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**SUBSTANCE ABUSE TREATMENT: SUBSTANCE ABUSE  
COUNSELORS' BELIEF SYSTEMS AND HOW  
THESE BELIEFS IMPACT TREATMENT**

by

**Ann Crabb**

**A Dissertation  
Submitted to the  
Faculty of The Graduate College  
in partial fulfillment of the  
requirements for the  
Degree of Doctor of Philosophy  
Department of Counselor Education  
and Counseling Psychology**

**Western Michigan University  
Kalamazoo, Michigan  
August 2002**

**SUBSTANCE ABUSE TREATMENT: SUBSTANCE ABUSE  
COUNSELORS' BELIEF SYSTEMS AND HOW  
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**Ann Crabb, Ph.D.**

**Western Michigan University, 2002**

**The treatment of substance abuse is an anomaly within the mental health field. Historically, the treatment of addicted people has relied more on the personal experiences of those who have recovered than empirical findings (Shaffer, 1987). The founding of Alcoholics Anonymous sparked the creation of a belief system regarding substance abuse and recovery that, despite contradictory research findings, remains strong today (McElrath, 1997).**

**This study was conducted to explore the belief systems of both recovering and nonrecovering substance abuse counselors today to determine what their beliefs are, how these beliefs were formed, and whether their belief system has changed over time. Eight master's level therapists with over 5 years experience were selected from a variety of agency settings. Four of the therapists were in recovery, and 4 were not. These therapists participated in semistructured interviews regarding their belief systems and how they view substance abuse treatment. The interview process included treatment planning based upon a written scenario to determine the treatment philosophy and methods of the individual therapists.**

Results indicated that the substance abuse counselors' belief systems form a continuum from traditional beliefs to nontraditional beliefs. This continuum ranged from counselors who maintain the belief that 12-step programs are the single most effective means of recovering from substance abuse to counselors who believe there are many effective methods and programs and tend to individualize their treatment planning. Recovering counselors were as amenable to changing their belief system as nonrecovering counselors. While beliefs regarding the etiology and treatment of substance abuse are changing, the belief that alcoholics or addicts cannot stop using on their own or learn to moderate their drinking remains strong.

Counselors begin to change their beliefs following an activating event that produces doubt in the traditional belief system. Once this doubt begins, peer influence was found to be an influence in the continuing change of beliefs. Individuals who work without significant peer influence retain the most traditional beliefs.

Recommendations for practice and research were made.

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## CHAPTER I

### INTRODUCTION

#### Overview of the Problem

The treatment of substance abuse is an anomaly within the mental health field. Historically, the treatment of addicted people has relied more on faith than science, more on personal experience than empirical findings (Shaffer, 1987). In his article "The Epistemology of 'Addictive Disease,'" Shaffer identified a strong pull in the field towards the conformity of beliefs and treatments and identified that breaking away from these traditional ideas regarding addiction and recovery constituted denial (Shaffer, 1987). This bias against research is compounded by the fact that, until recently, most substance abuse counselors were in recovery themselves and may not have been trained in research methodology (Chiauzzi & Liljegren, 1993).

The formation of the self-help group Alcoholics Anonymous (AA) sparked the creation of a belief system regarding substance abuse and recovery. This belief system continues to have a strong hold 60 years later despite contradictory research findings. This belief system was formed from the experiences of its members, their individual and collective attempts to recover from substance abuse problems, and the sharing of this experience with other alcohol dependent individuals. It was out of this belief system that the first substance abuse treatment centers were designed,



utilizing treatment methods that closely adhered to the philosophies of AA (McElrath, 1997).

Countering this traditional belief system that drives substance abuse treatment is tantamount to discussing taboo topics in public. These beliefs are held as sacred despite the existence of empirical data that does not support the belief (Chiauszi & Liljegren, 1993). Currently not only are some of the underlying beliefs being challenged, but the basic belief of alcoholism as a disease is being questioned and researched (Fingarett, 1985; Peele, 1988).

Recently the addictions treatment field has come under fire for providing cookie cutter treatment, that is, approaches to treatment that vary little from person to person and are based predominantly on the Minnesota Model (Collins, 1995; Stude, 1990). This treatment method, modeled after the AA philosophies, is not empirically supported to be effective (Hunt, Barnett, & Branch, 1971; Miller & Hester, 1980; Wallace, 1989). The Minnesota Model is still widely used in treatment centers, including the Hazelden Foundation.

According to Collins (1995), the managed care industry is forcing the field of substance abuse into change. Financial gatekeepers are imposing not just a cost-contained form of treatment, but are challenging the beliefs upon which the Minnesota Model treatment was constructed. These challenges are taking place both philosophically and empirically and provide the rationale for the drive for lower cost care. Third party payers are insisting treatment centers provide care that is based on research rather than folklore. With this emphasis comes a movement away from

paraprofessionals acting as treatment providers to requirements that treatment providers be licensed, trained professionals.

The status of substance abuse treatment today is a mix of the old and the new. Treatment providers are now increasingly trained professionals with knowledge of current research; however, they continue to work in an industry that retains the treatment ideals born from the AA movement and based upon the belief system it promulgated (Collins, 1995).

### Historical Perspective

The treatment of alcohol and drug abuse in America has historical roots not in research, in contrast to most mental health treatment, but instead developed from the foundations of AA. Two men who came together with a common problem, alcoholism, founded Alcoholics Anonymous in 1935. These two men developed a 12-step program based upon the principles of a religious group known as the Oxford Group. This 12-step program was used as a base for the development of a treatment method which became known as the Minnesota Model (Ragge, 1998).

According to Peele (1988), AA promulgated the view of alcoholism as a disease, an initial core belief that the alcoholic community embraced. From this core belief the following beliefs have been successfully incorporated into the American psyche:

1. Alcoholics don't drink too much because they intend to, but only because they can't control their drinking.
2. Alcoholics inherit their alcoholism and thus are born as alcoholics.

3. Alcoholism always grows worse without treatment, so that alcoholics can never cut back or quit drinking on their own.
4. Alcoholism as a disease can strike any individual—it is an equal-opportunity destroyer.
5. Treatment based on AA principles is the only effective treatment for alcoholism.
6. Those who reject the AA approach for their drinking problems are practicing a special denial that means death for the alcoholic. (Peele, 1988, p. 55)

These beliefs existed before any research had been conducted to verify them; they represent folk wisdom. These beliefs have come to be accepted by most Americans. According to a 1987 Gallup poll, 87% of Americans endorse the idea that alcoholism is a disease (Peele, 1988, p. 56).

The belief system, which was propagated by AA, is being challenged. In current literature, scientists in the field of substance abuse are questioning the efficacy of the Minnesota Model of treatment, the efficacy of AA, and the need for total abstinence as a treatment goal, and are raising doubts as to whether alcoholism is really a disease.

These challenges are being met with resistance. Any questioning of the group methods or beliefs can lead to group members confronting the questioner with accusations of being in denial and headed down the road to self-destruction. The 12th step in AA is to carry the message to those who still suffer, a powerful incentive to remain in the fold. The power of this group and its message can best be summed up in the words of John Wallace, the clinical director of the Edgehill Newport Hospital:

With regard to the controlled drinking issue, I feel that the alcoholism field has too long suffered these outrageous attacks by certain members of the

“Anti-Traditionalist” crowd. In the interests of our patients and their families, and in the interests of alcoholics who still suffer, we must begin to scrutinize more closely the activities of this group and to take steps to ensure they do no harm. (Peele, 1991, p. 39)

What are these scientific challenges to the traditional belief system?

Although there are a multitude of debates on going in the field of substance abuse, four issues appear to be highly controversial. These debates include questioning the effectiveness of the Minnesota Model as well as AA self help groups, debates regarding whether or not moderated drinking is an acceptable treatment goal, and the uncertainty of whether or not alcoholism and addiction are diseases.

### The Minnesota Model

The Minnesota Model continues to be the most popular treatment program in existence today despite empirical studies that show success rates below 50% (Hunt et al., 1971; Miller & Hester, 1980; Wallace, 1989). While studies have indicated that the Minnesota Model is not an effective treatment, research has been conducted on other treatment methods that have been found to be effective. These methods include aversion therapies (Rimmele, Miller, & Dougher, 1989), behavioral self-control training (Miller & Baca, 1983), the community reinforcement approach (Sisson & Azrin, 1989), marital and family therapy (McCrary, 1989; O’Farrell & Cowles, 1989), and social skills training (Monti, Abrams, Binkof, & Zwick, 1986). In spite of the demonstrated effectiveness of these treatment modalities, few of these treatment methods are being incorporated into treatment planning in treatment centers today. Many alcoholism treatment programs have not changed much for

more than 2 decades, and the personnel associated with them are reluctant to embrace a scientific approach to change and progress (Lang & Kidorf, 1990). These treatment programs and practitioners have been criticized for ignoring the individual characteristics and needs of the patients (Hansen & Emrick, 1983; Long & Kidorf, 1990).

### Efficacy of AA

AA attendance has been a mainstay of substance abuse treatment from its inception. AA is a program of recovery involving a twelve-step approach. A part of this program of recovery includes attendance at AA meetings. The need for attendance at these self-help meetings in order to recover has reached beyond the treatment centers into the American psyche. The belief in the efficacy of AA as a recovery tool remains powerful, not only within the treatment community but in the mainstream populace as well. Individuals are often given no choice as to whether they would like to participate in AA; it is deemed a part of their treatment and refusal to participate is seen as denial (Ragge, 1998).

The possibility of harm coming to some clients as a result of being given no choice but participation in AA has been raised (Ellis, 1992; Peele, 1988; Trimpey, 1989). While some individuals flourish in AA, others do not. Trimpey (1989) suggested that many persons do not succeed in AA because of (a) an inability or reluctance to work in group environments, (b) preference for rational methods of problem solving over belief-centered or spiritually-oriented solutions, or (c)

resistance to religious elements which persons may perceive as being an integral part of the AA program (Trimpey, 1989). Galaif and Sussman (1995) reviewed the literature on efficacy of AA and found that persons who report benefiting from AA tend to be middle class males who are less well educated and older than nonmembers. Conversely, their review indicated that persons not likely to be helped by AA tend to be members of minority cultures such as women, nonwhites, and persons with lower socioeconomic status. They tend to not be religiously oriented or do not fit into AA's definition of alcoholism. Persons with dual diagnosis issues, such as substance dependence with a co-existing mental illness, are also not likely to be comfortable with the group format (Galaif & Sussman, 1995).

Although AA attendance is widely recommended by treatment centers in the United States, AA is an intervention whose efficacy has been inadequately assessed (Koch & Ruben, 1997). In a review of alcohol treatment outcome studies completed since the early 1970s, Miller et al. (1995) found that there have been only two experimental studies in which the efficacy of AA as a treatment alternative has been explored. The conclusions reached by both studies indicated that no significant benefits were gained from attendance at meetings.

### Moderated Drinking

According to Miller (1983), moderated drinking, as a treatment goal is not a recent controversy. Research on the use of controlled drinking as a treatment outcome began to be published as early as the 1940s and 1950s and was not

considered controversial at the time. As more studies began to be published, the substance abuse treatment field reacted emphatically to the conclusion that problem drinkers could successfully employ moderated drinking. The circular and unscientific argument was invoked that anyone who drank moderately could not have been a “true” alcoholic, although the patients studied had been diagnosed as addicts and the follow-up was one of the longest on record. Miller reached the following conclusions as a result of his research:

1. Controlled drinking treatment methods produce overall success rates at least comparable to those for abstinence approaches at follow-up as long as 1–3 years.
2. Even when the goal of treatment is abstinence, between 5 and 20% of patients establish a pattern of nonproblem drinking over the years following treatment.
3. When specific training in moderation is provided, about 65% of patients maintain successful outcomes at 1 year follow-up, on the average.
4. Controlled drinking methods are in general no more (or less) likely than abstinence approaches to end in relapse or to bring about improvement in other life problem areas.
5. Controlled drinking methods are most likely to be effective with younger, less dependent problem drinkers and least likely to be effective with older, more advanced patients with symptoms of alcohol addiction.

Despite the results of this research, there is an indication that moderate drinking is not an accepted treatment goal in the United States.

In a 1994 survey, Rosenberg and Davis assessed the acceptance of moderate drinking as an outcome goal by alcohol treatment services in the United States. Of the 196 returned surveys, three quarters of respondents reported that nonabstinence was not an acceptable outcome goal for patients at their treatment program; however, 17% of this same group endorsed the statement that nonabstinence was acceptable for patients in other alcohol programs or for their own patients after discharge. This would appear to indicate that treatment programs are more reluctant to embrace change based on research than the independent counselors who work there are, but also that moderated drinking is still largely considered unacceptable by the majority of substance abuse counselors.

### Disease Concept

The very foundation of the belief system, the disease concept, is also under scrutiny by researchers. First promoted by AA in 1935, the disease concept has become traditional in the field of alcoholism (Sobell & Sobell, 1978).

The disease concept and the Minnesota Model have been criticized as reductionistic and reluctant to embrace a scientific approach to change and progress (Fingarrett, 1985; Miller, 1983). According to Caetano (1992), the focus on spiritual development takes recovery outside the range of empirical analysis, leaving the researcher with subjective reports of epiphenomenon. There are growing



numbers of researchers in the field who suggest alcoholism may be a syndrome rather than a disease. Advocates of the syndrome concept argue that problems with alcohol are not necessarily chronic, progressive, or irreversible. Their research demonstrates that there are degrees of alcohol dependence, and that loss of control over alcohol intake is better conceptualized as impaired to varying degrees rather than invariably lost completely. Further, alcohol dependence and the presentation of alcohol problems is highly influenced by social and cultural factors. In treatment, it is necessary to take a broad view that addresses social and cultural influences and gears therapeutic efforts to the level of alcohol severity (Caetano, 1992).

#### Purpose of the Study

It is the purpose of the present qualitative research study to examine the belief systems of substance abuse counselors and to consider how these beliefs were formed, how they impact treatment planning, and the extent to which substance abuse professionals are willing to change their beliefs when challenged by scientific research. This study will provide a framework for understanding the substance abuse counselor's response to research findings that challenge a traditional belief system that has been predominant for over 60 years. This study will also seek to determine if there are differences between recovering and nonrecovering counselors in the forming of their beliefs regarding treatment, whether or not recovering counselors maintain more traditional beliefs, and whether or not they are more resistant to change than their nonrecovering peers.

**It is the intent of this study to answer the following research questions:**

**1. How do substance abuse counselors form their beliefs regarding substance abuse and substance abuse treatment? Who and what influenced substance abuse counselors' view of etiology and treatment of substance abuse?**

**2. Have substance abuse counselors changed their beliefs regarding etiology and substance abuse treatment over time?**

**3. What are substance abuse counselors' current views on substance abuse and treatment?**

**4. If the belief system has changed over time, what influenced this change?**

**5. If the belief system has not changed over time, how do counselors process contradictory research or challenges by the managed care system into their belief system?**

**6. Are the belief systems of recovering and nonrecovering substance abuse counselors different? Does one group hold more traditional beliefs than the other?**

**7. Are belief systems different based upon the level of care that the substance abuse counselor is providing (inpatient vs. outpatient)?**

**The field of substance abuse treatment can be enhanced with additional information regarding the process by which substance abuse counselors form, maintain, or change their beliefs regarding what constitutes alcohol and drug addiction and how best to provide treatment. An exploration of this belief system can also help to determine if, and to what extent, there is a flow of information from researchers to practitioners regarding effective treatment ideas and information and**

whether this information is being incorporated into present substance abuse treatment practice. The information gathered in this study may be of benefit to treatment centers in terms of facilitating discussion regarding their own treatment philosophies and methods. It may be useful to those centers that wish to open up training programs to integrate new methods, ideas, and information which is being generated from academia or research facilities.

### Definition of Terms

This section will review some common terms used frequently throughout this dissertation. The terms *recovering* and *non-recovering* are commonly used in the substance abuse treatment field. For purposes of this study, the term *recovering counselor* refers to an individual who has experienced substance abuse problems in the past and has participated in a substance abuse treatment programs as a client. The term *nonrecovering counselor* refers to an individual who has never received treatment for a substance abuse problem.

*Denial* is a clinical term widely used in substance abuse treatment that refers to “a disregard for a disturbing reality” (Kaplan & Sadock, 1996, p. 20). Denial is a form of self-protection through self-deception to help an individual avoid anxiety and emotional distress (Shader, 1994). This is accomplished by selective perception of the past and present so that painful elements of reality are not recognized or accepted (Perry & Cooper 1989).

The terms *alcoholism*, *alcohol dependence*, and *alcohol abuse* are frequently used interchangeably. *Alcoholism* is a colloquial term that refers to alcohol dependence. The terms *alcohol dependence* and *alcohol abuse* are clinical terms defined in the *Diagnostic and Statistical Manual of Mental Disorders-IV* (1994). *Alcohol dependence* is defined as a “maladaptive pattern of substance use, leading to clinically significant impairment or distress” (American Psychiatric Association, 1994, p. 181). *Alcohol abuse* is defined as a “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (American Psychiatric Association, 1994, p. 182).

Throughout this dissertation there is frequent reference to traditional belief systems and practices as compared to nontraditional belief systems and practices. A counselor who has a traditional belief system and practices in a traditional way maintains a belief in the concept of alcoholism as a disease and in the efficacy of treatment through the principles of Alcoholics Anonymous or a 12-step program. A counselor who has a nontraditional orientation may not retain a belief in the disease concept or may question the concept. The counselors with nontraditional practices may use some of the principles of AA in treatment, but they also include a variety of other groups and treatment methods.

### Organization of the Dissertation

In the next chapter, this dissertation will first explore belief systems and the processes of forming group beliefs and maintaining these beliefs, and the challenge

and change of beliefs from a social psychology perspective. This information will provide a theoretical background for the next section that will examine the development of the belief system that became the basis of AA, the traditional treatment model of substance abuse. The final section will review empirical studies that have been conducted to determine whether substance abuse counselors are accepting new ideas and methodologies regarding substance abuse treatment and whether this new information is bringing about change in the methods used in the treatment of substance abuse.

Chapter III contains information regarding the methodology used in conducting this study. The first sections describe the selection of participants, the inclusion criteria and the interview process used to gather data. Following this is a section that describes the data processing and analysis and includes a description of the validity of the analysis.

Chapter IV contains the findings of this study. These findings are presented in narrative form. Following the narratives is a description of the themes that emerged from the data collected. The final section of Chapter IV presents the research questions and answers to each of the questions.

The final chapter of this dissertation is devoted to discussion and conclusions based upon the findings in this study.

## CHAPTER II

### LITERATURE REVIEW

This chapter will provide a theoretical background on belief systems from a social psychology perspective. Following this overview, it will explore more in depth the formation of AA, the belief system that was created from this group, and how these beliefs have influenced treatment standards today. The final section will review current findings from research conducted on the belief systems of substance abuse treatment providers today to determine if the treatment beliefs are changing due to the challenges being presented by scientific research.

#### Ideologies and Beliefs

##### Formation of Beliefs

The *Oxford American Dictionary* defines ideology as “The principle ideas or beliefs that characterize a particular class, group, or movement” (Ehrlich, Flexner, Carruth, & Hawkins, 1980, p. 435). Ideologies are culturally derived beliefs or meanings that are commonly shared and communicated within a culture, society, or group (Bar-Tal, 2000).

Personal ideology is a unique philosophical view which helps the individual determine what to lift from the background and make foreground, what to judge valuable and what to judge worthless, what to strive for and what to avoid, and

what to do and what not to do. Personal ideology is largely socially constructed, derived, and maintained through interpersonal transactions (Berger, 1969; Berger & Luckmann, 1966; St. Aubin, 1999).

Beliefs are defined as propositions that express thoughts. Beliefs are basic units of knowledge that reflect such broad categories as ideology, values, norms, decisions, inferences, goals, religious dogmas, or justifications (Bar-Tal, 2000). Beliefs can be differentiated into two groups, personal beliefs and common beliefs. Personal beliefs are formed by individuals and become a part of their private repertoire, not shared with other people. In contrast, a few individuals, small groups, or all the members of a society can share common beliefs. These beliefs are widely held and shared through interpersonal communication (Bar-Tal, 2000).

Groups of people come together through shared common beliefs and a clear sense of common identity. Individuals who belong to groups experience solidarity and a sense of unity. They establish, in essence, a common social identity (Giddens, 1984). According to Hofstede (1980) groups are characterized by three components: a perception of interdependence with others, a belief that group goals are either synonymous with an individual's personal goals or should supersede personal goals where the two are in conflict, and a strong sense of in-groups and out-groups.

Group beliefs are viewed as socially constructed by the members of the group. These beliefs are formed through social processes in social situations in which sociocultural meanings are established (Berger & Luckmann, 1966; Burr,

1995; Gergen, 1994). These processes range from negotiation to unchallenged acceptance. The negotiation process indicates that group members come to accept the common belief on which they agree. An unchallenged acceptance occurs when the belief comes from an external source that is perceived as a knowledge authority (Gergen, 1985; Resnick, 1991). Once the belief system is formed, group members communicate the shared beliefs both within the group and outside of the group (Bar-Tal, 2000).

The sharing of group beliefs becomes a part of self-identity for individuals within a group. By defining themselves as a group member, individuals adopt the beliefs of the group as part of their social identity. Sharing beliefs provides individual group members with validated information about how they interpret their reality. Group members typically transform their beliefs so they are governed by in-group conformity and not by their distinct biographical experiences. The sharing of beliefs also implies a shared expectation of agreement between in-group members. When there is disagreement within the group about beliefs that are supposed to be consensual, group members will begin to exert social influence through persuasion and negotiation to try to re-establish consensus (Bar-Tal, 2000).

Individuals feel more confident of knowledge that they know is shared by other group members. Awareness of a shared belief system validates an individual's belief content and increases the sense of knowing. Festinger (1950) referred to this process as consensual validation. The feeling that the majority of group members share beliefs leads to a sense of rightness and a will to impart them to all the group



members. A consensual group creates pressure on group members to join the consensus.

A study conducted by Hall, Varca, and Fisher (1986) found that when individuals discover that they share the same beliefs as their group members, they tend to move closer to the opinions of their group. This interplay between group conformity and the conviction with which an individual will maintain the belief was the subject of two recent studies by Bar-Tal, Raviv, Rosen, and Bruker (1999). The results of both studies showed that when respondents become aware that the majority of their group members shared their beliefs, they reported more confidence in the beliefs and reported a greater self-satisfaction as well as sense of similarity with group members. They also reported feeling a greater identification with the group and felt the group had a high level of cohesiveness.

To be accepted as a group belief the belief must meet certain conditions. First, to be acquired by group members, the belief has to be comprehended by them (Sniderman, 1975). Comprehension means the group's members can relate the belief to their stored knowledge (Winograd, 1972). Second, the content of the belief has to be perceived as valid. Group members have to attribute a high level of confidence in the belief, perceiving it as verities. This is a necessary condition because group beliefs define the reality of the group members, and this reality has to be firm and certain. Individual members rely on group beliefs to help form their judgments and decision. Reduced confidence in group beliefs may shatter an individual's sense of reality (Bar-Tal, 2000). The last condition for a belief to become a common belief is

the group member's perceived relevance of the belief to the group by group members (Sperber, 1996). Research has shown that individuals pay special attention to relevant beliefs, acquire them, and store them more easily than irrelevant ones (Wyer & Srull, 1980, 1986).

Once the group belief system is established, it is maintained by socialization among group members. The belief system is communicated and debated both in-group and out-group. New members of the group are indoctrinated into the belief system and brought into consensus (Bar-Tal, 2000). Group members may resist joining the consensus due to a change of their personal belief system or ideology. Those individuals can choose to remain in the group and risk internal inconsistency or they may decide to leave the group. This is seen more clearly in the context of religious practices. Spilka, Hood, and Gorsuch (1985) identified that belongingness in a religious group or possessing certain religious beliefs is largely determined by the belief system of the family in which the individual was raised. A person born of Protestant parents and raised with Protestant beliefs will typically retain these beliefs as an adult. Those individuals who question their belief system or religious affiliation may seek out, or be converted, into a new religious belief system or group that they believe will more closely reflect their personal ideologies. Religious conversion or denomination switching can encompass an entire range of psychological changes for the individual.

Starbuck (1914) suggested that there are two types of conversion experiences, suddenly or gradual, and that the two types suggest different

psychological processes. Sudden conversions are characterized by a passiveness on the part of the converts; they feel as though they are in the grip of forces beyond themselves. This feeling often presents itself at a moment of crisis in the individual's life and they soon surrender to the force. Sudden conversions are often characterized by intense feelings of unworthiness, sin, and guilt. Gradual conversions are characterized by an active search for meaning and purpose. There is an absence of emotional crisis or feelings of guilt and sin, and, rather than a sudden moment of surrender and acceptance, there is a continual progression into a deeper faith that they have cognitively assented to accept. Whether the conversion process is gradual or sudden, individuals experience a questioning of their beliefs and a change in their belief system in regards to their philosophy of religiosity. This change is the end result of a conflict in personal ideology.

Although the group maintains itself through internal consistency with the group beliefs, these beliefs can be challenged both inside the group and from forces outside of the group. This paper will now explore the challenging and changing of group beliefs.

### Challenge and Change of Belief Systems

According to Baumeister (1991), people sustain their beliefs by ignoring contradictory information and implications. When something confirms what they want to believe, they note it, think it through, and file it away in their memories right beside everything else. When something disconfirms what they want to believe, they

deconstruct it. They don't think its implications through. They keep it isolated rather than connecting it up with other relevant information, or they find some way of explaining it away so that their preferred belief is not threatened. The conflicting information is kept free from meaningful associations.

Ignoring conflicting information would seem to be a simplistic solution to a complex problem, that of what happens to belief systems when challenged. Groups and societies are continually challenging both their own beliefs, as well as the beliefs of others. The challenging of belief systems between different groups can be seen in one of the most notable challenges going today: the conflicting beliefs of theologians and scientists. Beginning with the church's conflict with Galileo regarding the adoption of the heliocentric view, these two groups have been debating each other's belief system, and attempting to find consensus, since the 1500s (Drees, 1996).

What happens to individual and group belief systems when they are challenged and what makes some individuals, groups, or belief systems more resistant to change? McGuire (1999) has extensively studied individual and group beliefs and the resistance to challenge when the beliefs are attacked by outside persuasion. He identified four areas that were related to the ability of a group or individual to resist changing beliefs: (1) commitment, (2) anchoring, (3) resistant cognitive states, and (4) resistance training.

The process of commitment involves individuals taking increasingly hard-to-revoke steps that would ultimately make it dangerous, costly, or embarrassing to them to recant the belief. The greater the level of commitment, the less likely the

individual is to change the belief. The least level of commitment to a belief is making a private decision to hold the belief as truth. The next level of commitment involves the individual becoming publicly identified with the belief so that he or she will be more resistant if challenged. The third level of commitment is actively participating on the basis of one's belief, such as writing an essay in support of it. The final level of commitment involves external commitment (McGuire, 1999). An external commitment has been identified as the process of telling an individual that someone else thinks he or she holds a specific belief. This makes the person more resistant to challenge by a self-labeling process (Rosenbaum & Franc, 1960; Rosenbaum & Zimmerman, 1959).

Anchoring a belief makes it more resistant to change. Anchoring a belief links it to other beliefs in such a way that, for the belief to be recanted, the individual would be required to change other beliefs or cognitions or endure internal inconsistency. Linking a belief to an individual's already accepted values, other valued beliefs, or to valued groups greatly reduces the chances that the individual will change the belief (McGuire, 1999).

Certain emotional arousal states or resistance states can induce resistance to new beliefs. These resistant states have been identified as anxiety, aggression, self-esteem, and ideological preconditioning (McGuire, 1999). Nunnally and Bobren (1959) found that people are less willing to receive further information on a topic after reading an anxiety-arousing message on it. It has also been identified that

chronic hostility may be associated with resistance to persuasion; however, this variable requires further study (Janis & Field, 1959; Linton, 1955).

McGuire (1999) identified several variables that he refers to as resistance training. These variables include general education, avoidance and distortion, and training in critical skills. It has been proposed that the more education an individual has acquired, the greater the resistance to persuasion; however, the empirical research findings are ambiguous (Weitzenhoffer, 1953). Avoidance and distortion have proven to be effective, although unhealthy, means of resistance to challenge. Avoidance and distortion involves the perceptual distortion of belief-discrepant information in a way that makes it no longer challenging (Cantril, 1957; Cooper & Dinerman, 1951; Kelley, 1957). Lastly, individuals who are resistant to change are likely to have critical skills in terms of their ability to recognize persuasive attempts and to detect flaws in the attacking arguments (Allport & Lepkin, 1945; Biddle, 1932; Collier, 1944; Citron & Harding, 1950).

Effectively challenging group beliefs can be even more difficult than persuading change in an individual. A shared belief raises its validity in the eyes of the group member; therefore, these beliefs, held as valid, are not easily changed (Kruglanski, 1989). Greenberg (1963) found that beliefs that are widely shared within the person's social milieu are highly resistant to persuasion.

Although group beliefs are durable, they are not stable and may change with time. Their content may be modified, or even disappear. Group beliefs will remain in the repertoire as long as they at least fulfill their epistemic and identity functions for

the group members. As long as group members believe the belief illuminates the group in a valid way and characterize it, the beliefs maintain their status, especially if they also satisfy other needs of the group members. When the belief ceases to fulfill these needs, group members stop considering them valid and eventually change them (Bar-Tal, 2000). Group beliefs change through a process of negotiation in which group members, group leaders, the intellectual community, media, and out of group members take part. The challenge of group beliefs takes place in public debate and may go on for years until a new group belief evolves (Bar-Tal, 2000).

The changing of group beliefs depends on various factors including the availability of information, the type of pressure to conform, and the availability of communication channels among the group members. A free flow of information, low pressure to conform, and a wide availability of communication channels facilitate belief change within the group. Depending on the nature of the group and the degree of challenge, this process of change can be accompanied by vivid public debate, disagreement, and conflict (Bar-Tal, 2000). If the conflict is serious enough, these debates can lead to violence, especially in the case of religious orders with strict conformity requirements and a rigid belief system. If exclusive groups or societies consider their belief as essential, and view the societal beliefs of the other groups as threatening to their basic values and denying their existential needs, they may resort to violence to impose their group belief on the whole of society (Bar-Tal, 2000).

In summary, belief systems can bring together groups of people who share common beliefs and a sense of common identity. The members of the group,

through a process of negotiation, socially construe group beliefs. By identifying with a group, individuals adopt the beliefs of the group members and use the beliefs of the group to provide validation for their view of reality. Being a member of a group also brings with it an expectation of conformity with the group beliefs. Group beliefs are resistant to change. The degree of resistance to change within groups is based upon the level of conformity, the free flow of information, and the ability of the group members to communicate with one another. Conflict can become part of resistance to change in groups if the group cohesion is high and the belief system is rigid.

The next section will further explore the formation of the belief system that became the basis of AA and the Minnesota Model of treatment which has become the standard form of treatment today.

## Historical Review

### The Formation of AA and the Minnesota Model

According to Ragge (1998) the treatment of alcohol and drug abuse in America has historical roots not in research, as with most mental health treatment, but developed from the foundations of AA. Prior to the forming of AA, few professionals were willing to work with identified alcoholics since, at that time, alcoholism was considered a moral issue rather than a medical issue requiring the intervention of medical personnel. In 1935 two problem drinkers, Bill Wilson and



Bob Smith, decided to work together to solve their mutual problem, alcoholism. From this encounter AA was formed.

The 12 steps of AA were based on the philosophies of a group known as the Oxford Group in which Bill Wilson became involved prior to the forming of AA. The Oxford Group was a religious conversion group that believed the secret of sanity was through God control. In the words of one of the leaders of the Oxford Group, "The only sane people in an insane world are those controlled by God. God-controlled personalities make God-controlled nationalities. This is the aim of the Oxford Group" (Ragge, 1998, p. 3).

The Oxford Group converted members in a systematic fashion known as the five Cs: confidence, confession, conviction, conversion, and continuance. In the first step, group members would find nonmembers and gain their confidence through friendship and by confessing their own shortcomings and revealing how the group had helped them overcome these shortcomings. The second step was to get the nonmembers to confess their sins and seek help through the group's guidance. Once the new members had converted to God control and group control, they became a part of continuance, or seeking out others to convert. An essential part of the Oxford Group was guidance through senior members and the need of all members to seek out the guidance of the group on all matters before committing to decisions (Ragge, 1998).

Bill Wilson wrote the 12-step program based upon this background. Steps 1 through 3 are referred to as surrender steps in which the individuals turn their "will

and life over to the care of God, as we understood him” (Alcoholics Anonymous, 1939, p. 59). Steps 4 through 9 involve a searching and fearless moral inventory as well as writing down lists of persons who have been harmed by the individuals in their addiction. Having made this inventory, they are to “admit to God, to ourselves, and another human being the exact nature of our wrongs” (Alcoholics Anonymous, 1939, p. 59) and become willing to make amends to those harmed. Steps 10 through 12 involve “remaining in constant contact with God and to carry this message to other alcoholics” (Alcoholics Anonymous, 1939, p. 59).

Alcoholics Anonymous continued to evolve, contributing to beliefs about alcoholism based on the alcoholic experience rather than empirical research. This ultimately led to treatment programs based upon this belief system that, in turn, evolved into the Minnesota Model (Ragge, 1998).

#### Development of the Minnesota Model

According to McElrath (1997), three institutions factored in the design of the Minnesota Model of treatment. The first institution was AA, which contributed three powerful beliefs which would become the core of the Minnesota Model of treatment: (1) alcoholism is a physical-mental-spiritual illness, (2) the 12-step program outlines the problem and solution, and (3) recovery takes place with one alcoholic talking to another over a cup of coffee.

The second institution that influenced the design of the Minnesota Model, was Hazelden, the first inpatient substance abuse treatment center in the United

States, founded in 1949 in Minnesota. Hazelden offered its patients an environment that promoted respect, understanding, and acceptance of the dignity of each patient. This treatment program was based essentially on the 12-step philosophy of AA and the belief that spending time away in association with other alcoholics was central to recovery. At Hazelden, patients were expected to be cooperative, attend lectures, and talk to one another about their experiences as a way to recover.

The third institution that contributed to the Minnesota Model was Willmar State Hospital in rural western Minnesota. Willmar, established in 1912, originally operated as a state facility that locked up inebriates and treated substance abusers in the same manner as mentally ill patients. Later, however, Willmar was successful in implementing a radical departure from the traditional psychiatric understanding of alcoholism. After an intensive study of substance-abusing clients, they separated them from the mentally ill patients and invited AA members from Hazelden to come in to talk to the patients. Willmar then prevailed upon the Minnesota legislature in 1954 to create paid positions called counselors on alcoholism, probably the first state in the country to create such positions (McElrath, 1997).

Willmar already had its physicians, nurses, psychiatrists, psychologists, social workers, recreation directors and chaplains. Now, in 1954, the hospital had non-degree counselors on alcoholism who were lay people—recovering alcoholics—sharing responsibility for a treatment program and having an equal say with the professional staff. It is difficult to imagine how radical a change this was, to go from a physician-oriented, psychoanalytic hospital to a treatment program conducted by drunks. (McElrath, 1997, p. 143)

The philosophies of these three institutions combined to produce the Minnesota Model of treatment that is still widely in use today. According to Sell (1995), the Minnesota Model has five distinctive components:

1. Alcoholism is seen as a primary, chronic, physical/genetically-predisposed disease with profound psychological and spiritual dimensions, dictating total abstinence as the goal of recovery.

2. The treatment team is multidisciplinary, involving chemical dependency counselors, medical professionals, psychologists, activities therapists, etc.

3. Many, if not all, of the chemical dependency counselors (who are the principal providers) are themselves recovering alcoholics actively involved in AA.

4. The therapeutic principles are based upon the first five “steps” of AA.

5. Inpatients are taken to local AA meetings several times a week, and the treatment staff strongly encourages, and assists, transitions to hometown AA involvement after discharge. It is expected that the recovering alcoholic will become a lifelong member of AA.

The establishment of the Minnesota Model demonstrates the use of popular belief in the development of substance abuse treatment. It was based on the experiences of the addicted persons who recovered using the AA program, but the scientist practitioners at the time, rather than conducting research into substance abuse, followed along the already established treatment program (Peele, 1988).

The following sections will explore studies that have been conducted regarding differences between recovering and nonrecovering counselors, the

acceptance of moderated drinking as a treatment goal, and the acceptance of the disease concept among substance abuse counselors.

### Contemporary Beliefs

#### Differences in Belief Systems of Substance Abuse Counselors

Studies conducted to determine if there are difference among substance abuse counselors based on recovery status or field of discipline indicate that while nonrecovering counselors were less committed to the disease model, both recovering and nonrecovering counselors are open to new ideas and methodologies (Sorenson, 1998). Another study indicated that, although there are differences between practitioners in various disciplinary fields in their view of alcoholism and substance abuse treatment, the view of alcoholism as a disease, the use of the 12 step model of treatment, and abstinence as a treatment goal continue to be widely believed (Hshieh & Srebalus, 1997). Several studies showed that, even though recovering counselors are more likely to believe in the disease model of alcoholism, this belief continues to be held among nonrecovering counselors as well (Crabb, 2000; Moyers & Miller, 1993; Shipko & Stout, 1992). In contrast, Stoeffelmayr, Mavis, Sherry, and Chiu (1999) found that being in recovery was associated with more varied treatment techniques and a broader range of treatment goals.

In 1998, Sorenson investigated whether or not there was a discrepancy between what is known scientifically about alcoholism treatment and what counselors in clinical settings practice. Sorenson examined how recovering and

nonrecovering addiction counselors' beliefs about alcoholism were affected by scientific information about alcoholism and training in Motivational Interviewing. Recovering and nonrecovering addiction counselor trainees were given a one-day workshop on various models of alcoholism, commonly held myths about alcoholism, and alternative alcoholism treatments. Training followed in the use of Motivational Interviewing, a nontraditional addiction counseling model. Sixty-five subjects were pre- and posttested using the Disease Model Subscale of The Understanding of Alcoholism Scale, the Disease Model Subscale of The Short Understanding of Substance Abuse Scale, and The Addiction Belief Scale that measures beliefs in the disease model approach. Participants also completed a variation of The Helpful Responses Questionnaire, a motivational interviewing quiz, and a research demographics form. The results indicated that prior to training, nonrecovering subjects were significantly less committed to the disease model concept than recovering subjects. Both recovering and nonrecovering subjects reported similar amounts of reduction in disease model commitment by the end of training. Sorensen's results suggest addiction counselors can be taught and are open to viewing alcoholism in nontraditional ways (Sorensen, 1998).

Hshieh and Srebalus (1997) examined the belief systems and treatment preferences of psychologists working in the substance abuse field and of addiction counselors to compare whether or not disciplinary field influenced their beliefs regarding treatment. The study surveyed 119 psychologists randomly selected from APA division 28 (Psychopharmacology and Substance Abuse) and 29

(Psychotherapy), as well as 110 addictions counselors affiliated with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). This study assessed the assumptions each group held about alcoholism and how it might be treated. Each participant completed a questionnaire that solicited demographic information, treatment philosophies and approaches, and information about collaboration with other treatment personnel and agencies. Issues of therapist personal recovery, multiple diagnoses, use of referrals, and combining psychotherapy with more specific addiction treatment were also examined.

The results from this study (Hsieh & Srebalus, 1997) indicated 98% of the addiction counselors and 66% of the psychologists agreed with the disease concept of alcoholism and that addiction counselors were more likely to ascribe to the 12-step treatment model. The majority of the addiction counselors supported abstinence as the treatment goal, while the psychologists tended to be more open to the possibility of controlled drinking. These preferences seemed to affect the clinical practice of the therapists, with addiction counselors tending to focus mostly on addictive behaviors and psychologists appearing to pay more attention to personal issues. Further, those practitioners who maintained a belief in the disease concept were more likely to prescribe abstinence as a treatment goal and were more likely to prefer a 12-step approach. The study showed that recovering practitioners were more likely to ascribe to the disease concept, 12-step model, and abstinence as a treatment goal. However, this study also found that even among practitioners who held a less traditional view about abstinence, the disease concept and 12-step model

were widely accepted. From this study it would appear that the field of discipline of the practitioner does account for some differences in treatment beliefs and approaches; however, the disease model and 12-step approach are still accepted by all groups.

Shipko and Stout (1992) conducted an examination of the personality characteristics of recovering counselors and nonrecovering counselors. Twenty-seven female and 18 male counselors were compared on characteristics of empathy, ability to be nonjudgmental, and flexibility, using the Sixteen Personality Factor Questionnaire (16PF) (Cattell, 1970). No significant differences were found between the recovering and nonrecovering counselors; there was homogeneity within both groups. However, this study noted that further research is needed to determine if the field of alcoholism is limited, both theoretically and philosophically. Research results indicated that 93% of the recovering counselors and 67% of the nonalcoholic counselors endorsed the disease model of alcoholism. This study does point out that recovering counselors may maintain stronger traditional beliefs than nonrecovering therapists.

Moyers and Miller (1993) also assessed the beliefs of substance abuse treatment providers regarding the nature and causes of alcoholism. Two reliable factors emerged, the first of which blended disease, moral, and characterological models (the disease model beliefs subscale); and the second of which emphasized psychosocial factors (the psychosocial beliefs subscale). Results indicated that high scorers on the disease model beliefs subscale were more likely to be in recovery



themselves and showed less flexibility in setting treatment goals for clients in an analog task.

Crabb (2000) conducted an unpublished qualitative study regarding differences in recovering and nonrecovering counselors in their belief systems and how these beliefs impacted treatment planning. Six counselors (three recovering and three nonrecovering) of equal educational background and years of experience participated in a semistructured telephone interview regarding their beliefs about commonly held concepts in the field of addictions treatment. These interviews were recorded, transcribed, and coded to elicit themes and comparisons between groups. The findings indicated that recovering counselors were more likely than their nonrecovering peers to retain beliefs regarding the effectiveness of a 12-step recovery group and the disease concept while rejecting moderated drinking as a treatment goal than their nonrecovering counterparts. The belief systems of both recovering and nonrecovering counselors impacted their treatment approaches and their view of the severity of the addiction. Recovering counselors relied on treatment planning based on a 12-step program, using abstinence as a treatment goal, and recommended inpatient treatment with a greater frequency. Nonrecovering counselors tended to recommend treatment based upon the preferences of the client, stated they would accept a moderated drinking goal and tended to recommend outpatient counseling. Recovering and nonrecovering counselors alike identified cue exposure as an effective means of treatment; however, none of them had incorporated this into their treatment planning despite knowledge of the technique.

Stoeffelmayer et al. (1999) conducted a study that appears to contradict the results from the previously cited studies. This study examined the influence of education and recovery status on substance abuse treatment counselors' approaches to patients. Three hundred forty-four drug abuse and alcoholism treatment counselors were questioned about treatment goals. A subgroup of 197 was also questioned about treatment practices. The influences of education and recovery status on the choice of treatment goals and treatment practices were examined through structural modeling procedures. Level of education influenced neither treatment goals nor techniques. Being in recovery, however, was associated with more varied treatment techniques and a broader range of treatment goals. The other variable related to treatment goals and practices was treatment modality. Working in residential programs was linked to a wider range of treatment goals and treatment practices.

The majority of these studies would indicate that recovering counselors are more likely to hold traditional beliefs regarding the disease concept and the belief in the effectiveness of a 12-step model of recovery. While recovering therapists are more likely to maintain these beliefs, nonrecovering counselors also show a high degree of consensus with these beliefs. Regardless of recovery status, both recovering and nonrecovering counselors are open to new ideas and methodologies when training is available.

### Acceptance of Moderated Drinking as a Treatment Goal

Studies have been conducted regarding the acceptance or nonacceptance of moderated drinking as a treatment goal. Wallace (1994) found that treatment professionals who are recovering counselors tend to adhere to the abstinence philosophy. Rosenberg and Davis (1994) found that moderated drinking is almost uniformly unacceptable as a treatment goal in residential alcohol service agencies. There is, however, some indication that outpatient programs are reporting that it is acceptable for at least a minority of their clients. Other studies investigating the staffing patterns of outpatient and residential settings found that males, recovering abusers, and nondegree counselors were most likely to be employed in residential and detoxification programs where outpatient counselors were likely to be women with advanced degrees and were least likely to be recovering (Hosie, West, & Mackey, 1989; Mulligan, McCarty, Potter, & Krakow, 1989) .

Wallace (1994), in her dissertation regarding the attitudes and beliefs of certified substance abuse counselors, surveyed the beliefs and attitudes of 394 counselors in Louisiana and Mississippi concerning abstinence versus moderation goals in the treatment of alcoholism and substance abuse. Members of the Mississippi Association of Alcohol and Drug Abuse Counselors and the Louisiana State Board of Certification for Substance Abuse Counselors were mailed a Likert-type survey to determine their attitudes and beliefs concerning substance abuse issues. Results indicated there were no differences between college educated and noncollege educated treatment professionals in their willingness to consider

moderation goals; however, treatment professionals who were recovering from substance abuse tended to adhere to the abstinence philosophy.

Rosenberg and Davis (1994) also conducted research regarding the acceptance of moderated drinking. This study focused on the treatment philosophies in treatment centers in the United States and their acceptance of moderated drinking as a treatment goal rather than focusing on individual practitioners. A questionnaire was mailed to 330 randomly selected alcohol treatment programs listed in one of two resource guides: (1) 305 of the approximately 9,600 alcohol and drug service programs listed in the National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs, and (2) 25 of the 152 Veterans Administration Medical Centers listed in the 1989 Directory of Psychology Staffing and Services. The sample analyzed in this study consisted of the 196 responding agencies of which 32% were free-standing, 28% were hospital-based, and 10% were part of a community mental health center. One third (31%) of the treatment centers did not complete this item or noted some other type of setting (i.e., military base, EAP) and were not part of the sample analyzed. Someone with administrative or clinical authority in the agency usually completed the survey, and presumably the responses were valid reflections of agency policy and practice. However, acceptance of controlled drinking probably varies across staff members and across program components within an agency.

Results indicated that 77% of the respondents checked "No" to the question asking if nonabstinence were ever an acceptable treatment goal for any of their

clientele; however, of these respondents, 17% endorsed the statement that nonabstinence was acceptable for patients in other alcohol programs or for their own patients after discharge. This would indicate that moderate drinking is almost uniformly unacceptable as a treatment goal in residential alcohol service agencies; however, almost one half of responding outpatient programs reported it acceptable for at least a minority of their clients. Respondents were given a list of five reasons for rejecting the nonabstinence goal: (1) belief in the disease model, (2) research evidence supports/does not support controlled drinking, (3) my own professional experience, (4) my own personal drinking experience, or (5) agency policy. They were asked to check all that applied and to them and to specify any other reasons for their decision to reject the nonabstinence goal. Since respondents were allowed more than one response, totals were greater than 100%. "Disease model" as the reason for rejection of controlled drinking was the basis given by 80% of respondents, followed by the reason of professional experience given by 79%, reasons of research evidence stated by 67%, agency policy by 45%, and personal drinking experiences by 3% of respondents.

Openness to negotiating or discussing outcome goals with clients appeared to be rare. With few exceptions, only that subset of outpatient programs for which nonabstinence was an acceptable goal was open to negotiating outcome goals with clients. Respondents in the other types of programs usually noted that their goal was abstinence, and they often explicitly noted that this was not open for discussion or negotiation with their clients. The disease model was a frequently cited basis for the

rejection of moderate drinking. Respondents commonly reported AA as a treatment intervention used by their service and as one of several (or the only) theoretical orientations guiding the work of their agency.

Rosenberg and Davis (1994) concluded that moderated drinking as a treatment goal is not accepted at residential settings. Their study, as well as studies conducted by Mulligan et al. (1989) and Hosie et al. (1989), investigated the utilization of recovering and nonrecovering therapists in treatment centers and the difference in philosophy between treatment modalities. All of the researchers came to the conclusion that more recovering substance abuse counselors work in residential settings rather than in outpatient settings. Whether recovering counselors are drawn to residential treatment because of the 12-step, abstinence philosophy or the residential settings maintain this philosophy due to the staffing has yet to be answered.

In 1989 a survey of 1,371 counselors (53% women) from 262 alcohol/drug abuse programs revealed that males, recovering abusers, and nondegree therapists were most likely to be employed in residential and detoxification programs. Outpatient counselors were likely to be women with advanced degrees and were least likely to be recovering. Respondents in outpatient settings tended to have graduate degrees and licenses; counselors in residential programs often relied on personal recovery experiences and became certified counselors. This study concluded that the movement toward more integrated treatment services for

substance abuse problems will be challenged more by differences between inpatient and outpatient settings than between counselors. (Mulligan et al., 1989)

In 1989, Hosie et al., surveyed the staffing patterns of 287 substance abuse centers. Responses to a questionnaire showed that persons with a master's degree in counseling or social work constituted the largest percentage of staff and that mental health counselors were first to fill program directors positions. Of the substance abuse centers surveyed, 83% reported they employed recovering abusers as paraprofessionals, comprising on the average 34% of the center's staff. It was noted that the employment rate of paraprofessionals might deter increases in the number of mental health counselors at the centers.

These studies would indicate that moderated drinking as a treatment goal is more accepted in outpatient settings than at inpatient treatment centers. There is some indication that more recovering counselors work at inpatient settings than in outpatient settings; however, whether the counselors are influencing the center's philosophy or are drawn to certain settings because it reflects their personal philosophy is unknown.

#### Acceptance of Disease Model

Studies which were undertaken to determine the level of acceptance of the disease concept came to the following conclusion: more recovering staff tend to work in programs where the goals and activities are consistent with a 12-step approach and based upon the disease concept. However, the relationship of being in

recovery and endorsing the disease model although positive, was not statistically significant (Humphreys, Noke, & Moos, 1996). One study indicated that the belief in the disease model appears to be culturally influenced (Ogborne, Wild, Braun, & Newton-Taylor, 1998).

Humphreys, Noke, and Moos (1996) undertook a study of recovering substance abuse staff members' philosophies regarding the disease concept of addiction. The sample consisted of all staff who had contact with patients ( $N = 382$ ) at 15 Veterans Administration inpatient substance abuse treatment programs of whom 329 agreed to participate. Out of the 329 participants, 47 (14.4%) identified themselves as having had significant problems with alcohol or other drugs in the past and as currently being in recovery from substance abuse. Many (78%) of the recovering staff reported regular attendance at meetings of AA, Narcotics Anonymous (NA) or Cocaine Anonymous (CA). Chi-square comparisons on categorical variables showed that recovering staff was not significantly different than nonrecovering staff on race or type of educational degree.

In terms of treatment philosophy, more recovering than nonrecovering staff tended to work in programs where the goals and activities were consistent with a 12-step approach and less consistent with a cognitive-behavioral approach.

In looking at the disease concept, age was associated with a greater endorsement of the disease model and education was associated with less endorsement. The relationship of being in recovery and endorsing the disease model, though positive, was not statistically significant. Twelve-step goals and activities



were positively, but not significantly, associated with disease model beliefs and significantly associated with less endorsement of a psychosocial orientation, whereas education was associated with greater endorsement of an eclectic orientation as was being in recovery. Twelve-step goals and activities were negatively associated with having eclectic beliefs about substance abuse treatment. The researchers state the mechanisms by which program goals and activities affect staff beliefs are not known, but speculate that a treatment program's culture shapes current staff members and filters out, through hiring and attrition, individuals who do not fit with the program's perspective.

Education of staff members was negatively related to disease model and positively related to endorsement of the psycho-social and eclectic orientations. Older staff endorsed the disease model more strongly than do younger staffs, which may reflect some shift away from this model in training such that younger staffs are being exposed more to alternative viewpoints.

The belief in the disease model also appears to be culturally influenced as indicated by the study done by Ogborne et al. (1998). This study investigated the belief systems of Canadian substance abuse treatment providers and concluded that the disease concept is not as widely held as it is in the United States; however, among those counselors who did maintain belief in the disease model, it was speculated that the reason for this belief was based on personal recovery.

In a survey conducted in Ontario, 2,087 front-line staff of specialized addiction treatment services were asked to indicate the extent to which they believed

53 different treatment processes to be necessary for the effective treatment of people with alcohol and drug problems. Overall response rate for the questionnaire was low at 44%, with the highest response from those working in assessment/referral services (70%) and lowest for those in detoxification centers (32%). Factor analysis identified three interpretable dimensions of belief: (1) cognitive-behavioral, (2) disease, and (3) medication.

Results indicated cognitive-behavioral processes that focus on cognitions, coping, and relapse-prevention skills were generally rated as almost essential for treatment to be effective. Among Ontario's front line staff that completed the questionnaire, there was a widespread belief in the efficacy of treatment processes. There was also a strong belief in the provision of information about community resources, in seeking client feedback on treatment, and in providing for treatment of mental health problems. Most other specific processes received mixed ratings, including several steps or principles of AA/NA, the promotion of the disease-model of chemical dependence, and the process associated with insight-oriented psychotherapy. Confrontation and pharmacological treatment were, on average, rated as detrimental.

One question asked respondents which clients, if any, would they be comfortable in setting nonabstinence goals. The response options and the percentage of respondents choosing each option were: (a) none (23%), (b) healthy clients who are not physically dependent and who have no other problems (23%), and (c) those unwilling to accept abstinence even if this is clearly desirable (31%). This result

would appear to indicate that, despite a belief system that is moving away from the disease model, the goal of abstinence is still seen as desirable.

Scores on the disease process scale varied significantly for all variables considered. These scores indicated increasing acceptance of the disease concept with age and were also higher for certified counselors, those working in detoxification centers and residential agencies, and those with fewer academic qualifications. Age, certification status, and place of work were similarly predicted membership in two subgroups of respondents distinguished by scores on the disease processes, insight-behavioral, and cognitive-behavioral scales. Service providers are divided in their support for disease and insight-behavioral processes. Underlying this division are differences in work settings, education, age, and certification status.

### Summary

Studies indicate there are difference among substance abuse counselors based on recovery status and field of discipline. Nonrecovering counselors are less committed to the disease model, but both recovering and nonrecovering counselors are open to new ideas and methodologies. Other studies indicate that, although there are differences between practitioners in various disciplinary fields in their view of alcoholism and substance abuse treatment, the view of alcoholism as a disease, the use of the 12-step model of treatment, and abstinence as a treatment goal continue to be widely believed. Several studies showed that, even though recovering counselors are more likely to believe in the disease model of alcoholism, this belief

continues to be held among nonrecovering counselors as well. One study was found which contradicted these studies. This study found that being in recovery was associated with more varied treatment techniques and a broader range of treatment goals.

Studies that have been conducted regarding the acceptance or nonacceptance of moderated drinking as a treatment goal indicated that treatment professionals who are recovering counselors tend to adhere to the abstinence philosophy. Other studies indicated that moderated drinking is almost uniformly unacceptable as a treatment goal in residential alcohol service agencies; however, there is some indication that outpatient programs are reporting that it is acceptable for at least a minority of their clients. In studies conducted by researchers into the staffing patterns of outpatient and residential settings, it was found that males, recovering abusers, and nondegree counselors were most likely to be employed in residential and detoxification programs. Outpatient counselors were likely to be women with advanced degrees and were least likely to be recovering.

Studies that were undertaken to determine the level of acceptance of the disease concept came to the following conclusion: more recovering staff tend to work in programs where the goals and activities are consistent with a 12-step approach and based upon the disease concept; however, the relationship of being in recovery and endorsing the disease model, although positive, was not statistically significant. One study indicated that the belief in the disease model appears to be culturally influenced.

## CHAPTER III

### METHODOLOGY

#### Description of Research Methodology

This chapter will describe the research design and methodology used in this study, beginning with the selection of participants, followed by the interview process and finally the data analysis and validation. The purpose of this qualitative research was to examine the belief systems of both recovering and nonrecovering substance abuse counselors to determine how their beliefs regarding substance abuse are formed, what factors influenced the construction of their belief system, and how they react to and integrate research which may contradict their beliefs. This study also investigated whether or not recovering and nonrecovering counselors differ in their belief systems regarding the etiology and treatment of substance abuse. If differences do exist, do the differing belief systems impact the counselors' ability to incorporate new ideas and beliefs into their treatment planning? Because little research has addressed this topic, the study was exploratory in nature with the goal of establishing theory.

#### Selection of Participants

Research by Mulligan et al., (1989) and Hosie et al. (1989) has shown that the staffing patterns of outpatient and residential settings were different. Residential

and detoxification treatment centers were more likely to employ males who were nondegree counselors in recovery. Outpatient counselors were more likely to be women with advanced degrees and were least likely to be in recovery. Due to these staffing pattern trends, treatment center level of care was taken into consideration in terms of the selection of participating treatment centers for this study. While the treatment center level of care was considered, no attempt was made to achieve gender balance between the participants.

In an effort to have as many views represented as possible, participants were selected from public and private agencies which offered either inpatient and/or outpatient treatment. Private practices that listed substance abuse services as a part of their practice were included in the selection. The selection of treatment centers and private practices was based on the treatment programs level of care (inpatient vs. outpatient), with inclusion of both public and private practices to ensure that the broadest range of treatment modalities was represented. These treatment centers were selected from the Michigan Drug Abuse Treatment Program Directory (Michigan Office of Drug Abuse and Alcoholism, 2000), a statewide directory of substance abuse programs. Treatment centers and private practices were selected from two counties: Kalamazoo and Kent.

After selecting a range of possible treatment centers in two counties, the clinical directors or administrators of selected treatment sites were contacted by telephone by the investigator. The investigator described the study and the purposes of the study to the administrators and asked if they would be willing to allow the

substance abuse counselors working on site to participate in the research on a volunteer basis. Administrators who verbally gave consent to allow the research to be conducted on site were sent a consent letter with instructions to photocopy the consent letter onto letterhead and return it to the investigator with their signature. These written consent letters were submitted as part of the application proposal to the Human Subjects Institutional Review Board (HSIRB) in order to obtain permission to conduct the research. Since the target pool of participants was between 8–10, only three letters of agency consent were obtained since this could provide up to 6 participants with an additional 2 participants being selected from a private practice setting. Private practice settings did not need submit prior approval since the individuals were acting as independent agents.

Three treatment center sites originally consented to participate in the research. Two sites located in Kent County offered both residential and outpatient treatment. The third site was located in Kalamazoo County and served a tri-county region by offering both inpatient and outpatient treatment. The Kalamazoo site that agreed to participate could not provide any eligible participants. Two participants who worked at different agencies in Kalamazoo agreed to be interviewed on their individual time.

The investigator submitted the study proposal to HSIRB at Western Michigan University along with written plans to ensure confidentiality to participants. This proposal included the agency consent letters that stated the agency

willingness to be a participating treatment site. Approval to proceed was obtained (Appendix A).

After approval was obtained from HSIRB, the administrators at the participating agencies were again contacted. A request was made to address the treatment staff at a staff meeting to describe the study and elicit possible participants. Two of the administrators asked that they be allowed to address their staffs with the intention of letting the investigator know if any of the staff were willing to volunteer. These administrators were given the selection criteria for participants so that they could present the criteria to the staff. Following the staff meeting, administrators contacted the investigator with names of possible volunteers and gave permission for the individuals to be contacted directly or made arrangements for the investigator to come on site and interview the volunteers. The third treatment site gave permission to the investigator to contact staff directly by telephone. Several of these staff members were contacted; however, eligible participants could not be found. A substance abuse counselor known to the investigator suggested two Kalamazoo area counselors who he believed would be willing to participate. These counselors were contacted and both agreed to participate in the study. These counselors worked in a local substance abuse agency and were independent contractors for that agency.

Private practices that offered substance abuse services were also contacted regarding possible participation. Two volunteer participants were elicited, one from Kalamazoo County and one from Kent County. A total of 8 participants volunteered



to be interviewed Eight participants provided both the richness of individual experiences while providing a large enough group to be able to detect themes among substance abuse counselors.

### Inclusion Criteria

The criteria for inclusion as a participant in this study was a minimum of a master's degree in counseling, psychology, or social work, and at least 5 years experience working in the field of substance abuse. The rationale for inclusion of counselors with master's degrees was to provide some consistency with regards to levels of education in order to separate educational influences from the belief systems. Inclusion of counselors with 5 or more years practice was to furnish the study with a pool of participants who have experienced substantial changes in the substance abuse field and have repeatedly faced challenges to their belief systems either through recent research or through changes forced by the managed care systems. Treatment site administrators screened for the inclusion criteria when they addressed the treatment staff at their agency. Independent participants were screened for inclusion during the telephone contact.

Ideally, a recovering and a nonrecovering counselor from each treatment site would have been selected; however, this was not achievable. Although the balance of a recovering and a nonrecovering counselor was not available at the individual sites, a balance was achieved among all sites.

### The Interview Process

The research involved semistructured interviews with eight master's level substance abuse counselors who have been working in substance abuse for a minimum of 5 years. The counselors all had degrees in psychology, counseling, or social work.

The interview process was conducted in several parts. Initially participants were asked to read and sign a consent document and permission was obtained to tape the session (Appendix B). Demographic data were gathered using a prescribed format which included age, recovery status, time in the substance abuse field, as well as additional information (Appendix C).

During the first part of the interview the participants were given a written scenario that described an individual who would typically present for treatment in a substance abuse clinic (Appendix D). The participant was asked to read the scenario and consider what treatment planning he or she would recommend if the individual described in the scenario were a client working with the participant. The participant was instructed that, for the purposes of the scenario, the participant is working as an independent practitioner and that the client was not limited in terms of financial resources. The purpose of placing the scenario in this setting was to allow the participants to prescribe a treatment plan which might be different from the mandates of the organization in which they are currently employed, thereby increasing the likelihood that the treatment prescribed will more closely resemble their own beliefs regarding treatment. After the participants read the scenario, they

were asked a series of questions regarding the treatment plan they would construct for the individual described (Appendix E).

The purpose of the scenario and the treatment-planning component was to provide information regarding how the counselor's belief system impacts his or her treatment planning and delivery of services. For example, if a counselor has a strong belief in the disease model, will he or she describe a treatment plan that is consistent with a 12-step approach?

The final part of this process involved a semistructured interview in which participants were asked to respond to a series of questions regarding their training prior to entering the field, what they learned and how they formed their beliefs after entering the field, and how this belief system has changed or remained stable over time. This was considered a semistructured interview in that the researcher followed up on themes presented by the participants to gain a full understanding of the participants' belief systems and how these beliefs impact treatment planning and delivery of services. Follow-up questions were asked by the investigator to clarify answers or to get more in-depth information regarding a participant's response.

Following the interview, the investigator taped her reflections and noted biases to the interview. These notes became a part of the data that were analyzed. Additionally, field notes were made as the interviews continued regarding possible themes that appeared to be emerging.

### Data Processing and Analysis

The purpose of this study was to explore the experiences and beliefs of both recovering and nonrecovering substance abuse counselors to determine how their beliefs change or remain intact. Raw data consisted of audiotapes that contained demographic data, treatment planning based upon the presented scenario, and the semistructured interview. These audiotapes were transcribed verbatim from the interviews. Following the transcription, the primary investigator read each transcript several times until the data were thoroughly understood.

As with all qualitative research, this study was exploratory in nature and designed to elicit common threads or themes from a relatively homogeneous group of participants. Construction of these common themes was determined through the process of coding. Qualitative data coding involves identification of themes contained in specific text passages or segments (Bernard, 1994; Gorden, 1992; Miles & Huberman, 1994). Themes can include beliefs, experiences, or opinions that the participant was trying to communicate in response to the investigator's questions. Different participants may express similar themes but state their ideas in different ways, or they may hold entirely different views. The qualitative data coding process requires that the investigator accurately read and comprehend similarities and differences across the various interviews, regardless of the manner in which the participants expressed themselves.

Qualitative analysis was conducted using qualitative data analysis software known as EZTEXT that was located on the Internet as a free download from CDC-NCHSTP-Divisions of HIV/AIDS prevention site.

Throughout the analysis process, memos were written and used by the investigator to allow a forum to process thoughts, ideas, and tentative construction regarding themes and meanings being presented in the data. These notes were included in the process of coding and data reduction.

### Validity of Analysis

The validity of qualitative analysis, the problem of quality, trustworthiness, and authenticity of findings can be highly contended. For the purposes of this study, five domains were considered in the matter of providing validity: Objectivity/confirmability, reliability/dependability/auditability, internal validity/credibility/authenticity, external validity/transferability/fittingness, and utilization/application/action orientation (Miles & Huberman, 1994).

### Objectivity/Confirmability

How free is this study from researcher bias? Are the conclusions reached reasonably free from researcher biases and developed from a neutral stance? An investigator's background may influence any qualitative research.

The investigator involved in this study has a Master of Arts in Counseling and is completing a doctoral degree. She is a nonrecovering scientist/practitioner

who has worked in the field of substance abuse treatment for over 15 years. Prior to entering the field of substance abuse treatment, the investigator had no formal training in the area of substance abuse. She was therefore trained on site by recovering substance abuse counselors and was indoctrinated into the traditional treatment belief system.

This traditional belief system was internally challenged over the years by experience and research that contradicted the belief system. These challenges resulted in change in her own belief system regarding her views of etiology and what formed the basis of effective substance abuse treatment. While embarking on this internal journey to a different belief system, the investigator observed her peers in the field struggling with identical issues as more and more contradictory information was being introduced into the field. It was this experience that spawned an interest in this study. A personal bias of this investigator may stem from these experiences. To the extent that it is possible, the investigator kept this bias in mind, realizing that a singular experience is not the basis for a wide range conclusion.

#### Reliability/Dependability/Auditability

Have things been done with reasonable care? Reliability and dependability speak to the process of the research methods and whether or not quality control measures are in place.

The interview process in this study was designed to specifically elicit information relevant to the research questions. The same investigator conducted all

interviews, leading to some consistency in data gathering despite being semistructured in form. Several participants were given a copy of their transcription as well as their narrative to review how the investigator interpreted or made meaning of their experiences. This was done to provide feedback to the investigator regarding the accuracy of the narrative to the content provided by the participant. Any discrepancies noted by the participant were corrected.

#### Internal Validity/Credibility/Authenticity

Are the conclusions reached in this study credible and what criteria are used to judge this?

The investigator selected the widest possible range of participants to ensure variation not only in recovery status, but also in terms of treatment sites. While variability was sought in these areas, consistency was sought in terms of participants' years of experience and educational background. The manipulation of these variables would yield enough variation to validate emerging themes, while at the same time controlling for factors of education and inexperience.

For reasons of credibility, 8 participants were selected for in-depth interviews lasting over an hour in each case. The number of participants, the length and depth of the contact was considered by this researcher as credibility validation. Eight participants provided a richness of data while allowing enough data to form a pattern that could be generalized. The interview process was semistructured, which allowed the investigator to cover identical issues in each interview while at the same

time allowing flexibility during the interview to follow up on beliefs or themes of interest.

#### External Validity/Transferability/Fittingness

Can these findings be transferred to another set of substance abuse counselors and generalized?

Whether or not the conclusions of this study can be transferred or generalized to other groups is dependant on several variables. One variable is seen as the geographic location. This study was conducted in the Midwest region of the United States in an area that is influenced by a Dutch Reformed theological base. Transferability to different regions cannot be presumed.

A second factor in transferability is the small sample population used. While 8 participants provided a richness of data, 1 or 2 participants whose beliefs or experiences lie outside the norm can skew the data when applied to a larger population.

#### Utilization/Application/Action Orientation

Does this study have a useful purpose?

The field of substance abuse treatment can benefit from this study by gaining an understanding of the process by which substance abuse counselors form, maintain, or change their beliefs regarding what constitutes alcohol and drug addiction and how best to provide treatment. An exploration of this belief system



can also help to determine if, and to what extent, there is a flow of information from researchers to practitioners regarding effective treatment ideas and information and whether this information is being incorporated into present substance abuse treatment practice. Treatment centers may also benefit from this study in terms of beginning to evaluate their own treatment philosophies and methods and to open up discussion and training to integrate new methods, ideas, and information which is being generated from academia and research facilities.

#### Confidentiality of Data

Any identifying information was considered confidential. No names appeared on any papers on which information was recorded. Transcriptions of the interviews were numbered and the researcher kept a separate list with the names of participants and corresponding numbers. This list will be kept in a locked filing cabinet in the principal investigator's office for a period of 3 years. Transcriptions were numbered for matching purposes only and were destroyed at the completion of the study. Audiotapes from the interviews were destroyed at the completion of the study. All other data will be retained for a minimum of 3 years in a locked file in the principal investigator's office; after that time, it will be destroyed. In addition, necessary safeguards were taken to report data in a manner that protected participant anonymity.

### Instrumentation

Instrumentation included the written scenario (Appendix D), the protocol used in conjunction with the scenario (Appendix E), and the protocol for the semistructured interview (Appendix F). The investigator designed the written scenario for the purposes of this study. The scenario is a composite of clients who have presented for substance abuse treatment in the investigator's 15 years of substance abuse treatment experience in both inpatient and outpatient settings. The scenario is specifically designed to touch controversial issues such as moderated drinking as a treatment goal, the possibility of cross addiction, and the inclusion of an Axis I diagnosis that may or may not be seen as impacting the substance abuse. Questions asked about the scenario and the structured interviews were designed to elicit responses that would provide data to answer the research questions. This scenario was field tested prior to use in this study in a preliminary study conducted by the investigator. In the field test, the scenario was presented to six substance abuse counselors, three in recovery and three nonrecovering in an effort to determine if the scenario would elicit the information the investigator was attempting to extract. The scenario provided the investigator with information regarding how the participating substance abuse counselors conceptualized their clients, their preferred treatment methods, and their priorities in regards to treatment issues. The scenario provided the information the investigator was seeking and was not changed following the field test.

### Consent Process

Participants were asked to read a consent form (Appendix B) after a description of the research had been given to them. The voluntary signature of the participants on the consent form was considered consent. After signing the consent form, participants were asked to verbally consent to audio taping of the interview prior to turning the tape recorder on.

### Limitations

This study is designed to elicit information regarding beliefs. Therefore, the sample size was limited to allow a complete and more thorough examination of several individuals rather than a more superficial look at a large number of subjects. This study was also limited by inclusion of subjects only in a southwest region of Michigan; a study of beliefs could yield different results in other parts of the country. While no ethnic group was excluded from participation, differing ethnic backgrounds could certainly influence the learning and interpretation of belief systems.

## CHAPTER IV

### FINDINGS

This is a study about the belief systems of substance abuse counselors. This research is an exploration into how substance abuse counselors form their beliefs regarding the treatment of substance abuse. It is also an investigation into whether or not these belief systems have changed over time and, if so, what has influenced this change. Eight substance abuse counselors were interviewed regarding their beliefs. The findings from these interviews will be presented in this chapter.

The findings of this study will be presented in five sections. The first section will provide a demographic portrayal of the participants who volunteered to take part in this study. The following section will describe the analytical process used to derive meanings from the transcribed data into the final format presented. The third section will depict the participants' beliefs, the experiences that contributed to the formation of their belief systems, and the influences that either maintain or force change in these beliefs. This section is written in narrative form to reflect the experiences of the participants. The next section will present themes, beliefs, and conflicts derived from the data. The final section in this chapter will review the research questions and the research findings in regard to these questions.

## Participants

Eight substance abuse counselors volunteered to participate in this study. Four of the participants were in recovery from substance abuse and 4 were nonrecovering. The participants were met through agency contact or by a call placed to a private practice. The investigator knew 3 of the participants prior to the interview.

Ideally this research would have drawn both a recovering and a nonrecovering counselor from the same agency or agencies offering the same level of treatment; however, this was not possible. The final pool of participants identified by recovery status and type of treatment center where they are employed is illustrated in Table 1.

Table 1

Participant Pool by Recovery Status and Treatment Level

Nonrecovering Counselors	Recovering Counselors
(1) Private Practice	(1) Private Practice
(2) Residential/IOP/Outpatient Nonprofit Treatment Center	(2) Outpatient Nonprofit Treatment Center
(1) Outpatient Nonprofit Treatment Center	(1) Residential/IOP/Outpatient Nonprofit Treatment Center

The ages of the participants ranged from 41 to 68. The participants have been working in the substance abuse field for an average of 14 years with a range

between 10 and 25 years. All participants were Caucasian. Seven of 8 participants have worked in a residential treatment center at some point in their career, all have worked in an outpatient setting, and five have worked independently in a private practice either currently or in the past. Six of the 8 counselors had master's degrees from a counseling program; two had Master of Social Work degrees.

The interviews took place either in the office or in the private home of the participants, based upon their request. Rapport was easily established with all of the participants; soon after the start of the interview it appeared to the investigator that the participants were freely sharing their information. It should be noted that the investigator did not ask any participant about his or her personal experiences regarding substance abuse or recovery. This information was shared at the discretion of the participant, usually as a means of illustrating his or her belief or as an explanation of how a belief was formed. One recovering participant did not elect to share his recovery experiences. He was not asked to disclose his experiences in order to keep consistency in the interview process. At the end of the interviews, all but one of the participants reported enjoying the interview and the opportunity for them to talk about their experiences and beliefs. One participant reported enjoying the interview but also feeling challenged.

### Analytical Process

Tapes of the interviews were transcribed along with the investigator's field notes following the interview. Throughout the analytical process, notes were made regarding possible themes and comparisons.

Transcripts were read multiple times to ensure familiarity with the content and to recognize patterns in the belief systems. The first process of analysis consisted of several re-groupings of the data to help clarify comparisons among participants and to give the researcher several ways to view the data. Through these multiple regroupings of data, a picture began to form of the belief systems of each participant and how these beliefs systems compared to the other participants. Based upon this conceptualization, the information gathered during the scenario was separated from the open interview questions. The write-up of the scenario questions provided direct comparison of the different treatment planning styles of each participant. By comparison of treatment planning components, the investigator formed a conceptualization of the participants; they appeared to demonstrate a range of beliefs and treatment styles.

This range, as conceptualized by the investigator, indicated that some participants maintained traditional treatments, while other participants were utilizing different and varied treatment methods. Two criteria were considered when defining participants as traditional or nontraditional in their treatment methods. The first criteria were the participant's reliance on 12-step principles and groups in their treatment planning and the degree to which they were willing to deviate from this

approach. The second criteria was the degree to which participants were willing to use external motivators to force clients into support groups that were 12-step based or into groups that they did not want to attend. Participants who maintained a 12-step treatment approach and strongly urged all clients into AA or NA groups were considered to have traditional belief systems. The traditional participants used either external motivators or persuasion to get their clients to participate in 12-step support groups. Participants who were seen as nontraditional had varied treatment approaches that did not favor any one method. They were against forcing any treatment methods on their clients, preferring instead to find a method that worked specifically for the client. They also tended to voice opinions against forcing clients into support groups with the general population, in particular, the criminal justice system.

A data display was constructed to allow the investigator to visualize where each participant fell in a continuum from a traditional belief system to a nontraditional belief systems based upon this comparison. This data display is presented in Table 2.

After constructing the data display, the investigator returned to the complete transcriptions of the interviews. The transcripts were then coded to tease out traditional beliefs from nontraditional beliefs, experiences and influences that contributed to the formation of the beliefs, and indications of what either maintained the beliefs or forced a change in the belief system.



**Table 2**

**Placement of Counselors on Continuum from Traditional Beliefs and Practices to Nontraditional Beliefs and Practices Based on Scenario Responses**

	Traditional ←-----→Nontraditional							
	Participant 1 Susan Nonrecovering	Participant 2 Linda Recovering	Participant 3 Mike Nonrecovering	Participant 4 Eric Nonrecovering	Participant 5 Jerry Nonrecovering	Participant 6 Peter Recovering	Participant 7 Bettye Recovering	Participant 8 Pam Recovering
<b>Adherence to 12 step model</b>	High	High	Moderately High	Moderately High	Moderately Low	Low	Low	Low
<b>Diagnosis</b>	Alcohol Abuse, R/O Dependence	Alcohol Abuse, R/O Dependence	Alcohol Abuse, Cannabis Dependence	Alcohol Abuse	Alcohol Abuse, R/O Dependence	Alcohol Abuse Episodic	Alcohol Dependent	Alcohol Dependent
<b>Treatment Goals</b>	Abstinence, primary; Depression, secondary	Abstinence, Work on denial	Alcohol Abuse, Unresolved grief, Concurrently	Alcohol Abuse, Issues regarding divorce, Concurrently	Depression, Grief, Childhood trauma if present	Alcohol Abuse, ADD, Relationships, Divorce, Grief, Concurrently	Alcohol Abuse, ADD, Depression, Concurrently	Alcohol Abuse, primary, Grief, secondary, ADD
<b>Client in denial</b>	Yes, monitor closely	Yes	"I would consider it"	Yes	No	No	No, in contemplative stage	No
<b>Moderated drinking</b>	Abstain first, try later	Will do reluctantly	Will do to try to break through denial	Will do to try to break through denial	Will do to try to break through denial	Will do to try to break through denial	Abstain first, then try	Try

Following the process of coding the transcripts, the investigator returned again to the original transcripts to produce a narrative of the participants' initial beliefs, experiences that contributed to their belief systems, and how their beliefs have changed over time.

Grounded theory analysis is a method of deriving meaning from text that is grounded in the data rather than being imposed on it. Grounded theory is a system by which investigators immerse themselves in the data in order to fully understand its context and meaning. It was during this immersion process in writing the individual narratives that the identified themes began to emerge.

While writing the narratives, great care was taken to remain as close to the participants' own words and expressions as much as possible. The narratives were read several times and all identifying detail removed to ensure that participants' anonymity was not compromised.

The investigator returned to several of the participants in the study to allow the participants an opportunity to read the narrative and correct any discrepancies that they felt did not accurately portray their beliefs. All of the participants felt the narratives were a summary of their belief systems. These narratives are contained in the following section. The narratives are in order from the traditionally oriented counselors to those with the least traditional beliefs.

## Narratives

### Participant 1

Susan is a nonrecovering counselor who has worked in the substance abuse field for approximately 15 years. Prior to entering the substance abuse field, Susan had very limited exposure to substance abuse and does not recall having any pre-conceived beliefs regarding what substance abuse was or what caused it. She reports that her family of origin did not have a history of substance abuse and that her initial knowledge of substance abuse was limited to her own experiences with substances in college.

Susan entered the substance abuse treatment field by coincidence. She reports that she was happily unemployed and not seeking employment when she was approached by a community agency that knew of her work. The agency had several openings for substance abuse counselors and ultimately offered her a position working part-time. Susan accepted the position and began her career in substance abuse counseling.

Prior to accepting this position, Susan's instruction in substance abuse was limited to a few trainings as part of her previous employment. After accepting the position, Susan reports that the training she received was what she got from attending conferences, attending staff meetings, reading, and going to 12-step meetings herself. Another source of information for Susan were the films available at

the agency that she reports she watched along with her clients. She reflects back on this time and wonders how much good she did for her clients in the beginning.

Susan maintains a traditional approach to substance abuse treatment. Her treatment approach is based on the 12-step principles and the AA program. She firmly believes that the AA program is doing good things for people and teaches them how to live a spiritual life.

Susan views 12-step groups in very positive terms. She believes the AA groups are helpful in providing a concept of universality, which helps clients start to rebuild the bonds and heal the shame caused by addiction. Additionally, she feels the group members hold up a mirror which helps give people another level of confrontation in a gentle, but sometimes not so gentle, way. Susan believes AA groups give people a sense of hope in that it exposes them to others who have lived through addiction and recovery. Another powerful piece of the program for her are the slogans. She feels the slogans contain an element of Rational Emotive Therapy that helps clients change their pattern of black and white thinking.

Susan does see some negatives in the program and recognizes that the program was developed by white, middle-class, professional males. She believes the problems with this model can be offset in counseling. When working with women, she will use the 16-step concepts or the work of Stephanie Covington, both programs designed to empower recovering women. She believes that, with the counseling, there can be some attention to what the AA programs can't do

effectively. To Susan, the combination of 12-step work and counseling is getting the highest results and the best results.

Susan maintains a high belief in the disease concept. She reports she doesn't have a problem with the disease model and would hate to see it return to a morality model. She does not believe alcoholics or addicts can go into spontaneous remission or quit using with willpower alone. She believes that if this were true, then AA would not have been formed. Susan is familiar with rational recovery and sees it as a viable alternative for people who are concrete and literal, but overall finds its usefulness limited.

While Susan's treatment approach is based on AA principles, she does bring into her practice new components to enhance this approach. Susan has maintained a growing interest in the impact of substance abuse in primary relationships and, as a result, her current work with substance abusers includes both individual counseling as well as couples counseling. She has also been trained in acupuncture, which she offers to her clients as a part of their treatment.

Traditionally oriented substance abuse experts such as Terrence Gorski, Claudia Black, Terry Bradshaw, and John Lee influence Susan. For Susan, the fact that these experts are in recovery themselves adds to their validity. Susan also believes that recovering counselors, people who know first-hand about recovery, dominate the substance abuse treatment field and are positive examples of the recovery movement.

Perhaps the most powerful influence on Susan in maintaining her traditional focus is spirituality. Although Susan entered into the treatment field by coincidence, she states she is very grateful for it because it has allowed her to begin to develop a spiritual influence in her work and in her life. This spirituality is readily evident as Susan speaks and is a focus she maintains when she works not only with substance abusers but with all of her clientele.

Susan does not appear to experience dissonance in her belief system regarding substance abuse treatment. Susan does report feeling somewhat isolated in her practice and is unsure what is going on in the substance abuse treatment field. Susan's lack of dissonance is displayed in her strong belief in the healing power of AA as well as her belief that through AA she is able to bring to her clients the gift of spirituality.

### Participant 2

Linda is a recovering substance abuse counselor who has worked in the treatment field for 10 years. Her prior knowledge regarding substance abuse stems from her own experiences with recovery approximately 18 years ago. Linda's recovery journey began with two separate residential treatments. She reports she was not seeking treatment the first time but that a friend had dropped her off at a treatment center and she agreed to remain for 2 weeks. The experience was not a positive one. Linda's second treatment was one that she sought out and initiated. She reports that during the second treatment she felt a tremendous relief when she

realized that she really was an alcoholic. For her it was an explanation as to why she felt crazy when she didn't think she was crazy. Following her treatment, Linda continued her involvement in AA, which enabled her to meet two friends who would become central to her recovery. It was through the buddy system and the talks over coffee after the AA meetings that her recovery became solid.

Linda entered into the field of substance abuse treatment by coincidence stating she needed a job and ended up being hired to answer phones at a substance abuse clinic while she completed a bachelor's degree. After completing both her bachelor's degree and her master's degree, she remained in the field.

Linda's only formal training in substance abuse was at the Mid-West Institute for Addictions subsequent to being hired as a substance abuse counselor. All other training was on-the-job knowledge acquired while watching films available at the clinic where she worked.

Linda maintains a strong belief in the disease concept which she remembers learning while watching films by Dr. David Ohms during her treatment. The book *Under the Influence* also influences her belief in the disease concept. Linda has also observed that, in her own family of six siblings, only two are chemically dependent. This, for her, is further validation that there is a genetic component in the etiology of substance abuse. Linda does not believe that substance abuse can be explained as a coping mechanism or as a system of self-medication for a mental disorder. It is Linda's opinion that people who have a mental disorder and are also abusing substances have two separate issues.

Linda does not believe that substance abusers can enter into spontaneous remission, quit by the use of willpower alone, or learn to drink in moderation. These beliefs, for her, are substantiated by experience; she has never seen these things happen.

Linda maintains a traditional approach in her substance abuse treatment. Her style can be characterized as one of gentle persuasion that she uses to bring her clients around to accepting AA groups and the 12-step principles. Linda does not believe in forcing people into treatment that they do not want. An example of this gentle persuasion can be found in her response to clients who state they don't like AA or NA groups.

How many meetings did you go to? I find out how many they went to, if they say one or two, I say well that's not a fair test, meetings vary, just like if you go to school there are classes you like, some you don't like, it's the same for AA.

She assures her clients that research shows that 12-step programs are effective for people who want to stop drinking and can offer a wonderful way to live. Linda's gentle persuasion approach is a change in style for her. Linda does not view herself as an AA fanatic who is going to tell anyone to memorize the "big book" but admits that at one point in her career she had done so. While Linda maintains a belief in the efficacy of AA, if the 12-step approach is not working, she will send clients to a rational recovery group if that approach makes more sense to her client.

Although Linda relies on the 12-step principles for her addictions counseling, she feels there are several problems with AA groups. Linda acknowledges that there



are people who attend AA who are, what she terms “self appointed executive directors.” She also has concerns regarding sponsorship and the amount of control that some sponsors exercise over others. She makes a point of telling her clients that sponsorship should not involve others telling them what to do, but rather be about friendship and having someone be there for them. Linda also acknowledges that AA is an organization that was begun by men and is male dominated but feels she can make up for cultural discrepancies in her counseling sessions. Linda attempts to help her clients work through problems associated with the AA groups to enable them to continue to be a part of it.

Linda appears to be influenced by her personal experiences with recovery and the work of Terrence Gorski and Dr. David Ohms. Gorski’s work is particularly powerful for her since his theories on post acute withdrawal symptoms helped her to understand a difficult part of her own recovery. Linda believes that her peers in the substance abuse treatment field are practicing in ways very similar to her, which further validates her beliefs.

Despite the recognition of problems with the AA groups, Linda does not appear to experience a significant amount of dissonance. Linda feels she has never really wavered in her beliefs. She reports that when colleagues challenge her beliefs that it generally ends up that they agree to disagree. Linda is familiar with the work of Stanton Peele but does not feel his opinions are valid.

Linda reports that she has formed her beliefs through a great deal of thought, reading, discussions, clinical experience, and working in different substance abuse

settings. She feels that she remains open to new ideas, but for her it is difficult to dispute what works. She strongly feels that people do get better through treatment and AA. She states, "It may be wrong, but it works."

### Participant 3

Mike is a nonrecovering substance abuse counselor who has been in practice for 13 years. Subsequent to entering the field he had no pre-conceived ideas about what an alcoholic was or what caused alcoholism. He states that if he had been asked back then what an alcoholic was he probably would have said that an alcoholic or addict would be somebody who couldn't quit using and that this was probably caused by peer influence and unresolved emotional issues. He reports that this would have been based on guesses.

Mike entered the field of substance abuse purposefully. In his prior work with the criminal justice system he became aware that substance abuse was a significant problem with felony offenders and began to take more of an interest in it. Mike became a court substance abuse assessor while continuing to work on his master's degree. Following completion of his degree, he became a substance abuse counselor at a clinic.

A bachelor's level-recovering counselor trained Mike in the field. He states that the majority of his training as a court assessor was clinically oriented and was focused on *DSM* criteria. Mike humorously describes his training at the treatment center as, "They put you into an office and gave you clients. I now had a master's,

by God, obviously I could handle anything!” Mike states he learned substance abuse treatment by the seat of his pants. When he first began his work, it was suggested to him that he recommend AA or NA to all of his clients. In response to this, he began reading Hazelden step manuals, parts of the AA book, and the entire NA book to enable him to speak the language of his clients. Even though he was actively pursuing knowledge through these resources, he states that it was still 2 years before he understood that powerlessness and unmanageability were program synonyms for obsession and compulsion.

When asked about his understanding about the disease concept, Mike began to recite the main ideas contained in the concept as if reading from a book. When asked if this meant his beliefs had changed, he replied that they had, but not completely. Today Mike believes that the etiology of addiction is much more complex than the disease concept allows. This change in his belief regarding the disease concept led to a change in his beliefs about substance abuse treatment over the years. He states he no longer believes in cookie cutter treatment, that, for him, it is no longer a matter of one-treatment fits all. Mike feels what has changed for him over time is his pre-conceptions of his patients as they walk through the door. He no longer believes that everybody is going to fit a certain model. This new understanding is reflected in Mike’s treatment planning; he now focuses on multiple issues concurrently and no longer practices with the singular focus of working first on substance abuse issues.

While Mike's views on the disease concept have changed, he does appear to retain some of the ideas. He does not believe that people who have progressed to a psychological and physiological dependency can stop using with willpower alone or return to social use. He also does not believe that alcoholics can go into spontaneous remission. He states the reason for this belief is the obsessive-compulsive relationship addicts and alcoholics have with substances. He believes that people who have developed an obsessive-compulsive relationship with alcohol experience a change at a medical level that seems to be irreversible.

Mike describes AA as the core of his treatment. To Mike the principles are as useful to the most highly functioning people in the world as they are for a skid row drunk. He views the AA and NA fellowships as being the largest and the best support system for any disorder in the world and feels he would be doing his patients a disservice if he didn't speak the language of the support system that he will be handing many of his patients off to following treatment. Mike does not view this as cookie cutter treatment since he believes the 12-step program has the potential to be broad enough to fit almost everybody in one way or another.

Although Mike's treatment planning is based on the principles of AA, his beliefs about AA groups are conflicted. Mike sees many positive aspects of AA groups including the support, the anonymity, the commonality, and the availability. He goes on to say that he believes it does people good to be involved with an organization that has 67 years of history. Mike believes that AA self-help groups relieve an enormous amount of shame for a lot of people.

Despite these positives, Mike also sees some powerful negatives. He believes that at some meetings unhealthy group members can victimize other members. He also believes that there are group members who are there to proselytize religiously rather than letting someone grow into their beliefs and their understanding of spiritual matters and recovery. He feels that this can cause damage to some people's recovery. Mike believes the wording in the 12 steps can be politically and emotionally charged and finds he plays apologist for some of the wording.

Mike is aware of rational recovery groups but states that his experiences of these groups have been overridingly negative so far. He has not had enough positives to say he would recommend someone go that way. Mike also states he would never send anyone to a moderated management group, a group that teaches substance abusers how to use in moderation, believing that the risk of self-destruction is too high. When Mike was asked whether or not he thought family and friends could provide enough support to a recovering person to sustain them in their recovery without AA, his reply was that a wife, an employer, and or an extended family who are really there and want to help is great, but it is not sufficient by itself as they do not have the inside-out understanding of the obsessive-compulsive nature of the disease.

Mike sees the substance abuse field becoming more professional. He believes that managed care has been a blessing because it has mandated higher educated, higher credentialed people to be doing the treatment. From Mike's perspective, the lay people in the field were unable to take individual treatment issues into effect.

With these changes he believes the field is no longer the recovery mill that it once was.

#### Participant 4

Eric is a nonrecovering substance abuse counselor who has spent approximately 20 years in the treatment field. Prior to entering the field, Eric had significant exposure to substance abuse by observing his family and the neighborhood in which he was raised

Eric's family has a long history of substance abuse that included his grandfather, several uncles, and his own father. Eric describes his father as a daily drinker who drank up until the day he died. Despite this, Eric has difficulty labeling his father as an alcoholic. For Eric, an alcoholic was someone like his uncle who became abusive when drunk. Eric's father never became abusive to the family when drunk, apparently due to a high tolerance. Eric has memories of watching his father play and win drinking games because he could drink more than the others and still maintain his focus.

Eric recalls that drinking took place not only in his home but was also prevalent in the neighborhood. He remembers that everybody drank but that it was a good neighborhood in which everybody watched out for everybody else. He sums up his initial impressions this way: "So alcoholism wasn't even a thought, there was just drinking, and some people drank and got stupid, and some people drank and

they were all right.” Eric has always believed that families developed alcoholism because they grew up with it.

Eric’s entry into the field of substance abuse treatment was coincidental. He had been working previously as an administrator in a nonprofit agency and had decided that he no longer wanted to work in administration. At this same time a substance abuse counseling position came open in a local agency and Eric was given the job.

Eric does not describe any formal training experiences in substance abuse but feels his clients are constantly training him. He believes he learns because he is open to learning. He recalls two “teachers” in particular who had made an impression on him: a woman and a man who were alcoholic and who Eric had given up on, believing that they would never get sober. He recalls that at one point he believed the man was going to die. By the time Eric left the clinic the man had been sober 7 years and the woman was sober for 5 years before she died. From this experience Eric learned to believe that, “miracles can happen.”

Eric believes in the disease concept because addiction, for him, has all the same symptoms of any other disease, progressive and fatal and chronic; however, he also sees addiction and alcoholism as a spiritual issue. Eric does not believe in controlled drinking and believes its effects on alcoholics can be disastrous. Eric believes that if a person is really not addicted, then he or she can control his or her drinking, but there is a cut off line between those that can control their drinking and

those that cannot. For Eric, one of the major symptoms of addiction is not having adequate control over your use once you start using.

The issue of when an abusive drinker becomes an alcoholic appears to be an issue that Eric has struggled over. Eric describes himself at one time in his life as being an abusive drinker. He states his drinking for many years was excessive at times and he believed that it was becoming a problem in his life. He states that he continues to struggle with whether he is alcoholic or not. Having come to the conclusion that his drinking was problematic, Eric made a decision to make some life changes. He recalls that he started living a healthier life style, began running, eating right, and worked on his relationship with his wife. Eric no longer abuses alcohol but is now a social drinker. Eric has integrated these conflicting messages between his experience and his beliefs by believing that he could not have been alcoholic if he were able to stop his abusive pattern and return to moderated drinking.

Eric believes in the AA principles and believes the philosophy is good. He uses the AA principle in his practice; however, there appears to be considerable flexibility to his treatment planning. Years of work in the field of substance abuse treatment have led Eric to the conclusion that substance abuse treatment is not black and white and never will be. Eric does not believe there will ever be one final answer.

Eric can see over time how this new belief has changed the way that he practices. Eric characterizes his early years in substance abuse counseling as being



rigid in his thinking. He states that if somebody were to come into the clinic in denial his attitude was, "I'm not going to deal with you because you're obviously alcoholic and you don't want to do what we want you do so, bang, bang with the heads and then they would leave treatment."

He now believes that all of his clients need to decide for themselves if they are alcoholic or not. While Eric prefers to work with AA principles, he is open to suggestions from clients who would like to choose alternative routes. Eric sees rational recovery as a good option for some individuals who struggle with the religious overtones of AA.

Eric designs his treatment plans according to where his clients see themselves. He believes it is his job to help clients see themselves accurately by giving them education, information, and holding up a mirror. He accepts the treatment goals of his clients even if clients only want to get their probation officer off their back. Eric's response to this is: "Okay, let's work on that." Eric describes this change in attitude as having found tolerance. He believes he is more tolerant of people because of his experiences. To Eric, the bottom line is his view that we don't know all there is to know about how to help people.

Eric refers clients to AA meetings; however, he has mixed feelings about these groups. He believes the positive aspects of the meetings are in the group process, in being able to listen to somebody who has had these experiences who's willing to share them. For Eric, that process is very healing. He believes that AA has

experience over the course of a lot of years, with people who have been in addiction and who are staying in recovery.

Eric also sees some negatives in these meetings, particularly for women. He believes that at times “it is like a meat market.” He struggles with the issue of women in AA since the founders of AA were all men. He worries that when you put vulnerable people with vulnerable people you will get people who have struggles with being alone and may see a woman as being the solution. Eric advises women in recovery to attend women’s AA groups.

Eric’s clients appear to influence him to continually change his belief system. Eric’s greatest education has been the opportunity to work with people long enough to learn from them. Coupled with this is his strong empathy for his clients. He states:

You see a lot of our folks that we work with who have lost so much, and their just, such terrible life situations and I guess anybody who is in this field, in my field, that’s worth a salt has to be empathic, you’ve got to want to see that change come about, recognizing at the same time that only they can make that difference. I see our job as providing an opportunity for making changes.

For Eric the greatest joy in his work is to “see people struggling honestly and sincerely everyday and then making some progress, that’s great. That is a bonus, everyday is a bonus.”

### Participant 5

Jerry is a nonrecovering substance abuse counselor who has worked in the field for approximately 6 years. Jerry had limited experiences with substance abuse prior to entering the field. His experiences were mostly second hand: hearing stories

about alcoholic uncles told to him by his nondrinking parents. Jerry also has a clear memory of watching the movie, "The Story of Bill W," at his church as a kid. Jerry did have some early exposure to the disease concept through a previous job. It was through this job that he had some knowledge about alcoholism and knew that there was possibly a hereditary connection.

Jerry's entry into the field was coincidental. He recalls sitting in a classroom while working on his master's degree and striking up a conversation with the woman sitting next to him who happened to be a clinical director at a substance abuse clinic. Jerry asked her if she had any job openings to which she replied no, but offered to let him work for free as an intern. Jerry decided to take her up on the offer. The woman sitting next to him was the investigator of this research.

Jerry's training began at his internship site where he worked under a recovering master's level therapist. He reports that he learned about treatment through a combination of reading the treatment site materials, listening to his supervisor and very quickly learning to trust the addicts with their knowledge of themselves and of their addictive experience.

Jerry maintains some belief in the disease concept; however, he also strongly believes that there is an environmental component in the etiology of addiction. He states that he sees the combination of heredity and environment as being crucial to a lot of people. He feels that there may be some people whose makeup is so strong that from the first drink they are alcoholic, but for a lot of people it's a combination of the environment and heredity that leads them to need alcohol.

Jerry's personal history may account for this view. Jerry states that at one time in his life he was a very abusive drinker and that by any stretch of the imagination he was alcoholic. Jerry admits that, had he walked into a substance abuse clinic at the time, he probably would have been diagnosed as alcohol dependant. Despite this, he does not view himself as ever having been alcohol dependant. Jerry believes he was able to stop himself before he reached the point where he was chemically dependant or an alcoholic. Jerry believes his environmental background was positive enough to enable him to stop his abusive pattern and return to the social drinking pattern that characterizes his drinking today. Jerry acknowledges that this experience influences his views on etiology. He is not a straight medical model believer because, for him, environment plays such a huge role. Jerry believes that some people do not have enough environmental stressors to push them over, but had they had a different environment they could have been pushed over into addiction. This environmental piece is validated further for Jerry with his observation that significant numbers of his clients suffer from a high degree of childhood trauma.

Jerry believes that some people will quit drinking on their own based upon their personal decision to stop. He also states a certain comfort level with working with clients with moderated drinking as a goal but does retain some skepticism about whether or not it is possible.

Jerry states that he is a firm believer in AA; however, he does recognize that there are a lot of people who don't like it for very good reasons. For clients who

have difficulty with the spiritual part of AA, Jerry recommends rational recovery. Jerry is not limited in his resources to these two groups; he will also consider an individual therapist, a pastor, “somebody, somewhere, some how,” who can provide support even if it means helping the client to build his or her own support system.

Jerry believes the AA groups give people a place to belong and that for some people it is the only place where they’ve ever belonged. He believes it helps get people through those very early years of recovery when the relapse rate is quite high. Jerry views the slogans as being trite and thinks that AA and NA can be difficult to use. In his words, “You walk into a group and there is a bunch of crusty ol’ guys, and they’ve got all these sayings, you got a problem and they’ve got a platitude and they offer it up.”

Jerry works with clients based upon how his clients perceive themselves in relation to their substance abuse. He personally does not like the word *denial*. To Jerry denial is his own lack of understanding of the client. He believes that as soon as he gets to the point where he understands his client, then his client suddenly is no longer in denial. When Jerry and his client both have an understanding of where the client is, they together look at the various modalities of therapy to decide upon a plan.

This person-centered planning concept is important to Jerry who believes that when counselors develop a treatment plan for their clients, it is almost guaranteed to fail. He believes that person-centered planning is a huge contribution from the mental health field to the substance abuse field.

Jerry appears to be influenced by his own experiences and that of his clients. He takes great pride in understanding his clients, their needs, and their perceptions. In Jerry's view he is "broken as much as they are," and believes this enables him to better understand their world.

#### Participant 6

Peter is a recovering substance abuse counselor who has worked in the field for over 20 years. Peter formed early impressions of what alcoholism was growing up next door to his best friend whose father was a binge drinker. He remembers this man and recalls that he went to church and had a good job but would be gone from his home for days. He recalls when he and his friend were around 13 years old they would drive his friend's father to bars and drop him off so that he could drink and return later to pick him up and return him home.

Peter entered the substance abuse treatment field purposefully. He was working with delinquent children as a youth specialist and began noticing that the kids he was working with had all used substances; they weren't alcoholics or addicts, but they had all used. He also noticed that the families these children were coming from were filled with addiction. This began an interest for him in familial issues associated with addiction and recovery.

Peter later found employment with the court system working with juvenile offenders and continued to see the same trend. At that point Peter, along with a fellow worker, decided to pursue training in substance abuse so they would be able

to do alcohol and drug assessments as part of their work. He reports he was able to attend numerous trainings and seminars by experts such as Claudia Black and Father Martin. He has also received formal training at the Mid-West Institute and has completed a specialist certificate from the local university in substance abuse treatment.

Peter learned the disease model while working at a residential treatment abuse center. He states, "You had to pledge allegiance to it, and that was it, or you got fired." Peter recalls that when he really began to understand the concept, that once you had the disease that you had it forever, and that the criteria for diagnosing the disease was subjective that he began to have problems with how this disease was diagnosed. Peter believes addiction is a disease and that alcoholics can never be recovered but will always be in recovery. He compares this to having cancer, in that cancer survivors would not say the word recovered because for the rest of their lives they're going to try to practice, monitor, and live a life that pays attention to signs or symptoms that occur so they can quickly be treated.

Peter compares quitting substance abuse using willpower alone to dieting: "You can lose all the weight that you want, but the numbers of people who keep the weight off is statistically small." Peter does not believe alcoholics can quit drinking on their own but that people who drink like alcoholics can. To him there is something that happens to some people that makes quitting on their own impossible. He refers to this as the invisible line. Peter believes that when hard drinkers are forced to make changes, or fall in love, or get a new job, they will quit abusing

substances by themselves. He states he personally knows five people who went into treatment, were diagnosed with alcoholism, went to AA for 2 to 5 years, and have returned to drinking without experiencing further problems. To Peter you cannot determine during assessment and treatment the difference between an alcoholic and a hard drinker and that the majority of people who are being treated for addiction aren't addicts. He believes over-diagnosing addiction is a problem in the substance abuse field today.

This belief affects how Peter practices today. He states he is cautious about over-diagnosing and over-treating. He believes that in today's managed care environment it is likely that the client may only get one shot, that if you shoot everything you've got and it doesn't work, you have nothing left.

Peter works with the 12-step model in his treatment and believes he can do this effectively without forcing his clients to attend AA or NA if they don't want to go. For individuals who like the 12-step concepts but do not want to go to groups, he will recommend they join the groups on the Internet. He also sees church involvement as a possible substitution for these meetings.

Peter believes that AA and NA have a lot to offer clients. One of the strongest components for him is the storytelling that allows clients to identify with others in a nonjudgmental environment. Along with this he believes these meetings help plant the first seeds of hope. He believes that it is powerful to be in a place with other people who can laugh at all the horrible things they've done and be happy that they don't drink anymore. For Peter, most of recovery takes place before or after



the meetings or on the telephone because those are the times when most recovering people get a chance to connect with another person. Peter believes it is unfortunate that treatment centers all based their treatment on the concepts of AA because it then became a “one size fits all” program which ultimately was harmful.

Peter thinks that there are some problems with AA groups, especially for women. He believes some AA members are authoritarian, sexist, and not very welcoming to anyone who is different. Peter feels sorry for women who wander into the wrong groups and end up getting hit on so much. He believes that, as a community, we don't educate our clients and set up alternative programs for them. Peter believes that NA groups have done a lot to help with some of these multicultural issues.

Peter is strongly against the criminal justice system forcing people into AA groups and treatment. To Peter, “There are a lot of people who have chronic and severe personality disorders and whether they use alcohol or drugs or not, they're still not nice, they are still dangerous.” He does not believe these individuals should be attending groups with people who are striving to get healthy.

Peter believes the substance abuse field is becoming more professional and is recognizing that there are a number of different approaches to substance abuse treatment. He remembers that in the past attempts were not made to engage the clients; it had always been that the treatment field had blamed the person with the disease for not getting better. He believes that in the future co-occurring disorders and substance abuse will become greater issues and receive more attention.

Peter appears to be influenced for the most part by research. While speaking, he frequently referred to current research and often quoted statistics. It is not known how Peter's recovery influences his beliefs since his only reference to his recovery was to state, "I don't tell people because it's not relevant, but I am in recovery."

### Participant 7

Bettye is a recovering substance abuse counselor who has worked in the field for over 10 years. Bettye's knowledge of addiction and recovery prior to entering the treatment field stem from two different sources: her own recovery experiences and from university level academic course work.

Bettye's own recovery from substance abuse began traditionally; however, after the first year, she made a decision to venture down an unconventional path. Bettye states that in her first year in recovery she attended AA meetings and felt they were important to her recovery. Following this first year, she questioned whether the program was a good fit for her and concluded that it wasn't. Bettye then set off on her own course and her recovery became an independent process; she did not attend self-help groups but pursued recovery through reading.

Bettye entered the substance abuse treatment field purposefully. While working on her master's degree, she attended several classes on substance abuse treatment and decided she could bring something to the field. Bettye felt her own history of substance abuse combined with education could make her a role model for those in recovery. Bettye continued to pursue a specialty in substance abuse

treatment at the university because she enjoyed all of the different models, beliefs, and different ways of looking at addiction being taught in the classes. For Bettye, this program validated her belief “that there is no one answer, no one easy answer.”

Bettye completed her internship at a substance abuse clinic where she was trained by many different counselors, both male and female, some traditionally oriented and others not. She believes this experience gave her a well-rounded view.

Bettye’s concept of the etiology of substance abuse has many components. Bettye learned the disease concept when she was in treatment and believes that addiction is, in part, is a genetic process. She also believes there is a part grounded in the social norms of growing up in alcoholic families. Bettye also sees substance abuse as being an attempt by some people, particularly women, to self-medicate emotional pain. Despite these differing views, Bettye finds the disease concept useful to use with her clients who are from the criminal justice system. The disease concept, in her view, helps this group to at least open their eyes to the possibility that they may have an addiction.

Bettye believes that people can spontaneously recover from their addictions and that it probably happens more than what we think. She thinks that many college students would be diagnosed as alcoholic using our testing equipment; however, based on their drinking patterns, family patterns, values systems, and their priorities after graduation, they eventually pull away from their abusive use patterns. Bettye believes that in these circumstances she would not have diagnosed them as alcoholic even if the testing equipment verified the diagnosis.

Bettye believes that some individuals can quit using willpower, “depending on how stubborn they are and how badly they want it.” Bettye is willing to work with clients towards a moderated drinking goal provided they go through a period of abstinence first.

Bettye’s treatment plans and her beliefs often go in different directions. Bettye believes that the 12-step program is great for white males but does not necessarily fit other populations, particularly women and minorities. Her view of the 12-step process is one in which people’s egos are pulled down and then rebuilt. In her opinion, there are many people who don’t have an ego to pull down. Bettye believes that these individuals need a way to lift them up, not tear them down. Bettye finds the 12-step model not particularly helpful to women. She believes women are downtrodden either through addiction or criminal behavior and that they don’t need somebody, once again, telling them what to do. She tries to empower women by helping them create their own recovery path. Bettye also believes that spirituality is an important part of recovery. Spirituality, to her, can be many different things for many different people and her part in treatment is to help her clients define spirituality for themselves. For Bettye, people who have addictions or who are headed towards addiction have to be dealt with as individuals.

Bettye does think that AA and NA groups have positive aspects that are helpful to clients. She believes that these groups offer clients a sense that they are not the only ones in this ship and that others have been worse than them and have

moved on. She also sees the slogans as positive because, through sheer repetition, they begin a cognitive restructuring process.

Bettye's treatment planning is dictated by the criminal justice system. She is mandated to use cognitive behavioral treatment by contract and works with probation officers and judges who order her clients to attend AA and NA whether the programs fit for them or not. She often tells her clients to attend the groups and get what they can from the experience while working with them to find their own recovery path which they can pursue after they are off probation.

Bettye sees many changes in the substance abuse field. She believes that substance abuse counselors are evolving different philosophies that have helped immensely. She thinks that the field is becoming better at spirituality and has moved away from "shoving religion" down people's throats to helping clients explore what spirituality means to them. She believes that substance abuse counselors are placing more responsibility on the clients to make their own choices. Bettye thinks counselors have become better at starting where their clients are rather than where we think they should be.

Bettye appears to be influenced by her own recovery and research on addictions. She feels her beliefs are validated by research and believes that others in the field practice substance abuse counseling in a way very similar to hers.

### Participant 8

Pam is a recovering substance abuse counselor who has worked in the treatment field for 10 years. Pam had significant knowledge about alcoholism and recovery prior to entering the field based upon her experiences growing up in an alcoholic family as well as her own recovery. Pam's family alcoholism includes both of her parents and two of the six children; of these family members only one sister is not in recovery.

Pam's own recovery journey began when she became pregnant for her first child. She reports that she made it through the pregnancy with only a few binge-drinking episodes by "white-knuckling it." Following the birth of her child, she began drinking again but states that she very quickly fell back into an abusive pattern. Pam made a decision to check herself into treatment after realizing that if she continued with this pattern she would lose her marriage and child, both of whom were very precious to her. With her husband's full support, Pam entered into a 28-day program that was based upon the principles of AA. It was after this traditional treatment that Pam's recovery took some nontraditional turns.

Pam followed up on her treatment recommendations and began attending AA; however, she quickly found that the treatment recommendations were not feasible. She was a young mother with a child to take care of and a husband who frequently worked out of town, taking with him the family's only car. She remembers the treatment center's recommendation: that she attend 90 meetings in 90 days, but wondered how she was supposed to go to AA meetings, drive there

without a car and find childcare for her baby. At this point Pam came to a conclusion, "This isn't working; something has to change." Pam decided to seek her own path to recovery, a path that would eventually lead her to the group Women for Sobriety. It was in this group that Pam found the support and validation she was seeking. Not only did this group provide day care, but also the philosophies seemed more holistic and more in tune to her needs. What particularly impressed her about this group was the way in which they introduced themselves at the beginning of the meeting. Instead of stating their names and saying "I am an alcoholic," which traditionally happens in an AA group, they would instead state their names followed by, "I am a confident, capable, and caring person." For Pam, who states her self-esteem was "down the dumper," this positive identification was an uplifting experience.

Pam continued to attend one AA meeting per week as well as Women for Sobriety weekly when she became pregnant with her second child. The response she got from the two groups regarding her news was very different. Women for Sobriety celebrated her pregnancy and the fact that she would be alcohol free throughout the pregnancy. Her AA group informed her that she was "on the road to relapse," and warned her "you're not supposed to make any life changes for a year." Pam left the AA group and never returned.

Pam entered the field of substance abuse treatment through a series of events beginning with a program in her church. This program provided training to parishioners to enable them to work with fellow parishioners in an outreach

program. Pam completed the training and began working with the alcohol-related problems that were referred to her. This work eventually led her to apply for, and get accepted into, the Master of Social Work program at the local college. Although she stated an interest in substance abuse treatment, the social work program's philosophy was to place students in areas other than their interest areas to provide them with a well-rounded education. Pam did not receive any formalized substance abuse training at the college but did submit a thesis on the topic of women in recovery. By the time Pam entered the field as a substance abuse counselor, she had been sober for 6 years.

Pam is aware of the disease concept but states her opinion that it is too simple. She believes alcoholism and addiction are much more complicated than allowed for in this concept. She strongly believes that substance abuse can be a secondary issue to other problems, especially for women. She acknowledges the role that dual diagnosis, both mood disorders and personality disorders, can have on addiction and believes that treatment must attend to these co-occurring disorders from the onset. She reports that she works closely with local psychiatrists so that she may refer clients for medication consultations. Pam believes that people can and do stop drinking on their own. This belief has been validated by experience; she watched her mother do it but does not understand how she did it successfully.

Pam does not base her treatment plans on any one philosophy. When she works with clients she draws them a map with "using land" on one end and "recovery land" on the other. Between the two points she draws in AA, NA,



Rational Recovery and Women for Sobriety and tells her clients the path that they choose doesn't matter, all that matters is that they travel from point A to point B. She lets them know that her own journey has involved different tools acquired in different places including AA, Women for Sobriety and her church.

Despite her experiences in AA, Pam maintains a belief that this is a good program that can help many people. She believes that millions of people have gotten sober through AA and the availability of meetings is high. She is adamantly opposed to forcing people into attending any group. She believes self-help groups should be just that: self-help. In her opinion, it should be not something therapists should be forcing on clients. Pam sums up her treatment philosophy in these words: "This is their work that they have to do. I think we, as a group here, we focus on what's best for the clients because they're the ones that have to get through treatment, not us."

Pam's beliefs are validated through her practice. She has spent most of her career working with two difficult populations, economically disadvantaged women and anti-social men housed in federal prison. To Pam it is obvious that one treatment will not fit both of these groups because "the whole mindset is different." Pam believes that substance abuse counselors need to look at the whole picture and the whole person when doing treatment planning.

### Themes

Several themes emerged while reflecting on the narratives. The strongest theme that presented was the continuing belief among the participants that

alcoholics and addicts cannot moderate their use of substances and cannot quit using willpower alone. A second theme that emerged was the movement from a traditional to a nontraditional belief system among the participants. A third theme was the power of peer influence in the challenge of beliefs systems. Each of these themes will be further explored in the following section.

### Moderated Drinking and the Use of Willpower

The belief that alcoholics and addicts cannot quit on their own and cannot learn moderated drinking was a widely held belief among all participants to varying degrees. When participants were asked whether or not they would work with a client towards a moderated drinking goal, the majority of them would do so, but only to help the clients realize for themselves that the goal was not possible. One participant stated he would pursue this with clients but saw his job as playing “devil’s advocate” along the way, starting with gentle confrontation leading to more direct confrontation down the road. Many participants would attempt to dissuade their clients from the goal or attempt to get the client to try abstinence first. Most of the participants saw the use of moderated drinking as a goal as a way to get beyond clients’ denial and help them see that they are addicted to substances and cannot control their use of chemicals.

Six of 8 participants believe that people who can quit with the use of will power alone or can learn to moderate their drinking or drug use were never truly addicted. The remaining 2 participants expressed some limited doubt. The 2

substance abuse counselors who have experienced drinking problems in the past most notably display this belief. Both of these participants describe a past pattern of drinking which was problematic for them. One admits that he would have been diagnosed by professionals as alcohol dependant had he sought help at the time, and the other continues to struggle with whether or not to self-label himself as alcoholic. Both participants believe they are not alcohol dependant based on their belief that if they were dependant they could not have made the decision to change their pattern of drinking and become the social drinkers that they are today. One of these participants expressed his belief that “if a person is really not addicted, then they can control their drinking” and that “there is a difference between addiction and abusive drinking.” The other participant believes he was able to pull away from the substances before becoming dependant because he did not have the environmental stressors to push him over the edge into addiction.

Other participants expressed their belief that alcoholics cannot stop drinking on their own or learn to moderate their drinking in various ways. One participant believes there is an invisible line that, once crossed, makes it impossible for the person to stop using on his or her own or become a moderated user. Despite this belief, he gives several examples of people he has known who have returned to a moderated drinking pattern following treatment for alcohol dependence, noting that they seem to be doing so without causing further problems. Another participant believes that once people develop an “obsessive-compulsive relationship” with a chemical they cannot stop using or become social users again.

Of all of the participants, only 2 expressed some doubts regarding this belief. Both of these participants were nontraditionally based and both are in recovery. One of these participants expressed the belief that people can stop an abusive pattern of drinking to return to a social pattern and that it “probably happens more than what we think.” She goes on to state that many college students would be considered alcoholics “based on our testing equipment,” but that she would not necessarily diagnose them as alcoholic regardless of what the test said. She believes some of these college students will grow out of their drinking patterns and others will go on to become alcohol or drug dependant.

The other participant stated that she believed that people could stop drinking on their own because she watched her mother do it but stated, “I still don’t understand it.” While she believes that people can stop on their own or mature out of their abusive drinking patterns, she also states that people who mature out of addiction or abusive drinking are people that don’t have addictive personality patterns.

#### Movement From a Traditional to a Nontraditional Belief System

The movement away from the traditional belief system appears to be a continuum with participants sharing commonalities with those who are placed close to them on this continuum. The continuum appears to range from participants who believe that there is one answer to the etiology of addiction and one best treatment to those who believe there is no one answer and no one best treatment.

The participants on one end of the spectrum, those maintaining the highest reliance on AA principles in their treatment, can be characterized as maintaining the belief in the disease concept and a belief that there is one best treatment. Both of these participants believe AA, combined with therapy, is providing the best treatment and the best results. At the same time, both of these participants acknowledge that AA is limited for some cultural groups and that they need to approach counseling with women in AA somewhat differently to make up for these cultural shortcomings. Both participants, while expressing doubt about alternative groups, were willing to send participants to different groups if they thought that it would help. Only one of these two participants was willing to use a probation officer to leverage clients into more intensive treatment than what they wanted; the other was against forcing clients into treatment or groups they did not want to be a part of.

Both of the traditional participants are grounded in their beliefs by powerful experiences. For one participant, learning the AA principles and concepts introduced spirituality into her personal life. She continues to be a strongly influenced by this spirituality today. The other participant entered into recovery using the AA principles and groups.

Both traditional participants feel isolated in private practices and report that they have little knowledge of what is going on in the field of substance abuse. Both participants have a tendency to dispute research or new ideas. One participant maintains a belief that there are only two theories about addiction, the disease

concept and the morality model. She acknowledges that she is unaware of any other models. This participant acknowledges that there may be breakthroughs that happen but doubts that it will “undo what we have already learned.” The other participant is aware of new research but states that she has “never wavered in my beliefs,” and that when colleagues challenge her beliefs systems, they end up agreeing to disagree.

Participants who fall into the middle of the continuum, between traditional beliefs and nontraditional beliefs, realize there are different methods available to reach recovery; however, they maintain that there continues to be one best method. One of these participants, who described his treatment as being based on AA principles, does not believe in the alternatives available. He states he would not refer a client to a moderated management group because he believes the risk for self-destruction is too high. He also does not like to refer clients to rational recovery and states that what he has seen in these groups so far is “overridingly negative.” Despite his reluctance to use alternative groups, he maintains a belief that not all clients are alike and that one treatment will not fit all.

Participants further into the middle of the continuum also believe in AA to varying degrees. They are more apt to find alternative groups based upon the needs of their clients. One of the participants believes that his or her clients should belong to some type of group that deals with addiction issues; the other 2 participants were willing to work with family, friends, or churches to form a support system for their clients. Participants in the middle are focused on client needs but generally rely on AA principles and groups as a first choice. One of these participants stated he liked

the principles of the rational recovery group and felt that this group fit in with his theoretical orientation of reality therapy. Another participant states he works with clients from a solutions focused perspective.

All of the participants in the middle of the continuum are against forcing clients into treatment plans or groups. They are more likely to develop treatment plans with their clients based on where their clients see themselves and their needs. Three of the 4 recognize that this is a change in their beliefs and treatment practices and remember a time when they also believed that there was “only one answer, AA.”

One of the participants specifically remembers what influenced him to question his beliefs about substance abuse treatment. The influencing force turned out to be, ironically, the investigator herself. The participant, through a previous work site, knew this investigator. He remembers beginning to doubt his beliefs based upon a conversation between him and the investigator that had taken place over 5 years earlier.

I remember a long time ago we had a conversation in your office and you made one statement during this conversation that has affected me rather deeply in a real positive way over the years. And that was that you thought that way more people got sober without using treatment or AA or anything, than the other way around. And I thought, boy, that's not my experience, you know, I don't see that. But that was really good for me in the long run because I think it really caused me to re-evaluate this traditional old, get sober first and then your mind will clear and work the steps, and jump through the hoops, is that really necessary in most cases? I think it's helpful in many cases but I think that that conversation we had really has made me question my beliefs about things over the years.

Two of the participants in the middle of the continuum state that their clients heavily influence them. Both of these participants state that their belief system has

changed over time from listening to and learning from their clients. Both of these participants have learned over time that no one system works for all of their clients.

One of the participants in the middle is influenced by research. He has completed university level training in substance abuse and continues to avidly pursue current trends in research. He is also a recovering person but did not disclose if his recovery experiences influences him in his belief in AA's efficacy.

The 2 participants at the nontraditional end of the continuum believe there is no one answer and "there probably never will be." They do not favor one treatment group or method but base treatment plans on the needs and preferences of their clients. They both indirectly question the disease concepts; both believe that co-occurring disorders can be primary and that clients may be abusing substances as a means of self-medicating. Both believe that a lack of coping skills contributes to the development of addiction. Both participants at the nontraditional end of the continuum believe that moderated drinking and spontaneous remission may be possible; however, they remain skeptical.

The nontraditional participants share two powerful influences that impact their belief systems: both went through AA based treatment programs for their own recovery and both felt the program did not fit for them. Additionally, both have been involved in university-level classes or research that validated their beliefs prior to entering the substance abuse treatment field.



### The Power of Peer Influence

A subtle theme that emerged among all participants was their perception that their beliefs and treatment planning fall into the norm of beliefs and treatments practiced by the majority of substance abuse counselors in the field. Both of the traditionally based participants feel isolated in private practices but believe that “we are pretty much doing the same stuff” as their peers. They maintain a belief that research will not come up with anything that will be significantly better than what is already known. One of the traditionally based participants continues to believe recovering counselors who recovered using AA principles dominate the field and that this substantiates the power of the program.

Nontraditionally based participants, when asked about changes they see going on in the treatment field today, responded with answers which indicated that all felt that the majority of substance abuse counselors were moving in the same direction in which they themselves were going. An example of this is the substance abuse counselor who takes pride in his person-centered treatment plans. When asked what changes he saw taking place in the substance abuse treatment field, he reported his impression that the substance abuse field is being positively influenced by the mental health system that has brought a focus on client-centered treatment planning. Another nontraditional participant who is focusing her treatment on working with co-occurring disorders believes that “anti-depressant medication and dual diagnosis is very big right now, we’re taking it more seriously.” This same

participant reports that another change in the field is the attitude of “whatever works for the client is being accepted more.”

Four of the participants from this study came from two different agencies. All of these participants placed on the continuum directly beside their co-worker. It was noted during the analysis that participants who worked directly with another participant shared many commonalities in their beliefs and treatment planning. One participant, who was the only person interviewed from her agency, reports that her agency as a whole maintains similar beliefs and that she and her co-workers frequently meet to discuss cases and new ideas. It was her belief that everyone in her agency believes and practices in much the same way.

### Research Questions

This study set out to answer several questions regarding the belief systems of both recovering and nonrecovering substance abuse counselors. These questions and the results found in this study are reviewed in the next session.

1. How do substance abuse counselors form their beliefs regarding substance abuse and substance abuse treatment? Who and what influenced substance abuse counselors' view of etiology and treatment of substance abuse?

Substance abuse counselors form their initial belief systems based on a combination of personal experiences and training. The majority of the recovering participants learned these traditional beliefs while in treatment for their own addictions. The 3 of 4 participants who shared their recovery experiences stated they

had received substance abuse treatment in a 12-step based recovery program and attended AA for a year or more following treatment. These participants all state they learned the disease concept while in treatment.

All of the nonrecovering participants recall learning traditional concepts in much the same way as the recovering counselors, by watching the films, reading treatment center materials, and attending trainings after they were hired in their first positions as substance abuse counselors. Several of the participants report receiving training or reading various authors who substantiated the traditional belief system including Claudia Black, Terrence Gorski, Dr. David Ohms, and James Lee. Two of the nonrecovering participants had some personal experiences with alcoholism and addiction prior to entering the field through family histories.

The traditional belief system, which all the participants formed, was validated by the treatment centers in which the participants were either hired as substance abuse counselors or attended as part of their own recovery. The participants in this study have subsequently moved various distances away from some of these traditional beliefs. Some of the traditional beliefs continue to have a strong hold today.

2. Have substance abuse counselors changed their beliefs regarding etiology and substance abuse treatment over time?

Substance abuse counselors are in the process of changing their belief system. The traditional belief system promulgated by AA was based upon the disease concept and the opinion that 12-step programs were the only effective

means of treatment and recovery from addictions. The beliefs systems of the participants in this study formed a continuum of beliefs from the traditional belief system to a nontraditional belief system.

Four of the 8 participants retain a belief in the disease concept. Traditionally oriented participants retained their belief in the disease concept. One of the traditionally based participants stated:

I don't have a problem with the disease model; I think it's very useful. I think it helps people a lot. I mean there's an incredible amount of shame to deal with; I think people need some way of understanding that this is not something they chose and to be able to do some forgiveness about how they got to where they're at and I think the disease model does it for them and that's great. I don't think I would change very much of that.

One of the participants in the middle of the belief continuum compares alcoholism to diabetes: "It has all the same symptoms of any other disease, progressive and fatal and chronic." Another states his belief in the disease concept in his comparison of alcoholism to cancer.

I think the only people who can be recovered are maybe those who never had the disease. Like they try to do the same thing with cancer. I think most cancer survivors would not say the word recovered because for the rest of their life they're going to try to practice, try to monitor and live a life that pays attention to if any of these signs or symptoms recur quickly so if that happens it could be treated. I don't think it's any different than that. You can't find it, the cancer cells, but it has to be there somewhere. I think they will they figure it out to some day but not in my lifetime.

Four of 8 participants indicated some movement away from the disease concept. Two of these participants felt that the disease concept was too simple of an explanation. One of these participant states:

I think it's much deeper or it's more of a genetic thing than just the disease concept. The concept that I learned it was too simple; I think it's much more complicated. I guess that would be the best way for me to describe it.

One of the participants shared his belief that environment plays a substantial role in the addictive process. Two of the participants believe that other issues can be primary and can contribute to the development of an addiction, especially in women. Two of the participants discussed the abuse of alcohol and drugs as a means of self-medicating the emotional pain of mood disorders.

3. What are substance abuse counselor's current views on substance abuse and treatment?

The treatment of substance abuse appears to be evolving away from traditional practices. One of the most notable changes is in the use of force to put clients into treatment, accept the traditional 12-step program, or go to AA or NA meetings. Only one participant stated a willingness to use a probation officer's leverage to put clients into more intensive treatment than they wanted. Most of the participants were against forcing treatment or meetings on any client. Those participants who are the most nontraditionally oriented are not only against using force to put clients into treatment or into meetings, but have also become vocal opponents to this practice with probation officers and judges. One of the participants shared his response to probation officers who order their charges into AA or NA meetings:

You don't go there [to AA or NA], you don't have it, you've not been in the field, you just got your degree from Western, and you're going to tell me that they need to do that? Why? Are you trying to screw them up on purpose?

The participants in this study are moving away from a “one size fits all” treatment and attempting to bring new methods and self-help treatment groups into their practice. One of the traditionally based participants has added family therapy and acupuncture to her treatment regime. Many of the participants state that they practice from a theoretical orientation including cognitive behavioral, solutions focused, and reality therapy. All of the participants, to varying degrees, are willing to work with groups other than AA or NA if their clients might benefit from it. All of the participants are moving towards a client-centered approach to treatment.

There also appears to be a movement away from the treatment of substance abuse as a stand-alone, primary issue. All but the most traditionally based participants will work concurrently on issues identified during assessment such as mood disorders, coping skills, and relational issues. All the participants saw value in evaluation of mood disorders for medication as a means of helping the clients to maintain their sobriety.

4. If the belief system has changed over time, what influenced this change?

The change from a traditional belief to a more nontraditional belief takes place over time and is a two-part process. The beginning of this process involves an activating event that causes the participants to doubt their belief that there is only one route to recovery. This activating event appears to be idiosyncratic. For 1 participant the event was a discussion of addiction with a co-worker, for 2 other participants it was their personal experiences of attempting to recover using a 12-step approach only to find that it did not fit their lifestyles. One participant began to

doubt based upon years of experience in the field and his observation that one treatment model was not working for all of his clients.

For the participants who retain traditional beliefs, there appears to be a lack of an activating event. Both of the traditionally based participants talk about working in isolation and not having knowledge about what is happening in the substance abuse treatment field. These participants work in private practices with higher functioning clients than would typically be seen in a nonprofit organization. It is highly probably that the AA and 12-step model treatment is effective treatment for the clientele that they serve. These participants were more likely to refute new information or theories.

Once participants have begun to doubt the belief that there is only one route to recovery, they are forced to seek out new answers. If there is no one treatment, what are the other choices? Following the activating event, the participants appear to become increasingly open-minded and willing to attempt new approaches. The three most nontraditionally based participants sought out research by focusing their studies at the university on substance abuse treatment. Other participants began experimenting with different methods and groups.

The greatest influence in the retention or change of the belief system appears to be peer influence. All of the participants in this research have the perception that their peers are practicing in much that same way that they are practicing. When participants were asked what changes they see happening in the substance abuse treatment field, all replied with an answer which indicated their belief that the

treatment field was moving, or not moving, in the direction which they themselves were going. Traditional participants felt the practice of substance abuse has changed very little, nontraditional participants believed the field was changing in ways that were consistent with their own new practices.

Participants who worked in the same agency displayed a great deal of consistency in beliefs with their participating co-worker. One participant reported that her beliefs were consistent with those of her co-workers:

We bring, and this is what our weekly clinical is about, "This is going on with this client and I'm struggling, has anybody got any ideas on what I can give that person to do." So we kind of laugh and work together, with each other because the other thing is that some therapists work harder than the client and I don't do that anymore which is hard but I won't work harder than my clients because this is their treatment plan, you know. This is their work that they have to do. And I think, as a group here we focus on what's best for the client because they're the ones that have to get through treatment, not us.

The combination of an activating event to set into motion doubt and the influence of peers or a perception that others in the field share their beliefs appears to start substance abuse counselors on a path to nontraditional beliefs. Traditionally based counselors appear to lack an activating event or do not have peer influences available.

5. If the belief system has not changed over time, how does the counselor integrate contradictory research or challenges by the managed care system into his or her belief system?

The traditionally based participants do not appear to integrate contradictory research. One of the traditionally based participants was not aware of new research



or theories. She indicated that she was unsure of alternative theories regarding etiology aside from the medical model and the view of addiction as being a moral issue. This participant states:

I'm not saying that there aren't breakthroughs that happen, anything can happen, but I don't think they're going to undo what we've already learned. I would be really suspicious of something that couldn't take into account what we already know.

The other traditionally based participant refutes research or opinions that contradict her beliefs. Challenges by her peers do not alter her views. She states she has read the controversial works of Stanton Peele but considers him "kooky." She later goes on to say that she considers the work of Terrence Gorski to be more relevant.

One of the traditionally based participants felt that the managed care system was hurting substance abuse treatment. She states:

In the broad spectrum of things I think that treatment is deteriorating. The dollars disappear and as the stays get shorter people are not getting the help they need. It's very, very sad. It's very hard to watch. You know this brief therapy just doesn't cut it with addiction. People need lots of time to get well with lots of support.

Several of the nontraditionally based participants felt that managed care had brought some positive changes into the field. Three of the participants felt that managed care is forcing the substance abuse treatment field into greater professionalism. One of these participants reports that the agency where he works had become professionally staffed with master's level, credentialed substance abuse counselors early in its history. He feels this has contributed to the clinically oriented, nontraditional treatment beliefs prevalent at the treatment center today.

6. Are the belief systems of recovering and nonrecovering substance abuse counselors different? Does one group hold more traditional beliefs than the other?

This research indicated there was a difference in recovering and nonrecovering counselors in terms of their belief systems. Three of 4 of the nontraditionally based participants in this study were all recovering counselors; however, it is noted that 2 of the participants were women who did not feel that the 12-step model was effective treatment for them. The third recovering participant works in a treatment center that is research oriented. The holding or changing of the belief system appeared to have more to do with an activating event and peer influence than with recovery status. Recovering counselors are as amenable to changing their belief systems regarding etiology and treatment as their nonrecovering peers.

7. Are belief systems different based upon the level of care that the substance abuse counselor is providing (inpatient vs. outpatient)?

In this study, level of care was not associated with a traditional or a nontraditional belief system. What appeared to influence the belief system was the amount of interchange and peer influence available at the different treatment sites. Treatment sites that provided a forum for counselor exchange of information and treatment ideas appeared to facilitate a change in the belief systems, while those working without significant interaction had a tendency to retain more traditional beliefs.

## Summary

Substance abuse counselors are in the process of changing their belief systems. The belief system regarding substance abuse treatment now forms a continuum between traditional beliefs and practices to nontraditional beliefs. Substance abuse counselors begin to change their beliefs based upon an activating event that causes them to question the traditional belief system. The belief that they begin to question is whether or not there is one way or one answer to recovery. Once counselors experience doubt in the efficacy of 12-step principles to treat all people, they are forced to seek out new theories and methods of treatment. This process of doubting and seeking new answers moves substance abuse counselors away from a traditional view of substance abuse treatment towards the use of new and varied treatment methods. Movement away from traditional beliefs is strongly influenced by peers in the treatment field.

Although substance abuse counselors are moving away from traditional views of substance abuse treatment, they still maintain a belief that alcoholics or addicts cannot quit abusing substances on their own, or learn to use substances in moderation.

These findings will be further discussed in the following section.

## CHAPTER V

### DISCUSSION AND CONCLUSIONS

#### Introduction

This chapter will discuss the findings of this study and its implications for the substance abuse treatment field. The first section of this chapter will explore the changing belief systems of substance abuse counselors from a social psychology perspective. The following sections will review the results of this study, comparing themes with previously conducted research on differing belief systems between recovering and nonrecovering counselors, the acceptance of moderated drinking as a treatment goal, and acceptance of the disease concept. The final section will discuss recommendations and areas for further study, followed by final reflections.

#### Discussion

##### Beliefs

The original members of Alcoholics Anonymous formed the traditional belief system regarding substance abuse treatment in 1939. This belief system has been propagated throughout the years by substance abuse treatment centers that based their treatments on the 12 steps and principles of AA. This study indicates that this belief system is in the process of change. The belief systems of substance abuse

counselors today form a continuum between traditional beliefs and practices to nontraditional beliefs.

In 1939 the first publication of *Alcoholics Anonymous*, commonly known as the big book, was printed and distributed. This book was instrumental in launching a belief system that would be prevalent in substance abuse treatment for over 60 years. In chapter 5 of the big book, the following passage is written:

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. (Alcoholics Anonymous, 1939, p. 58)

This passage had become a mainstay belief in substance abuse treatment: the belief that there is only one answer to recovery from alcoholism and addiction. Adherence to the 12-step program and philosophy has been the cornerstone of substance abuse treatment since the first treatment centers began to open.

The findings of this research indicate a movement away from the belief that there is one answer and one best method of substance abuse treatment. Substance abuse counselors are moving from this singular belief system to a continuum of beliefs that range from the traditional beliefs to a nontraditional belief system.

At one end of the spectrum are substance abuse counselors who continue to maintain a traditional belief system. They believe the AA program and principles is the single best program for helping alcoholics and addicts into recovery. Other substance abuse counselors are moving away from these traditional beliefs. Some

counselors believe that AA and 12-step programs continue to be the best treatment available but also acknowledge that the program may not be the most effective treatment for all individuals and are willing to explore alternative groups and methods. Substance abuse counselors on the nontraditional end of the continuum believe there is no singular best treatment for substance abuse. These counselors develop treatment plans specific to their clients that may include a multitude of resources including family, friends, and churches and may not include AA or 12-step work at all.

The movement away from the traditional belief system begins with an activating event that is idiosyncratic to the counselor. This activating event produces doubt regarding the truth of the traditional belief system. Activating events can include a controversial conversation with a co-worker, reading controversial research, a realization over time that the 12-step program is not equally effective for all clientele, or personal experiences with substance abuse and recovery that does not fit the traditional beliefs of treatment or the disease model.

Once an activating event has occurred to produce doubt regarding the traditionally held belief, the substance abuse counselor is forced to seek out alternative explanations, methods, and groups. If there is no longer one best answer, new answers need to be sought out and investigated. This produces movement away from the traditional belief toward a nontraditional belief system that may include changes in treatment planning and delivery of substance abuse services.

Peer influence appears to be an important factor in the changing the belief systems of substance abuse counselors. According to Bar-Tal (2000), group beliefs change through a process of negotiation in which group members, group leaders, the intellectual community, media, and out-of-group members take part. This study found this debate of beliefs taking place between peers in substance abuse counseling centers. Study participants who shared a work site with another participant demonstrated conformity with each other's belief system. Another of the participants also mentioned the process of sharing information with peers within the agency setting.

According to a study done by Bar-Tal et al. (1999), when people become aware that the majority of their group members share their beliefs, they feel more confident in the belief and reported a greater self-satisfaction as well as sense of similarity with group members. While beliefs are changing regarding substance abuse treatment, counselors in this study maintain a perception that the majority of their peers in the substance abuse treatment field believe and practice substance abuse counseling in ways similar to them. Although the participants in this study did not have knowledge that others share their belief system, their perception that they share these beliefs proves to be equally powerful.

The substance abuse counselors in this study who continue to maintain a traditional belief systems are not only isolated from peer influence but also have their beliefs anchored. McGuire (1999) identified that linking a belief to an individual's already accepted values, other valued beliefs, or to valued groups greatly reduces

the chances that the individual will change the belief. In this study, both of the traditionally based substance abuse counselors had their beliefs anchored in other powerful beliefs. For one of the counselors, it was her strong belief in the healing power of spirituality that she learned while working with the 12-step model of treatment. For her, spirituality has become an essential component to her work with all her clients. The other traditionally based counselor credits her own recovery to a 12-step program and AA groups.

Managed care systems may be contributing to the change in the belief system. The entrance of nonrecovering scientist-practitioners into the field may be impacting the traditional belief system by creating doubt. These practitioners may not be as anchored in the traditional belief system as counselors who have successfully recovered using a traditional approach. This infusion of scientist-practitioners into the field has likely contributed to the debate of beliefs within the field that ultimately leads to change.

#### Beliefs of Recovering Versus Nonrecovering Counselors

This study concluded that there is no difference between recovering and nonrecovering counselors in regard to their amenability to change of their belief systems. The capacity to change the belief system appears to be influenced by the combination of personal experience, peer influence, and research. The findings in this study were consistent with results of studies done by Sorenson (1998) and Stoeffelmayer et al. (1999). In her 1998 study, Sorenson concluded that both



recovering and nonrecovering subjects are equally open to viewing alcoholism in nontraditional ways, a finding substantiated in this study. Stoeffelmayr et al. found that being in recovery was associated with more varied treatment techniques and a broader range of treatment goals.

The results of this study indicated that 3 of the 4 recovering substance abuse counselors maintained the highest level of nontraditional beliefs of all of the counselors interviewed. It is noted that 2 of the 4 recovering counselors had personal recovery experiences that were different from the traditional treatment models. Additionally, all of the nontraditional recovering counselors had received university level training prior to their entry into the substance abuse treatment field.

Two studies were found that contradicted the results of this research. The study by Moyers and Miller (1993) indicated that high scorers on the disease model beliefs subscale were more likely to be in recovery themselves and showed less flexibility in setting treatment goals for clients in an analog task. These findings may be an accurate reflection of the belief system that was operative at the time the study was undertaken, approximately 10 years ago. The change in the belief systems of substance abuse counselors has taken place over time and is a gradual shift. The difference in the results in these two studies may further validate the changes taking place in the substance abuse field.

The second contradictory study was conducted by Crabb (2000), which found that recovering counselors were more likely to base treatment on the 12-step model and have abstinence as a treatment goal. Nonrecovering counselors had a

tendency to recommend treatment based upon the preferences of the client. The contradictory results between this study and the present study could be explained by the small sample size used in both.

### Moderated Drinking as a Treatment Goal

Although there is movement away from the belief that there is one best answer and treatment method, one traditional belief remains strong: that alcoholics and addicts cannot quit drinking or abusing substances with the use of willpower alone, nor can they ever become moderated drinkers or social users. This belief also has beginnings in the big book of *Alcoholics Anonymous*.

Moderate drinkers have little trouble in giving up liquor entirely if they have good reason for it. They can take it or leave it alone.

Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason—ill health, falling in love, change of environment, or the warning of a doctor—becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention.

But what about the real alcoholic? He may start off as a moderate drinker; he may or may not become a continuous hard drinker; but at some stage of his drinking career he begins to lose all control of his liquor consumption, once he starts to drink. (*Alcoholics Anonymous*, 1939, p. 20)

The findings in this study indicate that this belief remains strong among substance abuse counselors. The belief which continues to be widely held is that if alcoholics or drug addicts can quit abusing substances on their own or if they successfully become moderated drinkers, then they were never real alcoholics. This belief is most clearly seen in the continued nonacceptance of moderated drinking as a treatment goal. While all of the substance abuse counselors in the present study

were willing to make moderated drinking a goal in treatment, none of them believed it would be successful if the person were truly alcoholic. Moderated drinking as a goal is more often used as a method to break through denial, a means of proving to a client that moderated drinking is not an option through the experience of an attempt at control.

The difficulty of breaking away from this belief is in the circular nature of the logic. Individuals who have been given the diagnosis of substance dependence, who successfully stop abusing alcohol and return to moderate drinking, can easily be said to have been misdiagnosed. The subjective nature of diagnosing substance dependence was demonstrated in this study. Given identical criteria in a written scenario, 1 of the counselors diagnosed the individual as alcohol abuse episodic, 2 of the counselors diagnosed alcohol abuse, 3 diagnosed alcohol abuse with a rule out of dependence, and 2 of the counselors diagnosed alcohol dependence. Without definitive diagnostic criteria, the belief that alcoholics or addicts cannot quit using on their own or become moderated users cannot be proved or disproved.

This study found moderated drinking as a treatment goal to be acceptable only as a means of proving that moderated drinking is not possible for most substance abuse clients. This view of moderated drinking was consistent with the majority of the counselors interviewed, regardless of recovery status or the level of treatment where they were employed. These findings are somewhat contradicted by a study by Wallace (1994), which indicated there were no differences between college educated and noncollege educated treatment professionals in their

willingness to consider moderation goals; however, treatment professionals who were recovering from substance abuse tended to adhere to the abstinence philosophy. The results of this study are not completely contradictory. All of the substance abuse counselors participating in this study were willing to consider moderated drinking as a treatment goal; however, the majority of them did not feel the goal would be attainable.

The results of this study are consistent with the findings of a study conducted by Rosenberg and Davis (1994). This study indicated that moderate drinking is almost uniformly unacceptable as a treatment goal in residential alcohol service agencies, but that almost half of responding outpatient programs reported it acceptable for at least a minority of their clients. The results of the present study remain consistent with the belief that if a person is not truly an alcoholic, they can moderate their drinking. Those individuals who would be considered alcohol abusers rather than alcohol dependent would be more likely to be in treatment in an outpatient setting versus an inpatient setting.

#### Acceptance of Disease Model

The results of this study found that substance abuse counselors are changing their beliefs regarding the etiology of substance abuse. While counselors in this study did not directly state any alternative theories, several of the less traditional counselors expressed doubt that the etiology could be as simple as the disease model concept. Some counselors felt other factors including environmental influence, lack

of coping skills, or the need to self medicate a mood disorder could also be a factor in the development of substance abuse problems. In the present study, recovering counselors were less likely to endorse the disease model than nonrecovering counselors. These findings are neither confirmed nor disconfirmed by Humphreys et al. (1996), who did not find a statistically significant relationship between being in recovery and endorsing the disease model.

### Recommendations

Substance abuse counselors' beliefs regarding substance abuse treatment are changing. While counselors are moving away from the belief that there is one best treatment, the problem becomes one of finding alternatives.

The emphasis today in a managed care health system is focused on outcome measures. Treatment centers that can demonstrated a high degree of effectiveness in their treatments are more likely to obtain and retain contracts to provide mental health and substance abuse services. Substance abuse treatment centers that offer a wide variety of services and person-centered planning to their clientele are likely to demonstrate high outcome measures. There is a financial incentive for substance abuse treatment centers to remain innovative and to offer a variety of methods to clients seeking solutions to substance abuse problems.

The participants in this study mentioned several alternative groups including Women for Sobriety, Rational Recovery, and 16 Step Programs. These alternative programs have remained a secondary resource after AA and NA in terms of referrals

from treatment centers. For these groups to become a viable resource for persons seeking alternative paths to recovery, they need to be recognized and supported by substance abuse treatment centers. Treatment centers often allow space in their facilities for support groups to meet; however, these groups have generally been limited to those with a 12-step program. If alternative groups are given equal opportunity for space and time, these groups can grow and become as available to clients as the AA and NA groups are today.

Peer pressure was found to be an influence in the change of beliefs of substance abuse counselors in this study. According to Bar-Tal (2000), the changing of group beliefs depends on various factors including the availability of information, the type of pressure to conform, and the availability of communication channels among the group members. A free flow of information, low pressure to conform, and a wide availability of communication channels facilitate belief change within the group. Treatment centers seeking ways to bring innovative thinking and ideas into the centers can utilize peer influence by developing forums within the agency for the free exchange of information among the substance abuse counselors who work there. These forums can provide the impetus for change and allow new information regarding research and etiology to become general knowledge among staff. As staff members change their belief systems, treatment centers can also begin to expand their capacity to provide varied treatment methods to its clientele.

### Suggestions for Further Research

Further research needs to be initiated regarding moderated drinking and the successful use of willpower by individuals to stop substance abuse. The belief that alcoholics or addicts cannot return to moderated use or stop their use altogether without treatment remains strong among substance abuse counselors. Research is needed to determine how many persons have successfully quit drinking or learned to moderate their drinking. How severe was the addiction of those who have successfully quit on their own or who have become moderated drinkers? Are there factors other than severity of addiction which determines who can successfully quit or moderate their use? What are the methods those individuals who choose to change use to stop their abusive use patterns and return to social use?

A conclusion of this study is that substance abuse counselors begin to change their belief systems in response to an activating event. Further investigation into these triggering events may be warranted. What are triggering events? Can triggering events be instituted or manipulated?

The philosophy of the substance abuse treatment center as well as the center's ability to provide a forum for the exchange of information impacted the belief systems of the counselors who work there. How does treatment center philosophy impact the belief systems of its counselors? Are substance abuse counselors attracted to specific treatment centers because they reflect their own treatment philosophy, or do they have a tendency to take on the group beliefs after they are hired? Do treatment centers hire substance abuse counselors based upon a

similarity of treatment philosophy between the counselors and the center? The complete impact of the treatment center's philosophy on the individual beliefs systems can be further explored. Peer influence inside the treatment centers also has an impact on the belief systems of those that work there.

Further research is needed to determine how effective peer influence is in regards to changing the belief system. How does peer influence change beliefs? Can treatment centers use peer influence to foster new ideas and growth in treatment? How effective is peer influence in maintaining a belief system or resistance to change?

Finally, further exploration can be done to determine the belief systems of substance abuse counselors nationwide. Are the findings in this study consistent on a nationwide level? Are belief systems different in specific geographic areas of the United States? If changes in the belief systems happen across the United States, in what regions do these changes appear to originate? How does a change in beliefs spread from one region to another? Are some sections of the United States more nontraditional than others? The answers to these questions can provide a means of communicating new thinking and innovation across the nation.

### Final Reflections

This study set out to take a snapshot of substance abuse counselors' belief systems today to determine if traditional beliefs were changing and, if so, what was causing this change. In the course of this study, eight substance abuse counselors



were sought out and interviewed. These counselors freely volunteered time from their busy schedules to meet with the investigator and share their wisdom and experiences in an open and honest manner. It is the final conclusion of this study that, if the counselors interviewed for this study are representative of substance abuse counselors in practice today, the substance abuse treatment field will continue to move forward led by highly dedicated professional people. Whether the counselors interviewed were traditional or nontraditional in their belief systems, all demonstrated a high degree of caring, knowledge, and empathy for their clientele. The field of substance abuse treatment is in excellent hands.

**Appendix A**

**Protocol Clearance From the Human Subjects  
Institutional Review Board**



## WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: March 19, 2002

To: Suzanne Hedstrom, Principal Investigator  
Ann Crabb, Student Investigator for dissertation

From: Mary Lagerwey, Chair

A handwritten signature in black ink that reads "Mary Lagerwey".

Re: HSIRB Project Number: 01-12-05

This letter will serve as confirmation that your research project entitled "Substance Abuse Treatment: Substance Abuse Counselors' Belief Systems and How these Beliefs Impact Treatment" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 19, 2003

**Appendix B**  
**Protocol for Demographics**

### PROTOCOL FOR DEMOGRAPHICS

1. How old were you on your last birthday?
2. What is your ethnic background?
3. What is your highest educational degree?
4. What year did you graduate and from what university?  

Bachelors:	Masters:	PhD or EdD:
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5. What field of study did your degree come from, i.e., Counseling, Psychology, or Social Work?
6. How many years' experience do you have in substance abuse treatment?
  - Methadone or harm reduction clinic?  
years: \_\_\_\_\_
  - Detoxification center?  
years: \_\_\_\_\_
  - Inpatient or residential program?  
years: \_\_\_\_\_
  - Intensive outpatient program?  
years: \_\_\_\_\_
  - Outpatient program?  
years: \_\_\_\_\_
  - Private practice outpatient  
years: \_\_\_\_\_
7. Have you worked in counseling outside of substance abuse? What other kinds of populations have you worked with?  
years: \_\_\_\_\_
8. What kind of training have you received in the field of substance abuse? Was this during your Master's degree or post degree?

## **Appendix C**

### **Scenario**

### Scenario

The client is a 31-year-old Caucasian divorced male who is sent in by his probation officer. He arrives early for his appointment and is appropriately dressed. He exhibits an open and friendly manner and is cooperative throughout the interview. He speaks in a manner which is indicative of an Attention Deficit Disorder which the client confirms has been medically diagnosed in the past. It is believed that the information given by this client is accurate since he presents details that would not be helpful in getting a lesser diagnosis had this been his goal.

The client states that approximately two weeks ago he was feeling depressed since it would have been his 10th wedding anniversary had he and his wife not divorced 6 months previously. He decided to visit some friends to help with the depression and began drinking with them around 5:00 PM. The client states he consumed approximately one pint of whiskey in the next four hours. Just prior to leaving his friends house, he remembers drinking 2-3 shots in quick succession. The client was pulled over by police for a broken headlight less than 10 minutes later. His blood alcohol content taken by a breathalyzer was .17. The client states he passed the road sobriety test but feels this was due to the fact that the last shots he had consumed had not yet had an effect on him.

This client has two previous arrests: In high school he was arrested for possession of marijuana, and in 1998 he states he was arrested for possession but denies the marijuana was his since he had already quit using this drug at the time of

his arrest. He states immediately after the arrest he was drug tested and the test came back negative for cannabis.

**Drug and alcohol history:**

This client gives his current consumption as drinking up to 4 beers per incident, approximately 20 of 30 days. He reports that he has maintained this level of consumption for the past 10 years with the exception of the past 5 months following his divorce. Client states that following his divorce he would drink on a daily basis until he became intoxicated and would pass out, usually between 10–12 beers. Client no longer uses marijuana but states his heaviest usage of this drug occurred when he was a teenager when he would use 30 of 30 days, 2–3 joints per episode.

This client began marijuana use at age 13 and became a heavy user by age 15. He states the marijuana helped him slow down his mind and that he was able to concentrate after smoking. The client reports his favorite activity while high was reading. The client states that after a while he stopped questioning his marijuana use and that it became a habit. He states he was confronted by his wife regarding his drug use approximately 2 years ago and made a decision to attend an Intensive Outpatient Program to stop his drug use. He reports he successfully quit smoking the marijuana but did not like the AA and NA groups he was forced to attend as a part of treatment. He does not wish to return to these groups.

The client feels his alcohol consumption has never equaled his use of marijuana. The highest usage given, 10–12 beers daily, occurred following his



divorce when he was having difficulty dealing with the emotional crisis. He states he reduced his alcohol consumption when confronted by a recovering friend regarding his increasing reliance on the alcohol. This client believes that he has been addicted to marijuana in the past and that he now has an abusive relationship with alcohol. It is his goal to learn to control his drinking and to continue to abstain from marijuana use.

This client shows no history of substance abuse in his family of origin. His employment history shows steady employment with the exception of a job loss due to marijuana approximately 3 years ago. The client states he has several recovering friends and enjoys the support of his family of origin and his friends.

**Appendix D**  
**Protocol for Scenario**

### Questions for Scenario

1. Given the limited information you have been presented what would be your likely diagnosis in this case?
2. If this were your client what level(s) of treatment would you recommend?
  - a. Detoxification?
  - b. Inpatient treatment?
  - c. Intensive Outpatient Program?
  - d. Outpatient treatment?
  - e. Relapse prevention only?
3. What do you see as the primary issues for this client or the issues that you would make a priority in treatment? Do you consider denial an issue for this particular client?
4. What do you believe should be the treatment goals for this client?
5. This client states he has received previous treatment in the past and that it included AA/NA attendance that he did not like. How would you handle this issue? Would AA/NA attendance be part of your treatment plan?
6. This client would like to make moderated drinking his goal. How would you handle this?
7. Do you consider this client's Attention Deficit Disorder to be related to his substance abuse problem? Do you feel it needs to be addressed in treatment? If so, how?
8. Without treatment what do you believe would be his likely future?

**Appendix E**  
**Semistructured Interview Questions**

## PROTOCOL FOR SEMISTRUCTURED INTERVIEW

I would like to ask you a series of questions regarding your beliefs about substance abuse, recovery, and treatment. This interview will cover such things as educational training prior to entering the field, your training when you entered the field, and your experiences with some of the changes and challenges you have seen in the substance abuse field in the years that you have worked in this area. Since I will be asking you about your beliefs, if you should become uncomfortable with what I am asking or do not want answer any question, please let me know immediately so that we may move on to another section. Would you like to continue?

What circumstances brought you into the field of substance abuse treatment?

If I were to have asked you before you started in the field to describe an alcoholic or drug addict would you have said? What did you think caused someone to abuse alcohol or chemicals? What was this belief based on?

Prior to entering the field had you ever heard of AA or NA? What was your understanding of AA or self-help groups?

What types of formal training or information did you receive before entering the field? Did any of this information conflict with your prior beliefs about substance abuse or what substance abuse was?

When you first entered the field of substance abuse treatment how were you trained? Who trained you? What did they teach you?

When you were trained, were you trained in the disease concept or introduced to a variety of concepts? What is your understanding of the disease concept? Over the years that you have worked in this field how has your belief about the etiology of substance abuse changed? How has it changed? Since you have been in the field, have you been introduced to other concepts which led you to doubt your previous concepts?

Some researchers have theorized that some alcoholics or drug addicts will “mature out” of their addiction. What are your thoughts on this?

It is sometimes said in AA/NA that alcoholics or drug addicts cannot quit drinking or using with willpower alone. What are your thoughts on this?

**What are your views on spirituality and recovery?**

**How important do you believe it is to work a 12-step program in recovery or to attend AA or NA groups while new in recovery? In your opinion, are AA/NA group meetings effective in helping clients to quit their substance abuse? What are the components of these groups that you see as very helpful? What are the components of these groups that you see as unhelpful or even harmful? When do you believe a recovering person should stop attending these groups?**

**What is your response to a client who states that he or she does not want to attend AA or NA meetings for one reason or another? What recommendations do you make for those who believe they would not benefit from this group?**

**What are your views of moderated drinking as a goal for your clients? If you had a client who was a poor candidate for moderated drinking but was insistent that this was his or her goal, how would you handle this?**

**What are some of the changes you see going on in substance abuse treatment? What do you believe is bringing about these changes? Question regarding dual diagnosis.**

**If an empirical study was published that directly challenged your beliefs regarding the etiology and treatment of addiction, what would be your response?**

**What was this interview like for you?**

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