people who remain members...I have been to Auburn, Prattville, Opelika, Montgomery...well, minorities are not well represented there as far as I know. African Americans, Asian Americans, Hispanic Americans, women...it has been my experience that women are pretty well represented...minority women...minorities, just in general, are not well represented. You might find a handful here...a handful there...it's mostly Caucasians. I don't know the reason...that's interesting...I was just asking myself that question in my head. I haven't been to any Narcotics Anonymous (NA) meetings and I don't know about these meetings because I have heard some wild stories. AA looks down on NA as their ignorant rural cousins.

Interviewee #2's responses regarding the question of the people who join AA (gender, minority status/culture) she said,

I honestly don't know. I think in the United States it should be pretty good. Maybe 30%...I don't think it is over 50% of the people in it. I don't think it is even that because there is a lot of stigma involved, plus women are able to get away with it better. I think out of 10 people, maybe 3 to 4 will be members. {Interviewer: How many minorities out of the 10 will be members do you think?} Um...I think it is equal. It is still a stigma involved...being alcoholic, and I think white women will be less likely to join, and also black women too. It is a stigma to them too. {Interviewer: Black women are not in it basically?} No, because you know, I am not going to embarrass myself in public. So, if they have a problem they are still not going to “hop out there.” So I think with women you are going to find half and half.

Regarding the question of how AA fits into your practice, Interviewee #1 replied this way,

We can encourage clients to attend 12-step meetings but we can't make it mandatory. They are more likely to remain clean and sober and more likely to remain clean and sober longer if they are part of a 12-step program. If they feel welcome, they are more likely to

use telephone numbers, more likely to call before they take that next step. It is a very effective component of recovery. Unfortunately, there is a lot of controversy nowadays about client's rights. We cannot require them to attend. Well, AA has never defined itself as a religion, but if someone else has a religion that they feel is in conflict with it, then they cannot be required to go. God in the 12 steps is used to mean, "good order and direction." {Interviewer: It doesn't mean God?} No, they took that out a long time ago. In the original 12-steps, God was there. But when the 60s came up that is when AA began to change. But there are certain religions that say you can't have any other type of spiritual practices, so that is where the issue came up. Those who don't adopt it are less likely to stay clean and sober.

Another question asked was whether or not they have ever referred an individual to AA in lieu of counseling-based treatment? Interviewee #2 responded,

Um—if the person is not comfortable with the treatment format, or if the person does not meet the criteria for abuse or dependence, we normally recommend 12-step meetings.

It was then asked whether there is a difference between clients who adopt 12-step philosophy and those who do not adopt the philosophy. Interviewee #3 said,

Yes, um—like I said...AA doesn't work for everybody, and NA doesn't work for everybody, um...you need faith-based groups and some people will gravitate to something like Celebrate Recovery because they want something that is more identifiable. It's more like church to them and they identify to that more. And other people want something that's more—um—at least in theory...is more scientifically based, to that's where your Smart Recovery and Rational Recovery groups come in, because these are more scientifically based and that appeals to some, to certain people...so...and...that is the way it works.

To the question, what is your view of a stand-alone counseling method of treating individuals with substance abuse issues, Interviewee 2 answered,

It could be effective if a person has a good support system. They will have to develop some type of fellowship or support system for themselves for it to be effective, especially if they are long-term users. Short-term persons who use because of a situation or problem and that is the primary reason they use, you `know, just therapy can be very effective for them. But if you are looking at long-term, chronic issues, cognitive-behavioral therapy can be effective, but it is not going to be active in their environment once they leave the building. This is why they are given an AA referral once they leave the building.

My last question in this section asked the question, what are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA? Interviewee #2 said,

Well, I think it can be credible, in a sense, because of the traditional 12-step meetings. Traditional 12-step meetings can be a little more rigid...geared a little more towards white males who have been in there a long time. You can feel like you are a little bit out of it, but I emphasize traditional meetings now—um—meetings are becoming less traditional as they are losing people. {Interviewer: So it depends on the meeting} Yes, and the bigger the meeting the more likely the people will be involved. Most of the meetings that people are critical of are those small, isolated meetings with only a few people. They don't want anybody involved and when you do come in there you have to meet certain criteria, and there are no criteria other than the desire to stay clean and sober.

Interviewee #3 responded,

You know, I have been reading a lot of literature myself lately and—um—first of all, I have a lot of problems with women's groups. Anyway, when they say that everything is male dominated, well interesting, because I have been reading about homosexual domestic violence lately, and the rates for lesbians who abuse their partners is almost as high as it is for men. So the whole concept that women treat women better than men do isn't all that great, because people have relationship issues...they just do. If you put someone with a crazy attitude with someone who is not that crazy, and you know, or two "crazies" together, you let me borrow a nickel, a nickel, that means I'm fat—and then they throw something at somebody...you know...that is not going to work out well...no matter if you are a man or woman.

In summary, the answer to the effectiveness of AA may be far too complex to answer by a simple study. Effectiveness research in the field of substance abuse for AA or any recovery program is very limited.

Practical research is needed to help counselors do their job. This theme is related to the set of questions in this section that are intended to highlight counselors' views of the need for research in substance abuse counseling in determining what strategies and interventions are most effective and under which circumstances with substance abuse clients.

The first question to the interviewee stated, "As a practitioner, what do you need from researchers to help you do your work more effectively?"

Interviewee #1 said,

Um—longitudinal studies that deal with substance abuse. Studies that indicate to what degree relapses have occurred. I would like to see studies that show the individuals who dropped off. Maybe you had ten people to drop off in the first month, what was going on to make that group drop off. What made these people leave treatment at the different times that they did?

Interviewee #2, talking about her needs from researchers said,

I think a better understanding of the brain and the long-term chronic effect of certain drugs, especially something like crystal meth, you know, would be helpful. There is research out there, but it is still extremely difficult to deal with, but there is no long-term research out there, and you don't really know what you are dealing with when you have someone who is a meth user.

Interviewee # 3, articulating her need from researchers, said,

Well, I need practical research, research that tells me “stuff.” I don't care if it is “normed” on something in a quantitative way or in a qualitative way, but I need something that is practical. Well, something like just what we talked about earlier, why aren't minorities well represented in AA? Why doesn't somebody do a study about that and tell me what it is about, and use the research to help people overcome that. Is it because there aren't very many leaders? Maybe the chair at these meetings are all Caucasians, so maybe the meetings need to put more African Americans or Hispanic people in those positions. Maybe that is what it is, I don't know, but if that is what it is, I need to know.

My next question to the interviewees was, “What are your thoughts about suggestions from researchers in the field that AA meetings need to be more closely examined. Interviewee #2, an ardent advocate of AA, expressed her thoughts this way,

Um—I think AA meetings are an effective tool, but there is anonymity and privacy involved, and if you are not comfortable in referring a client to a meeting, then I don't believe we should violate their feelings just to see how they work simply for yourself. Now, everyone can go to an open meeting, but I am not going to a closed meeting trying to figure out something. Now, if there is a problem with a meeting, a client will tell you. Now there is nothing wrong with asking how a meeting goes without trying to break someone's anonymity about what happened in the meeting.

The final question was, “What are your thoughts concerning the need for research related to gender-specific and culture-specific treatment programs in studying best methods of treatment sensitive to gender and cultural differences?”

The thoughts regarding this question as articulated by Interviewee #2 is,

Um—if you believe that substance abuse is a medical issue, then the treatments are going to be more medical than cultural anyway. And if you find out treatments are more effective across the board, although I think it can be interesting and can be a tool, it is not really going to change the effectiveness of recovery. {Interviewer: Do you think women’s groups are more effective?} I think women’s groups are more effective in dealing with the other issues. When it comes to dealing with the symptoms of addiction, they are no more effective than a regular group. When it comes to substance abuse, women can deal with those issues in a mixed group. But when it comes to other issues in their life, those may be more effective in women’s groups. Um—I look at substance abuse first, you have to, because if you don’t get that under control, you can’t deal with the other issues. They are not going to stay and they are not going to be able to process anything else. Now with women, yeah, there is something else you have to understand. You have to also understand that if you are going to have any treatment at all, you may have to address case management issues, but that is different than therapy. Now women do have different issues when it comes to case management, such as, transportation, child care, and these issues effect whether or not they come to treatment, but substance abuse treatment can be done you know, either as a women’s group or as a mixed group, the solution is the same.

Interviewee #1 responded to this question as follows,

Well, maybe it is finding the right group. Because there is one group that I know of that caters to minorities. It is a highly popular, well attended group. I’ve gone to this group, it is a good support and well attended group and you can tell that they are connected to each other, and well attended by minorities. What I have seen is with populations that use substances is that what they have in common is that they have very low self esteem, and I can see them not feeling comfortable relating to people outside of their little network. And, so if a black man has very low self esteem or self worth, he is not going to feel comfortable in a group with white males even if they have substance abuse in common. They would probably feel more comfortable if he was catered to in a group of minorities.

In summary, there remains a demand for greater emphasis on research concerning alcohol and other drugs related to AA, counseling-based interventions, and gender and cultural issues. Research attempts in substance abuse treatment have produced a sparse number of controlled studies that can be replicated and clinically applied.

Within-Case Analysis (Site Two)

Site II was formed from the merger of four alcohol treatment centers in 1979. It operates the only adult short term crisis residential program for treatment of drug and/or alcohol addiction and the area's only adolescent outpatient and intensive outpatient substance abuse/dependency treatment program. The site is certified by the Department of Mental Health and Mental Retardation Substance Abuse Services Division.

Semi-Structured Interview Themes

The first set of questions posed to the interviewees at Site II were intended to ascertain those factors counselors consider as they make decisions about interventions to use in substance abuse treatment. In working with clients in the field of substance abuse, it is recommended by researchers in the field to become familiar in the theories that attempt to explain substance abuse and the implications for use of these theories in counseling.

Knowledge of the etiology of substance misuse/abuse is an important aspect of treatment. This theme was generated from the first set of questions intended for ascertaining those factors counselors consider as they make decisions about interventions and strategies to use in treating clients with substance abuse issues.

Interviewee #4 articulating her thoughts about why people engage in substance use and why some people become addicted said,

One reason some people develop addiction is some sort of childhood dysfunction, and then the other piece to that is the age old question, nature versus nurture. You know, there is genetics involved, environment involved, my grandfather was an alcoholic, my daddy was an alcoholic, and it goes from generation to generation. It is also learned behavior, if I grew up watching someone drinking and using, for me it is just a way of life. I wouldn't necessarily see anything wrong with doing that. So, I think there are multiple answers to this question.

When asked the question regarding thoughts about substance abuse and addiction, especially alcoholism being labeled a disease, Interviewee #5 articulating her thoughts said,

My thoughts about that are that I would tend to agree with that. And the reason that I do is because you can take the different characteristics of alcoholism and parallel them with the disease such as diabetes, for example, they both have symptoms, they both are progressive, they neither have a cure; they can both be treated, so the various things that characterize a disease you can find in alcoholism as well as a disease such as diabetes.

Responding to the same question about substance abuse and addiction, especially alcoholism, being labeled a disease, Interviewee #6 said,

To me substance abuse, like so many other psychological problems, deals with the nature/nature concept, heredity, learned behaviors, something we develop over time by the use and misuse of the drug we are talking about. I believe, and most of the things I have read, is that it is a combination of the three.

In summary, the etiology of a disease is the sum total of knowledge regarding its causes.

Researchers in the field of substance abuse realize that much remains to be learned.

Assessment and diagnosis involves a number of variables. This theme deals with the accurate assessment and diagnosis in treating substance abuse and is crucial for adequate treatment planning and delivery of services.

Interviewee #5, articulating how she views denial and tolerance associated with different drugs of abuse said,

Well, I think for most addicts it becomes an issue of problem solving and until and unless you can admit that you have a problem, there is really no solution for you. So breaking through that denial, my substance abuse is not a problem. I can quit any time I want—um—everybody in my family uses. It is an OK thing to do, it is not a problem until that person can get to that point where they say, “OK, this is a problem”, it is going to be very difficult to treat that person. With tolerance—um—I think that is one of the ways that addiction becomes chronic because people need more to get the same result. You know, the more I use to get high, the more I have to use to get the same high, and sometimes, if I don’t get the high that I want, I will go to some other drug to get it. I think tolerance is pretty dangerous for people because it just increases their risk for addiction.

Interviewee #4 articulating how she views loss of control and medical consequences that are associated with different drugs of abuse said in answer to this question,

Well, loss of control—um—mostly we see that with—alcohol. A lot of times, marijuana and people that smoke marijuana, they are not violent, they just...but with cocaine or crack and alcohol—um—it is a little bit different because of loss of control...alcohol especially...your brain gets into these different stages and your coordination gets bad...and anger...if someone has anger, it begins to show out and so they do things, say things, throw things, kick things, things they wouldn't ordinarily do if they weren't drinking. Also, with loss of control, they are combative, they'll fight, and they will even get into a fight and resist arrest, for example. Um—domestic violence...that's a "biggy." Again, we see that more with alcohol than we do with some of the other drugs. But if somebody is pretty high on crack or alcohol and anything else they might have used, they're probably going to be out of control also. {Interviewer: medical consequences?} We talked about the liver damage, brain now with marijuana. The general medical consequences have to do with the lungs brain, and I read that there are some other consequences such as infertility, it can cause that. We know that with cocaine it can...like...um...Lynn Bias, the famous basketball player...who blew his heart out with cocaine and there was no evidence he used it before, but he used it that one time. {Interviewer: What about prescription medications, do you see a lot of that?} We do occasionally...you know it kind of...there will be several, and then we don't have them. Prescription drugs, again, have to do with opiates usually.

The next questions were, "How do you assess and diagnose substance abuse problems?", "What are the common factors and problems associated with substance abuse?", and "How do you assess and treat individuals with a primary diagnosis of substance abuse and who have additional psychological disorders?" Interviewee # 5 discussing the assessment process said,

Um—the assessment process, we have a rather lengthy assessment process. Naturally, we look at the diagnostic criteria, DSM IV, and if that person meets the criteria, then they get that diagnosis. A common factor is relapse prevention, because a lot of people are here two, three, four, five, or six times, so relapse prevention is a really big factor. The other one, I think, is life skills and life goals, because a lot of people who chronically use do not develop those skills required to live on life's terms. They have spent so much time being high and avoiding responsibility that they don't really know how to do those things that they need to do in their sober life. We don't formally do co-occurring disorders; however, um...we do pay attention to that because we have people who come in here who are bipolar, who have major depressive disorder, have ADHD and various other diagnoses, along with their substance abuse. Um—we monitor that, some people we will refer for mental health evaluation. If we detect some sort of mental illness—um—we do address it, although, like I said, we don't have a formal program right now. But, like I

said that is one thing we are working on here is getting a co-occurring program started, because we are finding that more and more of our clients have a co-occurring disorder.

In summary, denial or minimization serve to keep reality at arm's length and allows the dependent person to believe that no one is aware of the excessive drug use and the negative impact it is having on he or her life. The use of denial to delude both the user and others tremendously complicates the assessment process. Establishing some standardized format for assessment and diagnosis is essential in helping clinicians maintain consistency in providing appropriate detection and treatment for their clients.

Evidence-based practices to form the basis of substance abuse programs in the future. In the second set of questions were asked about the counseling-based interventions that appear to be most effective with counselors' clients who present with substance abuse issues. In October 2009, Site II will be emphasizing the use of evidence-based practices, and they have been preparing to implement these new practices for the past year.

In this set of questions that highlighted the counseling-based interventions that appear to be most effective with counselor's clients who present with substance abuse issues, the questions included were: Was the treatment program grounded in a theoretical base?; Do you have a particular treatment approach or approaches you use to treat clients? What are your thoughts about the effectiveness of counseling-based interventions in the treatment of substance abuse? In response to my question regarding the theoretical base of the program, Interviewee # 4 said,

OK...well...our treatment modality is based on the 12-step program, and we encourage clients to go to AA and NA. We have AA here on Saturday and Sunday afternoons. Most of our clients who come to that are inpatients, but it is an open group, and so we have people from the community to come, and previous clients that would come to that.

When asked, Interviewee #5 expressed her thoughts about the effectiveness of counseling-based interventions this way,

We are...we are in the process of implementing a new treatment modality. We are—um—being trained in Motivational Interviewing (MI)—um—and that will be our treatment modality here at Site II—um—it is a much less “confrontive”, you know substance abuse treatment, in the past, has been very confrontational, very rigid; it was somewhat abrasive. This is a totally different approach. And as you might imagine, for us “old dogs,” who’ve been around awhile, trying to change our spots is a little bit painful, but we are learning, and I think it is a gentler kind of approach that we are trying to implement right now. {Interviewer: Will all counselors be required to use it?} Yes. Not only the counselors, but the staff will be required to use MI. MI is more person-centered than anything else. I have been doing this the same way for years and years, and now you tell me I got to do something else.

Interviewee #6 said,

Basically, it puts, from my point of view...I think it empowers the client more, it puts the client in the driver’s seat of their treatment. It allows the client to identify what their need is. And...uh...it is more of a collaborative partnership between the therapist and the client. You know, I’m not here to tell you what you need and how you are going to do it...this is something we are going to work out together, and you are part of that decision-making process.

In this section regarding counseling-based interventions that appear to be most effective with counselors’ clients who present with substance abuse issues, the question asked was, “Do you choose treatment approaches that take into account the gender and cultural differences of clients who present with substance problems?” Interviewee #4, responding to this question said,

Well, I guess it kind of goes back to what we call approaches. Obviously, I don’t think we can treat everybody exactly the same. And so, I always think there is going to be this element of gender, etc. I was going to say we have people from...when we talk about cultural differences, it is not only about race, but it can be age, you know you can’t, you don’t treat the 14-year old the same way you do the 30-year old, or the 60-year old the same as you do the 30-year old. Because everyone has different levels of experience and stuff in their lives—um—and cultural differences can also be something like dealing with someone who has just got out of prison, been in prison for 10 years, and their issue is basically what we call “emotional incarceration.” They’ve lived the same way and someone told them to live the same way for the many years they were in prison, and now, all of a sudden, they are suppose to act and think for themselves. It’s kind of like a 50/50 thing where one intervention may work well with this client, another intervention may work well with this client—um—however, we are trying to find these interventions, and again, MI, because it lends itself...uh...to being client-centered. You are helping the client to grow and to be able to see things for themselves. But when it comes to, say, the old way we do business, the old way helped a lot of people, so it was not that it wasn’t any good, it’s just that...ah...times have changed, and the pendulum is kind of going the

other way. Nowadays, you get up in somebody's face and they are ready to sue you for harassment. You know, some of those interventions that used to work were probably appropriate for that time, but times have changed and MI is not the only intervention, but it's one that we are using now. So, that is kind of what I know about now, and so, it has been awhile since I have been in school, so, I'm not really sure what all is out there. One of the neat things about MI that I just really love is before you give advice you are supposed to ask the client questions such as, "May I share my thoughts with you?" "Would you like to hear what I'm thinking about this?" And, if the client says, "no" then you just say, "that's fine," and we move on. Eventually, you will come back around and you will probably get to what you wanted in the first place. Because it is done in such a way, whereby, the client has the power...uh...it becomes their therapy, and not yours. And so, I really like that aspect. In fact, I even use that at home with my son.

In summary, at a time when our practitioners are stretched to the limit to provide critically needed services to clients, they are now also challenged with the task of integrating a continuous stream of evidence-based practices into their clinical settings. Managed care constraints, public set of regulations and policies, limited resources, underpaid staff, and a reimbursement system that calls for quality care with fewer client contact hours, are just some of the difficult conditions our providers face.

Participation in AA is seen as a positive aspect of recovery. This theme was chosen in response to the questions asked the interviewees regarding AA at Site II. In the third set of questions to the interviewees were asked about the counselors' views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems. The questions included: a) What is your definition of relapse?; b) With respect to the people who join AA (gender and minority status/culture) and remain members, how representative are they of the overall substance-abusing population?; c) How does AA fit into your practice and your views about AA as a component of recovery?; d) Is there a difference between clients who adopt 12-step philosophy and those who do not?, and e) What are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA?

Responding to the question regarding the common factors that are found to be present in clients who relapse, Interviewee # 6 said,

Ah...I believe it is failure to manage their addiction, to consistently incorporate recovery behaviors and recommendations. It is also a lot about motivation. If I don't want to stay clean, I am not going to. And some people will tell you, flat out, that even though they are here, they have no intention to stop using. So—um—I think it boils down to the individual person and what they want and are willing to do the work required to stay sober. And I think that is when a lot of people relapse, is when they realize that even though they realize that changing their life will be for their benefit, if it's too hard, if they perceive it as too hard, they step away, "it's just too hard for me"... "I'm going back to my old ways" because trying to live a new way of life is just too hard...too difficult.

In response to the question regarding the definition of relapse, Interviewee #4 said,

Relapse is getting back to the place where I started having problems again. A slip is a one-time use but nothing negative came of it other than you failed the drug screen. Which is not a bad thing, but not a good thing if you caught yourself before you got further down the road. Then, that could be a good thing. Relapse can help a client see that this is how easy it is. The question is how common is relapse in the recovery process. Well, what I tell folks in recovery is that relapse happens, but it doesn't have to happen. I think it is part of the recovery. You know, how many people go on a diet and say, "Well, I am going to have a piece of chocolate cake, even though it is not on my diet, but I've been good for two months, and I owe it to myself." I need to have that chocolate cake. Sometimes that's the thinking that our clients get into. Well, I haven't had anything for three months and one beer is not going to hurt anything. Well, if you got in your car and drove, well, it might be a problem. So, as I said, I try to use the....it happens....it just doesn't have to happen. We try to give you the tools for you to use to see and prevent it from happening.

When I asked Interviewee #5 if she believed relapse to be a common treatment outcome, she said,

I think it is very common. I think in some ways it is even expected. You know... everybody is going to stumble...everybody is going to fall...but what I tell my clients is that I am not giving you permission to relapse; however, if you do, it doesn't mean that you have blown recovery. Now recovery is available all the time. You've relapsed once...you've relapsed 5,000 times...you still have the opportunity for recovery.

Individuals involved in recovery and the treatment of recovering individuals recognize that maintaining sobriety is perhaps the most difficult aspect of recovery. There is a high degree of consensus in the field that relapse is a common element in the recovery process.

In this set of questions regarding AA, the participants were asked if people who join AA (gender and minority status/culture) and remain members, how representative are they of the overall substance-abusing population. Interviewee #5, articulating her response, noted,

I couldn't quote you a statistic, but my feeling is, they represent a very slim percentage. Some people who do make it to AA don't stay. But the people who have been in AA consistently for a significant period of time are really and truly...I don't think they are the norm. I think they are the most fortunate, however. Because it goes back to what I talked to you about earlier...about how hard this is. You know, if staying clean means that I have to go to a meeting everyday or couple of days, or if I have to talk to somebody, or I have to do this or do that...whatever it is that my recovery means, my recovery behaviors...and you're telling me I have to do this every day...you know...AA has a saying that when you're willing to go to any lengths then you are ready.

The next set of questions included: How does AA fit into your practice? What are your views about AA as a component of recovery? Have you observed any differences between clients who adopt the AA philosophy from those who do not? Have you ever referred an individual to AA in lieu of counseling-based treatment? If not, would you? What is your view of a stand-alone counseling method for treating individuals with substance abuse issues? What are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA? Interviewee # 4 responded by saying,

We encourage our clients to go to AA and NA. Occasionally, we use AA slogans, for example. We do have literature we hand out on AA. Generally, we have a group on sponsorship, etc. AA is a viable component of recovery. Those who adopt the philosophy, those who do and follow the program and become involved in it as another resource have a better recovery. I have referred an individual to AA, if they know that they have had some problems with drinking, but they know that it is not to the point that....they don't have DUIs...they get drunk and their wife says you got to go do something or else, and so, if we don't see that they meet the criteria for substance abuse or dependence, another option is education and generally what we say is you need to go to meetings, get a sponsor, do ninety meetings in ninety days—um—and then if that doesn't work out, then come back. We also might recommend AA to someone whose work hours are not conducive to go to treatment, but they are willing to go to AA and willing to get a sponsor, and so, again, we tell them to try that, and if it is not working for you then come back to treatment.

Interviewee #5 said,

I don't think that a stand-alone method in and of itself...ah...is sufficient. I think—um—giving my viewpoint, I think that this is a chronic thing. It requires long-term treatment, whether that's going to a meeting...whatever that is...it's not something...it's not a one-time thing. You come to treatment and when that's over, that's the end. It is something that has to be managed on a daily basis, in my opinion.

In responding to the question relating to criticisms of AA, Interviewee #6 said,

I think you can criticize anything...um...and I think AA answers that question best..."Take what you need and leave the rest." Um, there are some things about AA and NA that I personally don't agree with. There are some people in AA and NA that I don't particularly like, but...um...the benefits that are there, outweigh all of that. If you come to it expecting to have a problem, or expecting that it is not going to meet your expectations, it probably won't work for you.

In summary, in spite of the methodological problems aggravated by the anonymous, voluntary, self-selection of AA membership, there is evidence to indicate that AA is a very useful approach for alcoholics who are trying to stop drinking.

We need to know that the strategies and interventions we use are effective. This qualitative research theme is based on the fourth set of questions that were intended to highlight counselors' views of the need for research in substance abuse counseling in determining "what works" under which circumstances with substance abuse clients. The questions included were: a) What do you need from researchers to help you do your work more effectively? b) What are your thoughts about suggestions from researchers in the field that AA meetings need to be more closely examined?, and c) What are your thoughts concerning the need for research related to gender-specific and culture-specific treatment programs in studying best methods of treatment sensitive to gender and cultural differences?

Interviewee #4's response as to what she needed from researchers to help her work more effectively, and did AA meetings need to more closely examined said,

I never really thought about it really. Every once and a while I read statistics or reports that come out. The NIDA every so often...I'll read something like that or SAMSHA...right. The problem with AA—AA is not a government agency. It is

independent. There are no rules, no dues, everything is totally voluntary. So, I'm not sure how we can "go in" and more closely examine groups. I don't know. It is just something I haven't thought about.

Interviewee #5 said,

I think it is very important that we know that what we are doing is effective and why. I think we need some very definite parameters laid out for us so that we can gauge whether or not what we're doing is working for several reasons. One is for quality care of clients and another is accountability. If you are going to fund a program...um...wouldn't you want to know that it worked...wouldn't you want to figure out how you know that this works. You know, I can tell you, "yeah this works," but what do I have to show you in black and white on paper that this works. We need outcome research. And we need to know how to do the qualitative stuff...like success stories. How do we incorporate the people that we know are successful; how can we incorporate that into outcome measures. So, yeah, I think it's real important that there is research that's done...that we can stand up and say, "Yes this is effective and this is why." {Interviewer: Why do you think it is not being done; think people are afraid; they don't know how to do it?} Substance abuse and chemical dependence are not glamorous. I think part of it is the fact that non-profit agencies, particularly, that do this work, are so busy that there are two things...there is a time management issues and there is an expertise issue. Not everybody walking around here knows how to do statistics, and there are not very many people I know that even like statistics. I would be one of them. You have to have some sort of expertise and knowledge in order to do research, and most people who have an interest in research...well...I don't know very many people who are interested in research in chemical dependence.

Questions concerning the need for research related to gender-specific and culture-specific treatment programs in studying best methods of treatment sensitive to gender and cultural differences, Interviewee #4 articulated her response this way,

Well—um—like you said, there is research going on. I think I've read something about that. But on the other hand, I think there is value to having men and women in a group because we live in a male and female world. If we totally do everything in a women's group, then we isolate ourselves from this other side, then how are we ever going to know what really is going on. How do the men have any idea of what is really going on with women? I think women-specific groups are important for some issues if you talk about sex and domestic violence like men and their groups talk about rage and anger, stuff like that. And, again, I think there is value in gender-specific groups and the key is to be sensitive.

Interviewee #6 said,

We are not going to have an all-White group, we are not going to have an all-Black group. We are not going to do that. I think the counselors that I work with do take cultural issues into consideration. For example, when we talk about cultural differences, here is something I come to think of. Several years ago, I went to an adolescent training thing. The chief probation officer over the facility, he was talking about the fact that especially in the Black culture, there are no more grandmas. Because mom got pregnant at 15, her mom raised that child, right? Um, anyway, the one who is raising the child is the grandmother raising the children. The probation officer was explaining that the big problem is that there are no grandmas. You don't have a buffer to go to because mom, who is my grandma, who is now my mom is raising me, and I don't look at my grandma as that extra layer, that buffer. And so I've been aware, when they tell me that they have been raised by their grandmother. Another cultural thing which is...it is not totally unique to Black people...is that there is no dad. Where is your dad? I will ask, and they answer, "Well I don't know; I've never seen him." If they know who their dad is, they don't have a relationship. A lot of times they don't know who their dad is. This always creates an empty hole, and sometimes they use alcohol and drugs to fill the hole. They don't realize that and they are not going to come out and tell you that. And then, you get to working with them, and then you find out, yeah, life cheated me. I never had a dad. And, so, that is very uncomfortable.

In summary, there remains a demand for greater emphasis on research concerning alcohol and other drugs. Research attempts in substance abuse treatment have produced a sparse number of controlled studies that can be replicated and clinically applied. Despite some recent optimism, however, there are still few well-designed studies on substance abuse treatment. A major variable preventing clearly definable research in this field is the fact that substance abuse is a phenomenon usually not attributed to a single cause or even a small number of events.

Cross-Case Analysis

The first theme that emerged from Site I was, *Substance abuse is a disease; it is genetically based; it is learned behavior*. This theme was generated by the first set of questions that were posed to the interviewees at Site I. These questions were intended to ascertain those factors counselors consider as they make decision about interventions to use in substance abuse treatment. The theme that emerged from Site II based on this first set of questions was, *Knowledge of the etiology of substance misuse/abuse is an important aspect of treatment*.

Participants from both counseling center sites agreed that having knowledge of the cause of any disease or condition, in this case, substance abuse, is essential in having a general understanding of the condition, in selecting and implementing appropriate treatment, and in predicting possible outcomes of treatment.

The second theme for Site I was, *Assessment and diagnosis of substance abuse is not an exact science*. The second theme for Site II was, *assessment and diagnosis involves a number of variables*. These themes were generated from questions that asked the participants that dealt with accurate assessment and diagnosis in treating substance abuse, and proper assessment and diagnosis is crucial for adequate treatment planning and delivery of services to clients. Participants at both sites appeared to agree that there is no single medical or psychological test that can determine, with absolute certainty, that a person is drug-or alcohol-dependent. They agreed that the process of diagnosing substance abuse is perhaps most relentlessly complicated by the phenomenon of denial.

The second set of questions was intended to highlight the counseling-based interventions that appear to be most effective with counselor's clients who present with substance abuse. The theme that emerged from Site I relative to the questions posed stated that, *An eclectic approach appears to be most effective in treating substance misuse/abuse*. The theme that emerged from Site II was *Evidence-based practices to form the basis of substance abuse programs in the future*. Here, the two sites differed. Site I appears to continue to operate in the traditional 12-step treatment modality. Some of the participants at Site I indicated they used treatment modalities such as cognitive-behavioral therapy, reality therapy, but the overall impression was that they operated in the 12-step tradition, which the counselors that were interviewed stated their treatment programs were based. Although the treatment modality at Site II was based on the 12-

step program at the time the interviews were conducted, and they strongly encourage their clients to attend AA and NA meetings to combat relapse, Site II will begin to follow the mandate as established by the Substance Abuse and Mental Health Services Administration (SAMHSA) for using evidence-based practices beginning October 1, 2009. The counselors at Site II will use Motivational Interviewing (MI) as the treatment modality for the counseling center.

When participants at Site I were interviewed, it became readily apparent to me that she was aware of the mandate regarding evidence-based practices, and she expressed to me that everyone at the site was aware of it. However, it does not appear that they were taking any formal actions for implementing the mandate. The other interviewees at Site I never mentioned the new course of action to be taken in the new fiscal year. The counselors interviewed (at least two of them) appeared to be “stuck” in the 12-step treatment model mindset of doing business in treating clients with substance abuse issues.

The third set of questions considered the counselors’ views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems. Again the purpose of this qualitative study was to explore the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and also explore the perceptions of those counselors who ascribe to the AA model. The theme that emerged from this set of questions from Site I was, *Participation in AA will aid the client in remaining clean and sober*. The theme from Site II related to this set of questions was, *Participation in AA is seen as a positive aspect of recovery*. At Site I, it was apparent that the counselors realized change was in the air, but they expressed a resistance—a hesitation—to grasp it. They are comfortable in the old ways of doing business, and appear to be resisting the change that is probably inevitable. Site II has worked through their resistance, but it appears they will not give up their AA and NA meetings and passing out AA

literature. I also came to realize from both sites that AA is comfortable, and that is where they would like to remain; there appears to be some fear of the unknown by the professional counselors.

The fourth set of questions were intended to highlight counselors' views of the need for research in substance abuse counseling in determining what works, and under what circumstances with substance abuse clients. My first question to the interviewees in this set of questions stated, "As a practitioner, what do you need from researchers to help you do your work more effectively? The theme that emerged from Site I was, *practical research is needed to help counselors do their jobs*. The theme that emerged for Site II was, *we need to know that the strategies and interventions used are effective*. It seemed that the questions asked surrounding the area of research tended to make all of the participants in the study uncomfortable. It also became very clear that they did not engage in research activities, nor did they read current literature. One participant in the study put it bluntly, "substance abuse and chemical dependence is not glamorous." Part of the lack of interest in research and research activities lies is the fact that non-profit agencies (those agencies that represent a majority of substance abuse counseling in the United States), are so busy with the enormous demands in dealing with the substance abuse population with very little resources, that basically, there are time management and expertise issues. Although these are professional counselors, working in the field of substance abuse a number of years, not everyone is trained and comfortable with research activities. One counselor interviewed put it very succinctly, "You have to have some sort of expertise and knowledge in order to do research...and most people who have an interest in research...well...I don't know very many people who are interested in research in chemical dependence."

V. DISCUSSION

Introduction

The purpose of this study was to explore the perceived benefits of AA in the treatment of substance abuse, and also explore the perceptions of professional counselors who ascribe to the AA model of recovery, even in the absence of empirical support. Data was collected by means of on-site observations and by conducting in-depth interviews of participants from two outpatient mental health counseling centers. There were a total of six participants, three from each counseling center site. In this final chapter, the thematic findings are presented and explored, the implications of the findings of this study for theory, practice and research in the area of the role AA in substance abuse treatment will be discussed. The study concludes with the limitations of these findings and qualitative research in general, recommendations for future research will be presented, and implications for counseling practice and training will be examined.

Summary of Thematic Findings

This multi-site qualitative case study explored the professional counselors' perceptions of the benefits of AA in the treatment of substance abuse, and also examined the perceptions of those counselors who reported a belief and confidence in the AA model of recovery. The methodology included personal observation and the use of in-depth, semi-structured interviews of professional counselors employed at two selected sites. Qualitative data analysis generated themes that were analyzed and compared.

The themes generated from Site I included the following: 1) Substance abuse is a disease; it is genetically based; it is learned behavior, 2) Assessment and diagnosis of substance abuse is not an exact science; 3) An eclectic approach appears to be most effective in treating substance misuse/abuse; 4) Participation in AA will aid the client in remaining clean and sober, and 5) Practical research is needed to help counselors do their jobs. The themes generated from Site II observations and interviews included the following: 1) Knowledge of the etiology of substance misuse/abuse is an important aspect of treatment; 2) Assessment and diagnosis involves a number of variables; 3) Evidence-based practices to form the basis of substance abuse programs in the future; 4) Participation in AA is seen as a positive aspect of recovery, and 5) We need to know that the strategies and interventions used in treatment are effective.

This section will present a synopsis of the remarks made by the participants in the study and present previous literature attempting to link the thoughts of these professional counselors working in the field of substance abuse with previous theoretical works. In this context, it is important to put the claims made by these counselors in the context of the general literature of the research of substance abuse counseling.

Thematic Findings from Semi-Structured Interviews

The theme generated from Site I was based on the first set of questions asked that were intended to ascertain those factors counselors consider as they make decision about interventions to use in substance abuse treatment was, *Substance abuse is a disease; it is genetically based; it is learned behavior*. The theme for Site II was, *Knowledge of the etiology of substance misuse/abuse is an important aspect of treatment*. In the study of substance abuse and addiction it can more accurately be said that the etiology is the sum of knowledge regarding its cause, and much remains to be learned.

Erickson, (2001) states that knowing the cause of any disease or condition is essential in five areas: a) general understanding of the condition, b) selection and implementation of appropriate treatment, c) prediction of possible outcomes of treatment, d) construction of appropriate research, and e) prevention of the condition. In the first question the interviewee was asked his/her thoughts about substance abuse and addiction, especially alcoholism, being labeled a disease. Participants in this study articulating their thoughts about why people engage in substance use and why some people become addicted said,

“... I don't subscribe to the disease model, but I can see where that model might have an impact in the minds of some, in the minds of some researchers, where you realize that a heavy drinker created some dysfunction or some disease...”

“... you can take the different characteristics of alcoholism and parallel them with the disease such as diabetes, for example, they both have symptoms, they both are progressive, they neither have a cure; they can both be treated.”

In 1950 Dr. E. M. Jellinek, a physician, published a description of the disease of alcoholism based on a survey of 98 male AA members (Pratsinek & Alexander, 1992). Jellinek suggested that there are distinct signs and symptoms of alcoholism, a criterion important if it is to be termed a disease (Light, 1985). These symptoms are clustered into stages of alcoholism, early, middle, and late. These form the basis of 12-step treatment programs for substance abuse today.

Alcoholism runs in families. A review of the literature reveals a consensus that children of alcoholics run a higher risk of developing alcoholism than children in the general population. Influence is one of degree rather than solely determinant with environmental influences playing an important role.

“I believe learned behavior is the way people pick up things, conditioned by television, conditioned by other media exposures that get us to the point where we say it is OK to do drugs...”

“You know, there is genetics involved, environment involved, my grandfather was an alcoholic, my daddy was an alcoholic, and it goes from generation to generation.”

“To me substance abuse, like so many other psychological problems, deals with the nature/nurture concept, heredity, learned behaviors, something we develop over time by the use and misuse of the drug we are talking about.”

The behavioral theories, including social learning theory, have their roots in experimental psychology and learning theory (Bennett & Woolf, 1990). Substance abuse is seen as being influenced by a biological series of actions, past learning, cognitive operations, situational causes reinforcement. An assumption is made that social use through abuse of alcohol and other substances to addiction, is governed by similar principles of learning and cognition. Social learning theory, developed by Albert Bandura, also forms a part of the behavioral theory about substance abuse (Abrams & Niaura, 1987; George 1990). Cognitive, genetic, and socio-cultural factors are thought to predispose experimentation with alcohol or drugs as well as subsequent usage. The consequences of substance abuse become stressors leading to further substance abuse. Addictions are viewed as learned, socially acquired behaviors with multiple causes (MacKay, Donovan, & Marlatt, 1991). Current behavioral theories have added cognitive factors as intervening variables to the learning patterns believed to be responsible for development of addictions. While most individuals who agree with behavioral theories believe that learning

plays an important part in addiction in some individuals, other etiological factors may also play an important role (George, 1990).

In summary, each of the theories has strengths in explaining the origins of substance abuse, but none are complete in their explanation. According to the professional literature, research is particularly difficult because the factors involved in substance abuse behavior are so complex. Erickson (2001) states that recent trends in the treatment of substance abuse reflect this complexity and lean toward the use of combined theories to address the interactive aspects of the myriad of factors associated with substance abuse.

The next themes generated from Site I and Site II were based on the second set of questions posed dealing with questions related to the accurate assessment and diagnosis in treating substance abuse and is crucial for adequate treatment planning and delivery of services. The theme from Site I was, *Assessment and diagnosis of substance abuse is not an exact science*. The theme from Site II was, *Assessment and diagnosis involves a number of variables*.

Interviewees articulating how they assess and diagnose substance abuse problems and what were some common factors associated with substance abuse stated,

“Well, we use the DSM IV standard for diagnosing a person. And, once you determine what it is, then you determine what the client wants to do in terms of treatment and planning.”

“Um—I look at the difference between abuse and dependency. If there is control over use but unmanageability, I might say there is abuse there. If there is loss of control and unmanageability then you’re looking more toward dependency as the client defines it.”

According to current literature, there is no single medical or psychological test that can determine with absolute certainty that a person is drug-or alcohol-dependent. Gallant (1987, p.

47) notes that therapists must be aware of other problems that may interfere with the diagnostic process. The stigma of being labeled a “drunk” or “addict” is still a powerful deterrent to disclosing their pattern of substance use for many people, especially women. A counselor’s awareness of common factors and problems related to substance abuse is of great importance. An understanding of the dynamics of denial, tolerance, loss of control, and the diverse medical consequences associated with different drugs of abuse is an essential prerequisite for accurate diagnosis.

“We don’t formally do co-occurring disorders; however, um...we do pay attention to that because we have people who come in here who are bipolar, who have major depressive disorder ...have ADHD and various other diagnoses...”

It is noted that many individuals diagnosed with substance abuse problems also meet the criteria for other psychological disorders. Chamberlain and Jew (2001) indicate that it is important to discover whether symptoms of a psychological problem either preceded the onset of the abuse problems or persisted after the substance abuse had been treated, and a period of abstinence had been maintained for several months. Some clients may have begun using drugs to alleviate symptoms of anxiety or depression. Psychoactive drugs may initially offer some relief to individuals who suffer from mood disorders. Counselors should question clients carefully about their psychological history prior to using drugs or alcohol, seeking information regarding a family history of psychological problems.

With respect to common factors, problems associated with substance abuse, understanding of loss of control, understanding of medical consequences associated with substance abuse and the implications for treatment, some responses of the interviewees were,

“It has changed over time with respect to the traditional view of a single drug addict or alcoholic. Now it is more of a family or sub-family type of a format.”

“Um—I believe, to a degree, that we do have limited insight into our own problems and so as a result of that limited insight, clients will say that “I don’t have a problem”.

“We want to minimize what is going on with us. We don’t want to admit to ourselves that there is a problem.”

“Denial is a symptom of the disease, the chronic medical problems. All these are symptoms of the disease and the disease process. None of them get better over time.”

‘I think tolerance really sneaks up on people. They don’t realize that—man—it takes way more to get drunk than it use to, but everybody is cheering you know..”

“You tell yourself just 2 beers or I’m just going to smoke one over here, or I’m just going to do \$10 worth of cocaine, but you find yourself going to the ATM to get more money.”

“And there are all kinds of medical consequences...methamphetamine; it just amazes me to see what that does to people. I’ve had some teenage clients, and these are the smallest little girls, and you talk to them and find out they have been arrested for resisting arrest and beating up on police officers. They are 100 lbs.”

“Not only have they had sex with someone they have just met and didn’t know what was going on, now they are hooked on the drug too. Now they have HIV. Well, it’s pretty scary!”

What these professional counselors realize is that the process of diagnosing substance abuse is perhaps most complicated by the phenomenon of denial. Denial and minimization of the severity of a drug abuse problem are often an essential part of how substance abusers learn to function in their world, and without the mechanism of denial, users could not continue their

pattern of substance abuse. Chamberlain and Jew (2001) explain that denial or minimization serves to keep reality at arm's length and allows the dependent person to believe that no one is aware of the excessive drug use and the negative impact it is having on his or her life. The use of denial to delude both the user and others tremendously complicates the assessment process. Therefore, establishing some standardized format for assessment and diagnosis is essential in helping counselors maintain consistency in providing appropriate detection and treatment for their clients.

The deterioration of an alcoholic's lifestyle and health, the loss of significant relationships, and other problems related to excessive drinking along with the basic chemical effects of alcohol make it nearly inevitable that an alcohol-addicted client will appear depressed while they are actively drinking. However, this depression is usually reactive and should decrease significantly with abstinence and efforts to resolve life problems that accumulated during the period of addiction. In alcoholics with primary depression, the symptoms either preceded the onset of alcohol abuse or became more pronounced during periods of abstinence (Mayfield, 1985).

Other themes generated from questions asked in the second set of questions from Site I and Site II were, *An eclectic approach appears to be most effective in treating substance misuse/abuse*, and the theme generated from Site II was, *Evidence-based practices to form the basis of substance abuse programs in the future*. The intention of the questions asked was to highlight the counseling-based interventions that were used by these counselors and the interventions that appear to be most effective with counselors' clients who present with substance abuse issues. The participants were queried about their thoughts regarding individual, group and family therapies, counselor characteristics, and whether or not they chose treatment

approaches that take into account the gender and cultural differences of clients who present with substance abuse problems.

The participants responded to these questions in the following manner,

“I see it as the whole person approach. You have to look at the whole person’s life.”

“If there is an intervention needed regarding this substance abuser then I will bring the family in but...I try to refer out to Al-Anon or marriage counseling....”

“All counselors here try to integrate things like GED classes, a more holistic approach, and other agencies in town have things we can get them into.”

“No matter what we do, we incorporate a lot of theories, but I feel we should maintain the AA and NA. And the reason is, it has been proven—it is an evidence-based practice, it has been proven.”

“Regarding individual therapy, I don’t think you can perform good therapy unless you do it...doing individual therapy allows you to explore those issues you just surface in group therapy. Group therapy allows you to have that support among your peers.”

“We have the family therapy piece in place; the biggest problem is family non-compliance.”

“Acceptance of all people, no matter what, is the most important counselor characteristic to me in substance abuse treatment. I’ve learned that as a counselor you’ve got to know yourself; you’ve got to be respectful at all times; you’ve got to show empathy.”

“I am using the scientific-based books put out by Hazelden. These books are based on Reality and Cognitive-Behavioral theories. I got a letter from the publisher saying they are considered to be scientifically based.”

“If Hazelden doesn’t prove that they are scientifically based the government won’t fund these program in the future. It has been mandated by the federal government. We all have to change. It is about money and we are changing it.”

“With respect to counselor characteristics, um—being able to have good common sense and—um—the ability to read people effectively, because they are highly manipulative and cunning group of folks.”

“You have to do something that is going to be thought-based because their thinking is distorted. So, I believe going back and looking at past history is not going to help the crack addict.

“Counseling-based strategies work with people who are on stimulants, especially people who have had chronic, long-term drug use with minimal intervention.”

“...it is good to have a theory because you have a framework, but I think the important thing is to be able to help clients in establishing a collaborative, helping relationship with that client.”

A recent study documenting the effectiveness of professional treatment was the multi-site study conducted by the Project MATCH Research Group (1997). Project MATCH was originally designed to match clients with alcohol problems to different types of professional alcohol treatment. Clients were randomly assigned to one of three different types of individual treatment: cognitive-behavioral, motivational interviewing, or 12-step facilitation. Cognitive-behavioral treatment was designed to teach clients cognitive and behavioral skills to cope with situations that precipitate drinking (Kadden et al., 1992). Motivational-interviewing strategies were designed to facilitate internally motivated change through the use of a stage model of alcoholism as well as the use of techniques such as promoting empathy, eliciting self-motivating statements,

providing objective feedback, and supporting self-efficacy (Miller, Zweben, DiClemente & Rychtarik, 1992). The twelve-step facilitation efforts were designed to help clients learn about AA, attend AA meetings, and begin working on the steps of AA (Nowinski, Baker, & Carroll, 1992). Although Project MATCH was not able to demonstrate that particular subtypes of clients with alcohol problems responded differently to these approaches (which was the primary aim of the study), it did demonstrate significant and sustained improvements in drinking at 1-year follow-up for all three treatments (Project MATCH Research Group, 1997). The general findings of Project MATCH are consistent with other large-scale studies and recent reviews of the literature found both cognitive-behavioral treatments and AA to be effective in terms of reducing substance use and improving most areas of life functioning.

Individual counseling programs remain a viable option for many addicted patients. The outpatient-counseling model offers the individual a chance to live at home and, in most cases, continue working. There is a belief that for many patients, individual outpatient drug addiction counseling is as effective as inpatient chemically dependent programs (Doweiko, 1999).

Individual counseling approaches for drug use are viewed as heterogeneous in nature (Institute of Medicine, 1990) and often serve clients who have less severe drug-related problems.

Interpersonal relationships and social interactions are major factors affecting substance abuse clients. Because of this phenomenon, the group counseling process has been historically considered as a viable approach to use with substance abusers either alone or in conjunction with other treatment methods. Group programs attempt to help substance abuse clients alter distorted concepts of self, learn from others, regain hope and reduce isolation. Despite the generally stated advantages of using group counseling approaches with substance-abusing clients, these programs have been sparsely researched.

Miller and Hester (1986), after reviewing studies on the efficacy of group counseling programs with substance abuse clients, concluded that we have yet to consistently demonstrate measurable effective outcomes. Yet the general view has been that group therapy programs are effective with adolescent substance abusers.

Family therapy has been viewed over the years as a promising treatment approach for substance abusers (Kaufman, 1979). When therapy includes family members, it is believed that it can impact change significantly when working with alcoholic patients (Liepmann, Nirenberg & Begiw, 1989). Despite few controlled studies to validate this belief, Stanton and Todd (1982) report family therapy to be effective when compared to certain individual approaches used by themselves with clients. Todd and Selekman (1991) found that when family therapy was used with substance abuse cases, individuals tended to stay longer in treatment and maintain sobriety for longer periods of time.

With respect to evidence-based practices in the future the participants at Site II responded this way,

“OK...well...our treatment modality is based on the 12-step program, and we encourage clients to go to AA and NA. We have AA here on Saturday and Sunday afternoons.”

“We are—um—being trained in Motivational Interviewing (MI)—um—and that will be our treatment modality here at Site II—um—it is a much less “confrontive”, you know substance abuse treatment, in the past, has been very confrontational, very rigid; it was somewhat abrasive. This is a totally different approach.”

“Basically, it puts...I think it empowers the client more, it puts the client in the driver’s seat of their treatment.”

“When we talk about cultural differences, it is not only about race, but it can be age, you know you can’t, you don’t treat the 14-year old the same way you do the 30-year old, or the 60-year old the same as you do the 30-year old.”

“It’s kind of like a 50/50 thing where one intervention may work well with this client, another intervention may work well with this client—um—however, we are trying to find these interventions, and again, MI, because it lends itself...uh...to being client-centered.”

“You know, some of those interventions that used to work were probably appropriate for that time, but times have changed and MI is not the only intervention, but it’s one that we are using now.”

According to Clark, (2002), the abuse of alcohol and drugs leads to serious problems with health, criminal activity, lost productivity in the workplace, and automobile crashes. To treat those who suffer from alcohol and drug addiction, we must advocate treatment that is proven effective for the drug populace involved. However, Clark states that due to background, cultural, and language differences between substance abuse researchers, treatment providers, and policy makers, empirically tested treatments are not being put into widespread practice.

The Center for Substance Abuse Treatment (CSAT), sponsored by the National Treatment Plan Initiative, began a two-year effort in recent years to listen to multiple segments of the treatment field to bridge this gap. As we advocate treatment for those who suffer from alcohol or drug addiction, we must advocate treatment that is proven effective for the drug and alcohol population involved. During the past decade, there has been an unprecedented growth in support for substance abuse research. As a result, a wealth of promising research leads and findings are being reported at an accelerating pace across a broad range of areas, particularly neuroscience, pharmacology, clinical management, and health services delivery. The practitioner

in the field has neither the time nor the magic compass it would take to track the progress of validation studies or the application of clinically tested findings that prove sound in real world clinical practice.

At a time when our practitioners are stretched to the limit to provide critically needed services to clients, they are now also challenged with the task of integrating a continuous stream of evidence-based practices into their clinical settings. Managed care constraints, public set or regulations and policies, limited resources, underpaid staff, and a reimbursement system that calls for quality care with fewer client contact hours, are just some of the difficult conditions our providers face. The overburdened clinician winds up perplexed by demands that treatment methods have proof of effectiveness and concerned that the new approaches being touted are really just fads. This conflict reflects the background, cultural, and language differences between researchers, providers, and policy makers that, among other factors help create a gap between substance abuse research and practice (Clark, 2002).

In the third set of questions to the interviewees, the questions consider the counselors' views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems. The theme generated from Site I was, *Participation in AA will aid the client in remaining clean and sober*. The theme for Site II was, *Participation in AA is seen as a positive aspect of recovery*.

AA is viewed by many professionals in the field and recovering individuals as the single most important component of recovery in preventing relapse. Yet critics of the program suggest caution, stating that those people who join AA and remain members may not be a representative sample of the substance-abusing population (Emrick, Tonigan, Montgomery, & Little, 1993). The fact that those people remain members separates them from those who do not join or who

join and do not remain active. Additionally, research is difficult since the groups have a high degree of variability (McCrary & Irvine, 1989).

Some of the participant responses were,

“...you cannot relapse unless you have been in recovery, and that is something that people get confused about.”

“Relapse is a common treatment outcome.”

One powerful component of AA is the group support provided by the involvement in AA meetings. Anonymity is seen as an integral element in AA both to protect the identity of its members, and so that no one person becomes a spokesperson for the group (Doweiko, 1993). AA sees a commitment to recovery as a commitment to or involvement in AA.

“In my experience, the people who remain members...I have been to Auburn, Prattville, Opelika, Montgomery...well, minorities are not well represented there as far as I know.”

“...it has been my experience that women are pretty well represented...minority women...minorities, just in general, are not well represented. You might find a handful here...a handful there...it's mostly Caucasians. I don't know the reason...”

“I think in the United States it should be pretty good. Maybe 30%...I don't think it is over 50% of the people are in it. I don't think it is even that because there is a lot of stigma involved, plus women are able to get away with it better. I think out of 10 people, maybe 3 to 4 will be members.”

“Um...I think it is equal. It is still a stigma involved...being alcoholic, and I think white women will be less likely to join, and also black women too. It is a stigma to them too.”

“No, because you know, I am not going to embarrass myself in public. So, if they have a problem they are still not going to “hop out there.” So I think with women you are going to find half and half.”

Regarding the question of how AA fits into your practice, Interviewee #1 replied this way,

“We can encourage clients to attend 12-step meetings but we can’t make it mandatory. They are more likely to remain clean and sober and more likely to remain clean and sober longer if they are part of a 12-step program.”

“If they feel welcome, they are more likely to use telephone numbers, more likely to call before they take that next step. It is a very effective component of recovery.

Unfortunately, there is a lot of controversy nowadays about client’s rights. We cannot require them to attend.”

“Well, AA has never defined itself as a religion, but if someone else has a religion that they feel is in conflict with it, then they cannot be required to go.”

“God in the 12 steps is used to mean, “good order and direction.”

“No, they took God out a long time ago. In the original 12-steps, God was there. But when the 60s came up, that is when AA began to change. But there are certain religions that say you can’t have any other type of spiritual practices, so that is where the issue came up. Those who don’t adopt it are less likely to stay clean and sober.”

“Yes, um—like I said...AA doesn’t work for everybody, and NA doesn’t work for everybody, um...you need faith-based groups and some people will gravitate to something like Celebrate Recovery because they want something that is more identifiable.”

“And other people want something that’s more—um—at least in theory...is more scientifically based, so that’s where your Smart Recovery and Rational Recovery groups come in, because these are more scientifically based and that appeals to some, to certain people...so...and...that is the way it works.”

“Traditional 12-step meetings can be a little more rigid...geared a little more towards white males who have been in there a long time.”

“Yes, and the bigger the meeting the more likely the people will be involved. Most of the meetings that people are critical of are those small, isolated meetings with only a few people.”

“You know, I have been reading a lot of literature myself lately and—um—first of all, I have a lot of problems with women’s groups. Anyway, when they say that everything is male dominated, well interesting, because I have been reading about homosexual domestic violence lately, and the rates for lesbians who abuse their partners is almost as high as it is for men. So the whole concept that women treat women better than men do isn’t all that great, because people have relationship issues...they just do.”

The cornerstone of the AA model is the paradoxical belief that to gain control of one’s life, one must give up control to a Higher Power. Although God is mentioned in AA, members believe that one’s Higher Power can be many things or beings. AA distinguishes between spirituality and religion and believes that addiction is a spiritual disease as well as a physical one. By embracing spirituality, not a specific religious dogma, AA allows all individuals to embrace a Higher Power of their own choosing. AA is a “spiritual program of living” (Miller & Kurtz, 1994, p. 165).

Criticism about the AA program has been leveled by women's groups and minority groups who feel disenfranchised by AA. Many women believe AA perpetuates the powerlessness of women in steps 1 through 3. Minority groups believe that AA serves the white middle class and does not address ethnic issues in their philosophy. It would appear that some research supports this theory—that AA is more effective with “socially stable white males over 40 years of age, who are physically dependent on alcohol and prone to guilt, and who are the first born or only child” (Doweiko, 1999, p. 368). Some evidence also indicates that AA is not effective with individuals who are coerced into attendance. People who are sentenced to jail or to educational programs for driving under the influence appear to have better subsequent driving records than those who are court ordered to attend AA (Peele, Brodsky, & Arnold, 1991). This outcome may be associated with either motivation or the concept of self-efficacy.

“So—um—I think it boils down to the individual person and what they want and are willing to do the work required to stay sober.”

“Relapse is getting back to the place where I started having problems again. A slip is a one-time use but nothing negative came of it other than you failed the drug screen. Which is not a bad thing, but a good thing if you caught yourself before you got further down the road.”

“I think [relapse] it is very common. I think in some ways it is even expected. You know... everybody is going to stumble...everybody is going to fall...but what I tell my clients is that I am not giving you permission to relapse; however, if you do, it doesn't mean that you have blown recovery. Now recovery is available all the time. You've relapsed once...you've relapsed 5,000 times...you still have the opportunity for recovery.”

Individuals involved in recovery and the treatment of recovering individuals recognize that maintaining sobriety is perhaps the most difficult aspect of recovery. There is a high degree of consensus in the field that relapse is a common element in the recovery process. Some believe that the “most common treatment outcome for alcoholics and addicts is relapse” (Dimeff & Marlatt, 1995, p. 176). It is interesting to note, however, that, until recently, relapse and relapse prevention have had little research and there has been less attention in most treatment programs.

The meaning of relapse has changed over the years. Relapse was originally seen as a failure of the individual in recovery. According to AA, when individuals relapse, they revert to a pre-abstinence level of abuse/dependency and must begin the process of recovery from the beginning. As other concepts of both etiology and maintenance of dependency have developed, the view of relapse has also changed. Many now view relapse as a normal part of the recovery process, and as a learning experience for the recovering individual. In fact, after treatment most individuals still use substances on an episodic basis (DeJong, 1994). The first 90 days after treatment appear to be when clients are the most vulnerable to relapse. Clients have not developed strong coping skills this early in the process and, therefore, tend to be unable to make healthy decisions in regard to their life choices (DeJong, 1994; Dimeff & Marlatt, 1995; Doweiko, 1999).

Currently, recovery is defined not only as abstinence from mind-altering chemicals or nonproductive compulsive behaviors but also changes in physical, psychological, social, familial, and spiritual areas of functioning. These changes are a process and not an event in the recovering individual’s life. It is generally accepted that the dynamics that enable an individual to maintain sobriety are as different as the factors that initiate sobriety (Buelow & Buelow, 1998).

“Some people who do make it to AA don’t stay. But the people who have been in AA consistently for a significant period of time are really and truly...I don’t think they are the norm. I think they are the most fortunate, however.”

“We encourage our clients to go to AA and NA. Occasionally, we use AA slogans, for example. We do have literature we hand out on AA. Generally, we have a group on sponsorship, etc. AA is a viable component of recovery. Those who adopt the philosophy, those who do and follow the program and become involved in it as another resource have a better recovery.”

“I have referred an individual to AA, if they know that they have had some problems with drinking, but they know that it is not to the point that.....they don’t have DUIs...”

“I think you can criticize anything...um...and I think AA answers that question best...”Take what you need and leave the rest...”

In spite of the methodological problems aggravated by the anonymous, voluntary, self-selection of AA membership, there is evidence to indicate that AA is a very useful approach for alcoholics who are trying to stop drinking. A meta-analysis by Emrick, Tonigan, Montgomery, and Little (1993) of 107 previously published studies found that greater AA involvement could modestly predict reduced alcohol consumption. Findings also suggest that length of AA attendance is correlated with months of sobriety. Other studies support the idea that AA is beneficial as an adjunct to formal treatment and when used as a form of after care (Alford, Koehler, & Leonard, 1991; Walsh, et al., 1991).

The responses of participants to the research questions indicated that AA is still seen as viable component in the treatment of substance abuse in these counseling centers that participated in the study. However, counseling-based interventions or best practices are

becoming more prevalent in community mental health agencies treating individuals with substance abuse problems.

In summary, the answer to the effectiveness of AA may be far too complex to answer by a simple study. Effectiveness research in the field of substance abuse, for AA or any recovery program is limited. It serves the mental health practitioner to be aware that some individuals are best served by AA, and some individuals might be better served through other approaches (Stevens, 2001).

The following themes were generated from Site I and Site II based on the fourth set of questions that highlighted counselors' views of the need for research in substance abuse counseling in determining "what works" under which circumstances with clients with substance abuse issues. The theme generated from Site I, *Practical research is needed to help counselors do their jobs*. The theme generated by Site II regarding the fourth set of questions that were related to research was, *We need to know that the strategies and interventions used in treatment are effective*.

The present qualitative research study looked at two cases, two outpatient programs. As early as 1956, outpatient programs have been used to address alcohol-related problems (Fox & Low, 1967). Outpatient programs are wide-ranging in duration and treatment methods. They vary from one-session assessment followed by a referral, to 3- to 6-month programs including psychotherapy weekly, to 1- to 2-year programs with psychotherapy combined with other treatment activities. One conclusion of a few research studies, however, indicates that the longer patients remain in outpatient treatment, the better the outcome (Gerstein & Harwood, 1994). Clients staying in treatment fewer than 90 days showed negligible improvement when compared to those clients who stayed in treatment over 90-day-plus days. Clients involved in outpatient

program activities past the 6-month date significantly improve as related to drug abstinence and quality-of-life factors.

Below are some responses of interviewees that are related to questions regarding research in the field of substance abuse.

“Um—longitudinal studies that deal with substance abuse. Studies that indicate to what degree relapses have occurred.”

“There is research out there, but it is still extremely difficult to deal with it, but there is no long-term research out there, and you don’t really know what you are dealing with when you have someone who is a meth user.”

“Well, I need practical research, research that tells me “stuff.” I don’t care if it is “normed” on something in a quantitative way or in a qualitative way, but I need something that is practical.”

“I think women’s groups are more effective in dealing with the other issues. When it comes to dealing with the symptoms of addiction, they are no more effective than a regular group.”

“Um—I look at substance abuse first, you have to, because if you don’t get that under control, you can’t deal with the other issues.”

“Now women do have different issues when it comes to case management, such as, transportation, child care...”

“What I have seen in populations that use substances is that what they have in common is that they have very low self esteem, and I can see them not feeling comfortable relating to people outside of their little network.”

“...if a black man has very low self esteem or self worth, he is not going to feel comfortable in a group with white males even if they have substance abuse in common.”

“The problem with AA—AA is not a government agency. It is independent. There are no rules, no dues, everything is totally voluntary. So, I’m not sure how we can “go in” and more closely examine groups. I don’t know. It is just something I haven’t thought about.”

“I think we need some very definite parameters laid out for us so that we can gauge whether or not what we’re doing is working for several reasons. One is for quality care of clients and another is accountability.

“If you are going to fund a program...um...wouldn’t you want to know that it worked...wouldn’t you want to figure out how you know that this works.

“You know, I can tell you, “yeah this works,” but what do I have to show you in black and white on paper that this works.”We need outcome research. And we need to know how to do the qualitative stuff...like success stories.”

“Substance abuse and chemical dependence are not glamorous. I think part of it is the fact that non-profit agencies, particularly, that do this work, are so busy that there are two things...there is a time management issue and there is an expertise issue. Not everybody walking around here knows how to do statistics, and there are not very many people I know that even like statistics. I would be one of them.”

“You have to have some sort of expertise and knowledge in order to do research, and most people who have an interest in research...well...I don’t know very many people who are interested in research in chemical dependence.”

“I think there is value to having men and women in a group because we live in a male and female world. If we totally do everything in a women’s group, then we are isolating

ourselves from this other side, then how are we ever going to know what really is going on.”

“I think women-specific groups are important for some issues. If you talk about sex and domestic violence, like men and their groups with rage, anger...and, again, I think there is value in gender-specific groups and the key is to be sensitive.”

“We are not going to have an all-White group, we are not going to have an all-Black group. We are not going to do that. I think the counselors that I work with do take cultural issues into consideration.”

There remains a demand for greater emphasis on research concerning alcohol and other drugs. Research attempts in substance abuse treatment have produced a sparse number of controlled studies that can be replicated and clinically applied. Despite some recent optimism, however, there are still few well-designed studies on substance abuse treatment. A major variable preventing clearly definable research in this field is the fact that substance abuse is a phenomenon usually not attributed to a single cause or even a small number of events. However, general research findings have produced a few conclusions concerning substance abuse treatment. For example, research evidence (Doweiko, 1999) suggests that for many the use of outpatient drug addictions treatment is as effective as inpatient programs. This becomes relevant in today’s climate when considering health care delivery costs.

According to Peregoy and Tait, (2001), regarding the diverse groups that are prevalent in the United States with issues related to substance abuse, they indicate that implementation of individual and community alcohol and other drug interventions programs that are designed for particular groups need to be developed within the socio-cultural worldview in which they are applied. Peregoy and Tait further state that what counselors do not want to do is impose

dominant middle-class, white male interventions in communities not reflecting these values. These themes regarding research speak to the need of professional counselors to challenge their perspective of the world and develop an awareness of how one perceives culturally different clients. In developing this awareness, counselors need to gain an understanding of the history and background of their clients to address their issues within the context in which they are presented. In doing so, they will not only serve the needs of their clients more fully but also empower them within the counseling process.

Implications for Theory, Practice and Research

Qualitative analysis of the data collected in intensive interviews with professional counselors working in the field of substance abuse treatment provides an informative, though somewhat disturbing view of the field. Several implications lead to calls for change in research, practice, and theory. Because of the absence of previous studies on the perceptions of professional counselors about the role of AA in substance abuse treatment, findings of this study stand alone, needing further validating studies, both qualitative and quantitative. AA is seen by the professional counselors in the present study as a powerful component in recovery from substance abuse in remaining clean and sober. Furthermore, counseling-based interventions are seen as effective, but after counseling treatment, individuals are seen as needing the support of group membership in AA to maintain the sobriety acquired. Relapse does not have to occur, but professional counselors believe that relapse is a natural part of the recovery process. In many cases, no one stand-alone method of counseling intervention in treating substance abusers is recognized as being effective in and of itself. Professional counselors believe that accurate assessment and diagnosis are vital in conceptualization of the problems associated with substance abuse issues. It was noted that not all individuals with substance abuse problems are

suited to the AA model of recovery; some women and minorities appear to feel disenfranchised in their dealings with AA, and others are referred to AA without the benefit of counseling-based interventions. One of the counseling centers used in this study will incorporate evidenced-based practices by all counselors and staff in the center effective the new fiscal year, but presently the program is based on the 12-steps.

Finally, it is clear that the current literature regarding best practices in substance abuse treatment is not being read by professional counselors in the field. It also appears field research is not being conducted by the professional counselors in these not-for-profit counseling centers. This is particularly troubling because of the fact that these participants were carefully selected because they are licensed professional counselors (LPC) who have been working in the field of substance abuse a number of years. Research needs to become a greater part of the regular work and the professional identity of counselors providing therapeutic services in the field of substance abuse.

To validate and test these complex claims requires the design and creation of instruments that will utilize these concepts of professional counselors about the role of AA in substance abuse treatment to test large samples of professional counselors working in substance abuse, and track which, when, and how counselors experience the role of AA in substance abuse treatment in the future, especially in light of the fact that these agencies will now conduct treatment using evidence-based strategies. This will allow the generalization of the results, and a more specific discussion in separating all the variables that lead one to continue to use AA as an adjunct to substance abuse treatment. However, AA's very structure, and the complexity of the perceptions of the role of AA in treatment will make the implementation of this process difficult. In fact it may be necessary to continue to do more qualitative studies to learn all the specific variables of

the concepts or perceptions of professional counselors about the role of AA in substance abuse treatment before one is able to design an instrument to capture these concepts in their entirety quantitatively.

The perceptions of professional counselors regarding the role of AA in substance abuse treatment comes from the literature, and the professional counselors, themselves, who work with individuals in substance abuse treatment. As reported in the 1990s, there are over 94,000 Alcoholics Anonymous groups, 11,000 Narcotics Anonymous groups, more than 32,000 Al-Anon groups, as well as thousands of other related groups across the country, and because of their widespread availability, the 12-step programs have been seen by many as the best hope in stopping the continued growth of substance abuse. And although scant, outcome studies on the effectiveness of AA have been conducted (Dorsman, 1996; Humphreys & Moos, 1996; Watson et al., 1997). Ninety-five percent of inpatient addiction treatment programs in the United States incorporate AA and Narcotics Anonymous (NA) at some level (Brown et al., 1988).

Brown (1985) found that 77% of the AA participants in the research had experienced some form of psychotherapy before abstinence and 45% after abstinence. In another survey of AA members, Maxwell (1976) reported that 31.5% seek additional professional help after entering AA. Studies designed to evaluate and review AA groups and their effectiveness have been burdened with scientific design problems. Most of these studies did not include control groups. The two controlled AA studies included in the Miller et al. (1995) meta-analysis both revealed no beneficial effect of this modality. However, this conclusion is contradictory to earlier findings, with their limitations, that have generally shown positive results (Bebbington, 1976; Leach & Norris, 1977; Madsen, 1974). Leach (1973) reports four studies involving AA treatment in New York, London, Finland, the United States and Canada. The results from United States

and Canada report 38% of the sample were abstinent from 1 to 5 years. Madsen (1974) compared AA treatment with other approaches in California. From responses to questionnaires in an ethnographic study, AA showed outstanding gains when compared to a variety of other treatment modalities.

Clinical implications of this finding are noteworthy. Professional counselors need to broaden and deepen their cognitive grasp of the role of AA in substance abuse treatment. Also, they need to build a greater knowledge of counseling-based interventions that are appropriate for treating substance abuse. The present study shows very clearly the importance of having a thorough understanding of what constitutes accurate assessment and diagnosis. The study also underscores the significance and relevance of developing an understanding of the theories of etiology as well as a thorough knowledge of the current literature as it relates to substance abuse issues and treatment.

In this cost-conscious mental health environment, counselors need not to waste time implementing therapeutic strategies that are redundant and inappropriate for the recovering person. A thorough understanding of the AA model of recovery including its strengths and limitations, a thorough understanding of counseling-based interventions that have been proven effective in the treatment of substance abuse, along with a knowledge of the current literature regarding substance abuse issues, may help counselors develop programs that are most effective for alcoholics and implement therapeutic strategies that could produce positive outcomes for clients.

Limitations of the Study

Though qualitative studies allow the investigation of complex phenomena, the very nature of qualitative study creates limitations, most notably about the ability of the results to be

generalized. Because there were six participants in this study, three from each case, or site, generalization may not be possible, especially in the context of the absence of previous theory and empirical data on the perceptions of professional counselors about the role of AA in substance abuse treatment. In addition, since the six participants were purposely selected to represent licensed professional counselors working in the field of substance abuse, it is not clear whether the perceptions that were observed in these six participants are a common or universal phenomenon. It will require new instruments and large and diverse samples to achieve the goals of generalization.

The qualitative methodology is highly dependent on personal reports, and has limited ability to check the validity of the subjective experiences of participants (this limitation is not different than quantitative studies that rely on personal reports). Though there is no reason to suspect participants intentionally deceived the researcher, participants may have responded in the way that would make them appear more highly functional than they are, to impress the researcher, or to enhance the image of AA in the eyes of the researcher. The interview questions as structured by the researcher may be skewed to more positive experiences of the participants and may also have encouraged more positive responses than warranted; the researcher may also have structured the interview and designed a set of questions to achieve the intended outcome.

These are all the problems of qualitative research, where objectivity and the ability to generalize are compromised for complexity, in-depth information, and subjective experiences. To safeguard against observer bias the researcher spent a considerable amount of time at the two counseling center sites, getting to know the subjects and the environment (both physically and culturally) in which they live. The researcher was aware that most situations and settings are very

complex. There was no effort made to manipulate variables or to control the activities of individuals, but simply observed and recorded what was said.

Recommendations for Future Research

As counselors move into the 21st century, they are increasingly called on to be change agents, and it is critical that they have the knowledge base and skills necessary for work in the substance abuse field. Most would agree that continued training and experiences are necessary in this field. With multiple diagnosis cases, the need for family treatment, use of medication and so forth, substance abuse counselors need to continually update both their skills and knowledge base.

More outcome studies need to be conducted on the change processes of AA and long-term sobriety. We also need studies of long-term sobriety in the absence of active participation in AA to see how the experience and coping styles differ among those actively involved in AA versus those who have stopped using through counseling-based interventions or never used AA in their recovery.

There have been few studies and very little written on the treatment of ethnic minority drug and alcohol abusers. Some believe that culture-specific treatment programs need to be explored to meet the needs of varied ethnic groups.

While training standards for the best counselor education programs include provisions for overall health promotion and prevention, recent studies indicate that a gap still persists in the preparation of counselors in the area of substance abuse, addiction, intervention and prevention. We also need better preparation in the counselor education programs in the field of research, how to feel comfortable with the current literature and how to actively conduct outcome research when working with individuals with substance abuse issues using best practices.

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APPENDIX 1

SITE AUTHORIZATION/COOPERATION LETTERS FOR
LIGHTHOUSE COUNSELING CENTER, INC. AND
CHEMICAL ADDICTIONS PROGRAM, INC. (CAP)

April 22, 2009

Auburn University Instructional Review Board
c/o Office of Human Subjects
307 Samford Hall
Auburn, AL 36849

Please note that Ms. Maria D. Rogers, Auburn University doctoral candidate has the permission of the Lighthouse Counseling Center, Inc. to conduct research at our Montgomery, Alabama facility for her project, "Perceptions of Counselors about the Role of Alcoholics Anonymous (AA) in Substance Abuse Treatment".

To *recruit* licensed professional counselors (LPC), Ms. Rogers will make a group presentation at a clinical staff meeting. At the meeting, she will distribute an information letter notice informing the staff that participation is voluntary, that the information provided will have no identifying information and will therefore be anonymous. Ms. Rogers also plans to arrive at the facility at least 45 minutes prior to the scheduled interview to gather field notes by observing the physical structure as an "outsider"; then moving into the setting and observing as an "insider", and then gathering other data that may include such items as: DVDs, books, pamphlets and other multimedia available to the clients that may or may not be AA oriented if available. The research activities will be finished by April 30, 2009; a copy of the transcript of the taped interview will be provided to participants no later than May 10, 2009.

Ms. Rogers has agreed not to interfere with the flow of work as counselors conduct their business assisting clients. The interview is expected to last no longer than 90 minutes. Ms. Rogers has also agreed to provide to my office a copy of the Auburn University IRB approved, stamped consent document before she recruits participants at the Center, and she will also provide a copy of any aggregate results.

If you need additional information concerning the participation of the staff of this agency in this research project, please contact me. We look forward to supporting you in your research endeavor.

Sincerely,

Douglas Lindley, MBA, MA
Executive Director

April 22, 2009

Auburn University Instructional Review Board
c/o Office of Human Subjects
307 Samford Hall
Auburn, AL 36849

Please note that Ms. Maria D. Rogers, Auburn University doctoral candidate has the permission of the Chemical Addictions Program, Inc., to conduct research at our Montgomery, Alabama facility for her project, "Perceptions of Counselors about the Role of Alcoholics Anonymous (AA) in Substance Abuse Treatment".

To *recruit* licensed professional counselors (LPC), Ms. Rogers will make a group presentation at a clinical staff meeting. At the meeting, she will distribute an information letter notice informing the staff that participation is voluntary, that the information provided will have no identifying information and will therefore be anonymous. Ms. Rogers also plans to arrive at the facility at least 45 minutes prior to the scheduled interview to gather field notes by observing the physical structure as an "outsider"; then moving into the setting and observing as an "insider", and then gathering other data that may include such items as: DVDs, books, pamphlets and other multimedia available to the clients that may or may not be AA oriented if available. The research activities will be finished by April 30, 2009; a copy of the transcript of the taped interview will be provided to participants no later than May 10, 2009.

Ms. Rogers has agreed not to interfere with the flow of work as counselors conduct their business assisting clients. The interview is expected to last no longer than 90 minutes. Ms. Rogers has also agreed to provide to my office a copy of the Auburn University IRB approved, stamped consent document before she recruits participants at the Center, and she will also provide a copy of any aggregate results.

If you need additional information concerning the participation of the staff of this agency in this research project, please contact me. We look forward to supporting you in your research endeavor.

Sincerely,

John E. Cospers, MA, LPC, LMFT
Executive Director

APPENDIX 2

RECRUITMENT SCRIPT

RECRUITMENT SCRIPT

(I will recruit participants for the project by calling each site to identify licensed professional counselors (LPC) working in the field of substance abuse, who use Alcoholics Anonymous (AA) as part of their treatment strategy and are 19 or older. Once I am referred to an individual, I will either telephone that person or meet with the individual in person).

My name is Maria Rogers, a doctoral candidate from the Department of Special Education, Rehabilitation, Counseling/School Psychology at Auburn University. I would like to invite you to participate in my research study to explore the perceived benefits of Alcoholics Anonymous (AA) to the counseling professional in the treatment of substance abuse, and also look at the potential for developing protocols for determining those clients who might be referred to AA, those clients that might be treated with more counseling-based models, and those particular clients that might benefit most from some combination of the two approaches in treating substance abuse problems. I am recruiting licensed professional counselor (LPC) working in the field of substance abuse, use AA as part of your treatment strategy and you are age 19 or older. Please do not participate if you do not meet these specific criteria.

As a participant, you will be asked to complete a demographic sheet and participate in a one-on-one, in-depth interview that will be audio taped and a transcript of the interview will be provided to you

There are no known risks, compensation or benefits, or costs with this study. All data obtained in connection with this study will remain anonymous. To protect your privacy and the data you provide, you will be asked to provide a pseudonym to use for the study. The pseudonym you use will not be connected to your real name in any file or data. Information collected through your participation will be used to fulfill an educational requirement and may be published in a professional journal and/or presented at a professional conference. This research may provide additional information about treatment options in counseling persons experiencing substance abuse problems.

If you would like to participate in this study, we can set up a time and place for the interview, and your total time commitment will be approximately 90 minutes. Do you have any questions now? If you have questions later, please contact me at (334)-284-5980 or e-mail rogerm2@auburn.edu or you may contact my advisor, Dr. Debra Cobia, at e-mail cobiadc@auburn.edu.

APPENDIX 3

INFORMATION LETTER

AUBURN UNIVERSITY LETTERHEAD

INFORMATION LETTER

For a Research Study entitled
Perceptions of Professional Counselors about the Role of Alcoholics Anonymous (AA) in
Substance Abuse Treatment

You are invited to participate in a qualitative research study designed to explore the perceived benefits of Alcoholics Anonymous (AA) to the counseling professional in the treatment of substance abuse. This study is being conducted by Maria D. Rogers, ALC, under the direction of Dr. Debra C. Cobia, Professor in the Auburn University Department of Special Education, Rehabilitation, Counseling/School Psychology. You were selected as a possible participant because you are a licensed professional counselor (LPC) working in the field of substance abuse, you use AA as part of your treatment strategy, and are age 19 or older.

The data for this research project will be collected at three points. First, I will make observations of the physical site and record these observations in my journal. Next, one-on-one, in-depth, interviews will be conducted with you that will be audio-taped and a transcript of the interview will be provided to you. Finally, I want to gather other data such as: DVDs, books, pamphlets and other multimedia available to the clients that may or may not be AA oriented may be included. Prior to the interview, I will provide you with a demographic sheet to complete. If you are eligible and decide to participate in this project, your total time commitment will be approximately 90 minutes.

There are no known risks and/or discomforts associated with this study. All information obtained in connection with this research project is anonymous. There will be no way to connect the data with specific individuals. There are no direct benefits that can be expected by participating in this study. However, there is a possible indirect benefit to the general population. Results of this study will be used to help elucidate factors counselors use in developing protocols for determining best methods in treating clients with substance abuse problems, and may suggest a possibility for identifying areas related to additional training for alcohol-related training courses.

If you change your mind about participating, you can withdraw at any time during the study until the data have been analyzed and tapes destroyed. At that time, it will not be possible to identify your data. Your participation is completely voluntary. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, or the Department of Special Education, Rehabilitation, Counseling/School Psychology.

All data obtained in connection with this study will remain anonymous. To protect your privacy and the data you provide, prior to the taped interview, participants will be asked to provide a pseudonym to use for the study. The pseudonym you use will not be connected to your real name in any file or database. Information collected through your participation will be used to fulfill an educational requirement and may be published in a professional journal and/or presented at a professional conference. This research may provide additional information about treatment options in counseling persons experiencing substance abuse problems.

If you have questions about this study, please ask them now or contact Maria Rogers by phone (334)-286-5980 or e-mail at rogerm2@auburn.edu. If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Maria D. Rogers, MS, ALC, Primary Researcher
Doctoral Candidate, Auburn University

Date

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APPENDIX 4

DEMOGRAPHICS SHEET

Please respond by filling in the appropriate answer in the space provided.

What is your employment title?

What is the highest degree you have earned?

When did you become a licensed professional counselor (LPC)?

How long have you worked with the substance abuse population?

**Have you acquired special education and training in the field of substance abuse?
If so, what type of education and training?**

APPENDIX 5

OBSERVATION PROTOCOL

Length of Activity: 45 Minutes

<i>Descriptive Notes</i>	<i>Reflective Notes</i>
<i>General: What are the experiences of professional counselors in the treatment of clients who present with substance abuse issues?</i>	
See facility layout and comments about physical setting at the bottom of the page.	
	<i>SKETCH OF SITE</i>

APPENDIX 6

INTERVIEW PROTOCOL

Project

“Perceptions of Professional Counselors about the Role of Alcoholics Anonymous (AA) in Substance Abuse Treatment”

Time of Interview:

Date:

Place:

Interviewer:

Interviewee:

Position of Interviewee:

This study will explore the perceived benefits of AA to the counseling profession in the treatment of substance abuse, and also explore the perceptions of those counselors who ascribe to the AA model in the absence of empirical support. This study will also look at the potential for developing protocols for determining those clients who might be referred to AA, those clients that might be treated with more counseling-based models, and those particular clients that might benefit most from some combination of the two approaches. Additionally, these findings may suggest a possibility for identifying areas related to additional training for alcohol-related training courses.

Questions:

The first set of questions are intended for ascertaining those factors counselors consider as they make decisions about interventions to use in substance abuse treatment.

- 1) What are your thoughts about why people engage in substance use and why some people become addicted? What are your thoughts about substance abuse and addiction, especially alcoholism, being labeled a disease?**

- 2) How do you assess and diagnose substance abuse problems? What are the common factors and problems associated with substance abuse?**

- 3) What is your understanding about the dynamics of denial, tolerance, loss of control and medical consequences associated with different drugs of abuse?**

- 4) How do you assess and treat individuals with a primary diagnosis of substance abuse who have additional psychological disorders?**

The second set of questions is intended to highlight the counseling-based interventions that appear to be most effective with counselors' clients who present with substance abuse issues.

- 5) Do you feel the term "hitting bottom" plays a significant role in treating substance abuse problems?**
- 6) What aspects of an individual's life do you integrate into a substance abuse treatment program?**
- 7) Is your treatment program grounded in a theoretical base? How does the theoretical base of your program influence the treatment of the clients?**
- 8) Do you have a particular treatment approach or approaches you use to treat clients? How effective do you believe individual therapy is in treating clients with substance abuse issues? How effective is group therapy in substance abuse treatment? What are your thoughts about family therapy in substance abuse treatment? What counselor characteristics do you believe to be important in substance abuse therapy? Do you choose treatment approaches that take into account the gender and cultural differences of clients who present with substance abuse problems?**
- 9) What are your thoughts about the effectiveness of counseling-based interventions in the treatment of substance abuse? In your experience, what type of client benefits from counseling-based strategies?**

The third set of questions considers the counselors' views regarding the use of the 12-step (AA) model of recovery in the treatment of substance abuse problems.

- 10) What common factors do you find to be present in clients who relapse?**
- 11) What is your definition of relapse? In your experience, how common is relapse in the recovery process? Do you believe relapse to be a common treatment outcome?**
- 12) With respect to the people who join AA (gender and minority status/culture) and remain members, how representative are they of the overall substance-abusing population?**
- 13) How does AA fit into your practice? What are your views about AA as a component of recovery? Have you observed any differences between clients who adopt the AA philosophy from those who do not? Have you ever referred an individual to AA in lieu of counseling-based treatment? If not, would you? What is your view of a stand-alone counseling method for treating individuals with substance abuse issues?**
- 14) What are your thoughts about the criticisms of the AA program leveled by women's groups and minority groups who feel disenfranchised by AA?**

The fourth set of questions are intended to highlight counselors' views of the need for research in substance abuse counseling in determining "what works" under which circumstances with substance abuse clients?

- 15) As a practitioner, what do you need from researchers to help you do you work more effectively?**
- 16) What are your thoughts about suggestions from researchers in the field that AA meetings need to be more closely examined?**
- 17) What are your thoughts concerning the need for research related to gender-specific and culture-specific treatment programs in studying best methods of treatment sensitive to gender and cultural differences?**

(Thank individual for participating in this interview. Assure him or her of confidentiality of responses and potential future interviews)