THERAPISTS’ KNOWLEDGE AND APPROACHES TO TREAT CLIENTS WITH
SUBSTANCE DEPENDENCE

A Project

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by

Cristina Whitlock

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SUBSTANCE DEPENDENCE

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by

Cristina Whitlock

Approved by:

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Date
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Dale Russell, Ed.D., LCSW

Division of Social Work
Abstract

of

THERAPISTS’ KNOWLEDGE AND APPROACHES TO TREAT CLIENTS WITH
SUBSTANCE DEPENDENCE

by

Cristina Whitlock

The purpose of this study was to determine what knowledge mental health therapists’
have on substance dependence and what treatment approaches they utilize to treat clients
with co-occurring disorders. A qualitative content analysis design was used in this study.
A purposive sampling method of 10 mental health therapists participated in this study.
There were three main themes: 1) The majority of therapists relied on the DSM-IV as the
only tool for assessing substance dependence; 2) Therapists referred a co-occurring
substance dependence diagnosis to either a county agency or a private treatment center;
and 3) Overall, 12-step programs were recommended by mental health therapists;
however, there was ambivalence in what has been perceived as the program’s religious
and/or spiritual orientation. Implications for social work practice and policy relative to
this study are explored. The need for future research is also discussed.

_______________________, Committee Chair
Maria Dinis, Ph.D., MSW

_______________________
Date
DEDICATION

I would like to dedicate this project to my mother and father, Piera Lusso Whitlock and Lawrence Fulton Whitlock. You have always supported and encouraged me to persevere and succeed: you have been my strongest advocates. Without your belief in me, your inspiration, and emotional and financial support, I could not have accomplished my goal of obtaining a Master’s Degree in Social Work. During my darkest moments throughout this endeavor, you were the light that gave me hope. I love you both more than words can express.
ACKNOWLEDGEMENTS

I am extremely grateful for having had the opportunity to be a part of the 2012 Rural Cohort Program. I am thankful for those individuals who encouraged me to succeed and cheered me on from the beginning to the end.

This project would have not been a success without the participation of the mental health therapists who were more than willing to participate in this research project. All of the participants were open to discussing a topic that can be adversarial in nature. I appreciated their candidness and cooperation.

I would like to express my sincere appreciation to my thesis advisor, Maria Dinis, Ph.D. I have been exceedingly impressed by her patients and dedication in assisting and supporting me throughout this process. The speed of her responses, the depth of her feedback, and her determination to see me succeed will always be remembered and appreciated.

This endeavor was not undertaken alone and could have not been accomplished without the love and support of my family: my mother and father, Piera Lusso Whitlock and Lawrence Fulton Whitlock, and my sister and brother-in-law, Monica Whitlock Caston and Darriel Caston. Thank you all for your endless reassurances, your love, patience, and always welcoming me home.
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Chapter 1

THE PROBLEM

Introduction

The National Service on Drug Use and Health estimate that in any given year, 5.6 million adults in the United States have co-occurring mental illness and substance use disorder (NYDMH, 2006). In clinic samples, as many as 40-60 percent of patients presenting in mental health settings have a co-occurring substance use diagnosis, and 60-80 percent of individuals in a substance dependence setting present mental health diagnosis (Drake, 2006). The co-occurrence of mental health and substance use diagnoses is also commonly referred to as “dual diagnosis.” Dual diagnosis became recognized in the 1970s, and in the 1980s. At this time, mental health clinicians were debating which should be treated first: mental illness or substance dependence (Van Wormer & Davis, 2008). Although dual diagnosis has been a topic over the past 30 years with clinical evidence showing the benefits of treating both diagnoses concurrently, there continues to be a lack of awareness, identification and treatment of substance dependence with mental health therapists.

The author chose mental health therapists and their level of knowledge on substance dependence as the symptoms of a mental health diagnosis can easily be mistaken for substance dependence. Conversely, symptoms of substance dependence, at any stage, can be misdiagnosed as a mental health diagnosis. The absence of assessing, diagnosing and treating substance dependence can aggravate a mental health diagnosis, making each more difficult to diagnose (NIAAA, 1996). If a therapist has little to no
knowledge of substance dependence, the impact can be detrimental to the client’s success in recovery and subsequent quality of life.

Chronic drug abuse may occur in conjunction with any mental illness identified in the American Psychiatric Association’s Diagnostic and Statistical Manual of mental Disorders IV (DSM-IV). The National Institute of Mental Health (2007) lists the most common serious mental disorders associated with chronic drug abuse:

Table 1
Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial personality disorder</td>
<td>15.5%</td>
</tr>
<tr>
<td>Manic episode</td>
<td>14.5%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>10.1%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>04.3%</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>04.1%</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>03.4%</td>
</tr>
<tr>
<td>Phobias</td>
<td>02.1%</td>
</tr>
</tbody>
</table>

Background of the Problem

In the late 1970s, practitioners increasingly became aware of the relationship between mental health disorders and substance use and the implications of these disorders occurring together. Initially, it was the association between depression and substance abuse that was striking and therefore became the subject of several of the early studies (Daley & Moss, 2002). In the 1980s and 1990s, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with
substance abuse, not only depression (SAMHSA, 2011). Studies conducted in substance abuse programs typically reported 50 to 75 percent of clients having some type of co-occurring disorder (COD), not one that would be considered “serious” mental disorder (Bride, MacMaster & Webb-Robbins, 2006; Kessler et al., 1996; Regier et al., 1990). Studies conducted in mental health settings reported that between 20 and 50 percent of their clients had a COD disorder (Bride, MacMaster & Webb-Robbins, 2006 Kessler et al., 1996; Regier et al., 1990).

The multiple studies conducted during the 1980s and 1990s reflect the extent to which COD was established as a clinical concern. At the same time, these studies varied in that they were conducted in an array of settings and on a range of sample sizes from 68 to 20,291. Measures and criteria for determining a disorder were diverse and reported on different time periods (i.e., either Lifetime, current, or both) (SAMSHA, 2011; Drake, et al., 1998). This range in reporting can produce differing estimates and suggests a need to address the broad range of survey and analytic strategies used to generate estimates (research). Work to clarify the type, severity, and clinical significance of COD contributed to an improved understanding of the phenomenon and treatment.

Researchers not only found a link between substance abuse and mental illness, they also saw the connection of the dramatic impact the complicating presence of substance abuse can have on the course of treatment for mental illness. As an example, one study of 121 clients with psychoses found that those with substance abuse problems spent twice as many days in the hospital over the two years prior to treatment as clients without substance abuse problems (SAMHSA, 2011; Crome, 1999; Menezes et al.,
Researchers have clearly demonstrated that substance abuse treatment for clients with co-occurring mental illness and SUD can be beneficial, including individuals with serious mental illnesses.

In recent years, dissemination of knowledge on COD has been widespread with numerous and hundreds or articles have been published, training seminars, and conferences (Horsfall, Cleary, Hunt, & Walter, 2009). In spite of these developments, individuals with COD commonly appear at facilities that are not prepared to treat them. The individual may be treated for one disorder but not the other, often going between one type of treatment to another. Many times, these individuals fall through the cracks as counselors and/or mental health therapists are unsure what to do with an individual with a COD. Therefore, this population becomes an oversight and receives no treatment in either system of care. These are the individuals who have a higher rate of homelessness, multiple visits to the Emergency Room, become victims of violence or participate in illegal activities resulting in incarceration and possible institutionalization within the criminal justice system (Van Wormer & Davis, 2008).

Although there have been studies, discussions, articles, books, conferences, etc. that have considered the implications of COD, there appears to be a lag in available resources. The assessment, diagnosing and treatment of COD are not consistent or uniform across the various disciplines and intuitions that directly interact with COD (Polcin, D. L. (2000). Educational institutions that decide the curriculum mental health professionals complete in their masters or Ph. D. programs does not appear to give adequate education and/or training to substance dependence itself nor to the co-
occurrence of SUD and mental health disorders. This is also reflected in each state’s licensure standards, requirements and processes not responding to the needs of this large population (Drake, Mueser, Brunette & McHugo, 2004).

Statement of the Research Problem

Individuals with COD may not be aware of the co-occurrence. Individuals with COD who are unaware, may believe they are experiencing a mental health issue and seek help from a mental health professional overlooking the SUD. Many of these individuals could be experiencing problems that negatively impact almost every aspect of life such as housing, relationships, employment, medication maintenance, physical problems, and possibly legal problems. Due to the negative stigma and stereotypes of substance dependence deeply rooted in our culture, individuals with COD may not consider SUD to be an option. The ability for mental health therapists to proficiently assess, diagnose, and treat or refer co-occurring diagnosis is essential. There is a lack of information regarding social workers or mental health therapists’ knowledge of substance dependence and treatment approaches.

Purpose of the Study

The purpose of this study is to explore mental health therapists’ knowledge of substance dependence, treatment and resources. This includes their knowledge of diagnosing substance dependence, collaboration with substance abuse specialists, primary care physicians, their belief in substance dependence as a disease, and their opinion of 12-step programs. Common themes will be identified and analyzed in the hopes to further
discourse on the necessity of mental health therapists’ understanding of substance dependence.

Research Question

This study examines the following question: What knowledge do mental health therapists have of substance dependence and treatment approaches for their clients with chemical dependence?

Theoretical Framework

There have been a number of barriers to providing treatment for individuals with COD, most specifically the substance dependence diagnosis. To understand the barriers and structures involved and the influence they have on the treatment of substance dependence, the author will use conflict theory.

Conflict theory is most often linked to Karl Marx and asserts social systems are not united and harmonious, but are divided by class, gender, race, and any other characteristics that reflect difference in social power (Johnson & Rhodes, 2010). According to this theory, problems are defined as social and structural rather than individual, and can only be resolved by social change, not individual adaptation. Conflict theory maintains it is continually what one group with power does to another group which has no power, whether in the name of physical or mental health, safety or security (Donovan, 2011). Ultimately the fight for equality is the elimination of subordination.

There are basic assumptions of conflict theory: society is perpetually in conflict which can explain social change; or that tradition and conflict are diverse enough for action to occur (Andersen, Logio & Taylor, 2008). The principle of conflict theory can
best be represented by a pyramid structure in which the elite dictate terms to the larger masses (Donnovan, 2011). All major institutions, laws, and traditions in the society are designed to support those who have traditionally been in power, or the groups that are perceived to be superior in society (Blau, 2007). This can also be expanded to include any society’s morality as well as their definition of deviance. Conflict theorists state that powerful people use prejudice and discrimination to hold onto their status and wealth in society by exploiting minorities (Donnovan, 2011). Conflict theory seeks to catalogue the ways in which those in power seek to stay in power (Hur, 2006).

Conflict theorists maintain that dominant groups have a disproportionate amount of power which enables this group to define what positions are socially rewarded, and which stereotypes and what discrimination benefit the dominant groups (Andersen, 2008). Among the stereotypes and those discriminated against, and other social groups (class, race, gender, etc.), there is a struggle for dominance. When conflict theorists look at society, they see the social domination of subordinate groups through the power, coercion and authority of dominant groups. The most powerful members of the dominant group(s) create the rules for success and opportunity in society, often denying subordinate groups the same successes, opportunities and access to resources. This continual succession of supremacy safeguards those in power to continue to monopolize control, influence, privilege and authority. Anything that challenges the control of the elite will likely be considered deviant or morally reprehensible (Andersen, 2008).

Early social workers recognized structural inequity and oppression but it has only been until recently that social workers have drawn upon conflict theory as a way to
conceptualize human behavior in the social environment (Johnson & Rhodes, 2010; Ryan, 1976). The development of empowerment theories utilized in the social work profession have their roots in conflict theory and have led to a renewed interest in using this theory as a way to explain social injustice and privilege. There are three issues basic to the understanding of empowerment theory. Empowerment is multidimensional in that it occurs within sociological, psychological, economic, political, and other dimensions (Hur, 2006). Empowerment also occurs at various levels, such as individual, group, and community, by definition, is a social process because it occurs in relation to others (Hur, 2006, Page & Czuba, 1999; Peterson, Lowe, Aquilino & Schneider, 2005). Empowerment is a process that is fluid, often unpredictable, and changeable over time and place.

Application of Conflict Theory

The focus of the present study is to better understand mental health therapists’ knowledge of substance dependence and treatment approaches for their clients who have a COD that includes substance dependence. Although it may appear that conflict theory is not related to the research question, the entire mental health and service delivery systems are embedded in a capitalistic system based on competition and conflict. Historically, conflict between mental health and substance abuse professionals has linkages to social, cultural, political, financial, educational, as well as training issues.

There has been a longstanding philosophical conflict between mental health and substance abuse treatment systems which is rooted in separate traditions, differing views of etiology, different treatment approaches, and separate administrative systems. Such
conflicts have led to competition between both systems for scarce funds for diminishing services for persons with dual diagnoses. Some examples of conflict is the ongoing argument between mental health and substance dependence professionals over which disorder, substance abuse, or mental illness is primary and which is secondary (Hamilton Brown, Grella & Cooper, 2002). Another example is the mental health perspective that substance abuse/dependence is a symptom of a mental health diagnosis not a disease. Substance abuse providers view a mental illness diagnosis as a symptom of substance dependence: once abstinence is achieved, the mental illness will cease to exist.

Definition of Terms

The following terms are used throughout this project and are relevant to the discussion of substance dependence and mental illness.

Co-occurring disorder/dual diagnosis. “The coexistence of diseases within an individual. Often the disease of its treatment influences the other disease or its treatment, especially if not identified. These terms are most commonly associated with a substance use disorder and mental illness” (Baker, 2003, p. 131).

Substance dependence. “Physiological adaptation to a psychoactive drug to the point where abstinence triggers withdrawal symptoms and re-administration of the drug relieves those systems. Psychological need for psychoactive drugs to induce desired effects or avoid negative emotions or feelings. Reliance on a substance or a compulsive behavior” (Inaba & Cohen, 2007, p. 576).
Disease concept. “Substance dependence is a chronic, progressive, relapsing, incurable and potentially fatal condition that is mostly the consequence of genetic irregularities in brain chemistry” (Inaba & Cohen, p. 226).


Assumptions

The author makes the following assumptions: 1) mental health therapists’ with negative attitudes and beliefs towards individuals with an SUD have an adverse effect on the therapeutic relationship and the client’s treatment; 2) there is an absence of proficiency in assessing and diagnosing substance dependence; 3) there is the belief that substance dependence is not a disease; and 4) participants in this research are the experts in defining and describing their own practices.

Justification

The ethical principles outlined in the National Association of Social Workers (NASW) Code of Ethics (2009), make it clear that this study is in accord with the goals of social work practice, as "Social workers' primary goal is to help people in need and to address social problems" (NASW, p. 5). This study puts into practice the mission of social work as it elevates service to others above self-interest. This study addresses the significance of understanding the diagnostic and therapeutic needs of the substance dependent and dually diagnosed clients we serve. If social workers truly wish to assist their clients, there is a need to be able to assess a client for referral to appropriate
services, or if in a clinical setting, have the therapeutic and diagnostic skills to treat the client. Social workers must also be proficient in assessing an individual’s strengths and resilience capacities to be effective in this vulnerable population’s treatment.

Social workers have ethical responsibilities to their clients; one aspect of this is competence (NASW, 2009). According to NASW’s *Code of Ethics* “Social workers should provide services and represent themselves as competent only within the boundaries of their education, consultation, license, certification, consultation received, supervised experience, or other relevant professional service” (p. 8). This study asserts there is an ethical responsibility to practice only within our scope of practice and experience. In order for social workers to fulfill this responsibility, academic programs need to expand their curriculum to include a comprehensive chemical dependency program which is a requirement for graduation. At the same time, licensure boards need to have the same expectation and requisite for all mental health professionals working towards licensure and also as a condition to maintain their license.

The information gathered from the interviews with mental health providers may contribute to the body of knowledge to assist in the need for a chemical dependency program and competency as a requirement for the various mental health professionals’ academic programs.

**Delimitations**

Because this study is exploratory, its findings are limited to the subjects interviewed. The sample size is small—convenience and snowball sampling will be employed—of the specified population. The findings of this study cannot be generalized
beyond the subjects interviewed in this study, but may serve as a legitimate starting point for other studies of this nature.

Summary

In this section, the author discussed the background of the problem, the statement of the research problem, the purpose of the study, the theoretical framework, the definition of terms, the assumptions, the justification, and the limitations of this study. In Chapter 2, a review of the literature will be presented on the following thematic areas: historical background of substance dependence; diagnosing substance dependence; treatment of substance dependence, including 12-step programs; and mental health therapists’ beliefs of substance dependence individuals. Gaps in the literature will be addressed. Chapter 3 will include a description of the methodology used in this study. In Chapter 4, the data analysis will be presented. Finally, in Chapter 5, conclusions and implications of the study will be discussed.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

In this chapter, six sections of the literature will be reviewed. The first section is an overview of the historical background of substance abuse. The second section describes assessing and diagnosing substance dependence. The third section presents methods of treatment for co-occurring disorders, including 12-step programs. The fourth section describes recommended treatment modalities. The fifth section reviews some beliefs held by mental health therapists’ on individuals who are substance dependent. Finally, the sixth section addresses the gaps in literature.

Historical Background

The history of psychoactive drugs begins in prehistory and the Neolithic period (8500-4000 B.C.), when psychoactive drugs were accidentally discovered in plants and deliberately cultivated (Inaba & Cohen, 2007). In ancient civilizations dating back to 4000 B.C. – A.D. 400, the Sumerian, Egyptian, Indian, Chinese and South American civilizations used opium, alcohol, marijuana, peyote, mushrooms and cocoa leaves (Inaba & Cohen). In the middle ages, 400-1400, psychoactive drugs such as belladonna and psilocybin mushrooms were said to be used by witches and shamans for healing and spiritual reasons (Van Wormer & Davis, 2008). In the period of the Renaissance and Age of Discovery, 1400-1700, the ruling classes, merchants and governments controlled the trade routes of opium, tobacco, coffee, tea, and alcohol (Inaba & Cohen).
In the Age of Enlightenment, and the early industrial revolution, 1700-1900, new refinement techniques (opium to morphine), new methods of use (hypodermic needle), and new manufacturing techniques attributed to increased use, abuse and addiction (Inaba & Cohen, 2007). During this time in history, temperance and prohibition movements began to grow. The first of the temperance movements was the “Good Creature of God,” later known as the “Demon Drum” (White, 1998). William White suggests the publication, “The Mighty Destroyer Displayed,” written by Anthony Benezet in 1774, could possibly be America’s first text on alcoholism (White). One of the first temperance groups formed in the mid-eighteenth century was a 20 man group who met at the Chase Tavern on Lincoln Street, Baltimore, Maryland (White). In April of 1840, from this group came the recognized, Washingtonian Society. In 1934, Alcoholics Anonymous was formed by Bill W. and Dr. Bob which is currently the largest mutual help group.

In the twentieth century there was wider distribution, new synthetic drugs, extensive drug regulations and an increased legal and illegal use. Today, the use of club drugs may be declining, but an increase in prescription drug abuse increases. Inaba and Cohen (2007), suggest five historical themes of drug use:

1) The basic need for humans to cope with their environment and enhance their existence; 2) The vulnerability of brain chemistry to psychoactive drugs, behavioral addiction, and mental illness; 3) The involvement of ruling classes, governments, and businesses in growing, manufacturing, distributing. Taxing and prohibiting drugs; 4) Technological advances in
refining and synthesizing drugs; and 5) The development of faster and more effective methods of putting drugs into the body. (p. 2).

A brief history of treatment begins with temperance and mutual self-help groups, also institutions, i.e.; Asylums and designated hospitals for medical treatment. There were the temperance groups, for instance; the Washington Temperance Society in the 1840s; the Oxford Group in the 1920s; and Alcoholics Anonymous (AA) in the 1930s. AA is a spiritual program that teaches the 12 steps to recovery and is said anecdotally to be the most successful recovery system in history (Trice, 1981).

Eventually, the treatment of addiction consisted of medical and social interventions such as therapeutic communities, medical treatments in hospitals, free clinic approaches, outpatient clinics and 12-step fellowships. Addressing the social problems of addiction was focused on: (1). Demand reduction, prevention and treatment; (2). Supply reduction, prohibition, and stricter laws in relation to use; and (3). Harm reduction which can be medical or social techniques to reduce the physical and social damage caused by abuse and dependence (i.e. needle exchange and methadone maintenance) (White, 1998).

Currently, Inaba and Cohen, 2007, designate the seven treatment approaches to chemical and behavioral addictions currently being practiced or proposed:

1). The use of medications to lessen symptoms of withdrawal, cravings and promote short and long-term abstinence; 2). Diagnostic techniques to see the structural and physiological effects on the brain; 3). The development of effective tools in assessing clients and the interventions needed; 4). Increased emphasis on evidenced-based treatment and practices; 5). Research supporting coerced
treatment being as effective as voluntary treatment; 6) More funding to resources that have not proven to be effective; and 7). The continued conflict between the philosophies of abstinence-oriented recovery and harm reduction that still exist (p.117).

**Assessing Substance Dependence**

As the researcher has previously discussed, clients who have a mental illness are more likely to have a substance use disorder (SUD) than individuals who do not have a mental illness. Therefore, it is important that mental health therapists are knowledgeable about assessing for SUD whether in private practice or in a treatment setting (SAMHSA, 2009). There are assessments available for SUD as a single diagnosis or as a co-occurring disorder (COD). A mental health therapist ought to have access to and knowledge of the various assessments available for SUD independently or as a COD. The assessment is a tool to guide the therapist in choosing the most appropriate treatment for the client.

A comprehensive assessment includes a thorough substance use history as well as a review of medical, psychological, family, educational, occupational, legal, spiritual, interpersonal and recreational functioning (Daley & Moss, 2002). When a therapist is exploring the client’s specific types of substances used, the conversation needs to include substances used currently and in the past, the amounts used then and now (everyday, weekends), and how the drugs are administered (oral, injected, inhaled). Also important is what the client’s drug(s) of choice, the effect of the substance and what they like about
the effect. Likewise, finding out where they are getting their drugs and how much money they are spending on them daily, weekly and monthly.

Another part of the assessment is asking the client what negative consequences they have experienced because of their substance use. Areas to make inquiries are medical, emotional, academic, professional, family, social, legal, spiritual and economic (McLellan, Cacciola, Alterman, Rikoon & Carise, 2006). Part of the assessment includes asking the client what negative consequences they have experienced as a result of their substance use. Areas to make inquiries are medical, emotional, academic, professional, family, social, legal, spiritual and economic (Kinney, 2009). The most widely used tool for treatment planning and treatment efficacy is the Addiction Severity Index (ASI) (Perkinson, 2011). The ASI was first introduced in the early 1980s and has been widely implemented (McLellan, Cacciola, Alterman, Rikoon & Carise, 2006). The interview is a semi-structured interview that collects data from 7 areas: medical, employment, legal, alcohol, other drug-use, family-social functioning and psychological status (Perkinson). For each area there is a score indicating the severity of the problems in that area.

During an interview, the mental health therapist can assess a person’s psychological and psychiatric functioning to find out if a mood, anxiety, psychotic, personality, or other disorder is present (Department of Human Services Chemical and Mental Health Services Administration, 2009). The assessment is an instrument used to help the therapist determine treatment decisions and select treatment options that cater to
disorder is present (Department of Human Services Chemical and Mental Health Services Administration, 2009). The assessment is an instrument used to help the therapist determines treatment decision and select treatment options that cater to the specific needs of the client.

Attention should also be given to how the assessment is administered. Therapists need to be aware that the legitimacy of the assessment can be affected by such circumstances as the manner in which the questions are asked or instruction given in relation to what the client believes about how the information will be used, privacy, trust, and the rapport between the client and the clinician (New York Office of Mental Health, 2008). For the assessment to be as accurate as possible, it is important the therapist is sensitive to the ways in which culture may influence responses to inquiries. Cultural barriers may be an obstacle to recommended treatment need to be revealed (Daley & Moss, 2002).

There are numerous assessments available and many use similar formats. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), recommends an assessment organized around 12 specific steps to the process (SAMHSA, 2011). Part of the assessment is to obtain a detailed chronological history of past mental health diagnoses and the treatment modality used, especially prior to the onset of substance use. Another goal is to attain a detailed description of the client’s current strengths, supports, limitations and deficits. The final steps to the assessment process are to determine the stage of change for each problem and
to identify external possibilities which may help support treatment adherence (SAMHSA).

Diagnosing Substance Dependence

For many years there has been an attempt to classify mental and emotional disorders and illnesses. In 1952, the first edition of the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) was published (Inaba & Cohen, 2007). At this time and up until the DSM-III revision of 1980, substance dependence was considered a mental illness like schizophrenia and depression. In the latest edition of the DSM, the fourth edition revised in 2000, DSM-IV, substance dependence is considered a substance-related disorder not a mental illness and is divided into two general categories: substance use disorders and substance induced disorders.

The definition of substance use disorders include patterns of use and are divided into either substance dependence or substance abuse. Substance dependence is defined in the DSM-IV-TM as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (APA, p. 176). Substance dependence is also identified as the continued use of a substance which can lead to tolerance, withdrawal and incontrollable personal conduct (SAMSHA, 2011). In either substance abuse or substance, the symptoms must have persisted for at least one month or have occurred repeatedly over a longer period of time.

In the centuries before the classification of mental-disorders and substance-related disorders, substance dependence was primarily looked at as a moral failure, a character
defect and a mental sickness (White, 1998). Within the past 50 years, biological research, brain imaging techniques, epidemiological studies, and examination of the users’ environmental, psychological, and genetic histories has to some degree changed the societal view of substance dependence from a moral weakness to a medical disease.

Treatment approaches and Co-occurring Disorders

Traditionally, patients with COD have received treatment from two separate systems: mental health and alcohol and drug (AOD). This therapeutic model is known as the Parallel Model as both diagnoses are being treated independent of each other not integrated (Watkins, et al., 2001). For example, the SUD would be treated in the AOD system by an individual and/or a team of para/professionals in one setting, and the mental health disorder would be treated with by a therapist and possibly include a psychiatrist in a different setting. Interventions from two distinct systems can work; however, this increases the odds of noncompliance. Noncompliance can be attributed to client having to adjust to two treatment philosophies; develop separate relationships with at least two different treatment professionals, and possibly receive services at different locations (Perron, Bunger, Bender, Vaughn & Howard, 2010). Treatment philosophies and expectations between the two disciplines can contrast significantly, making the overall treatment difficult and confusing for the client.

Another traditional model is the Sequential Model which is stabilizing the most acute disorder first and then addressing the other disorder: again, separate treatment. As the researcher has previously indicated, chemical dependency and mental health disorders symptoms often overlap, therefore making it difficult to distinguish which disorder is
primary and which is secondary. Overlapping symptoms can put the client in a situation where she or he is being misdiagnosed and specific symptoms are not being addressed. It has been noted however, that the Sequential Model has been found to work in cases where the client’s psychiatric symptoms are stabilized, and from that juncture, the client participated in a structured SUD treatment program (Sterling, Chi & Hinman, 2010).

The ideal is for the client is to receive support and attention to both disorders simultaneously as well as having assistance with related problems: integrated treatment. Related issues can be primary support system, social environment, educational, occupational, housing, economic, access to health care, and interaction with the legal system. For the severely mentally ill diagnosed with a co-occurring SUD, integrated treatment is indicated to be the most appropriate (Perron, et al., 2010). Many of the severely mentally ill have more difficulty abstaining from a substance and therefore are not ready for abstinence-oriented treatment (Horsfall, Cleary, Hunt, & Walter, 2009).

Looking at treatment within the context of private practice, treating clients with COD can be complicated as the therapist is balancing both substance dependence treatment and mental health treatment. Essential for the therapist is attempting to understand COD from the perspective of the client and family, if the family is involved (SAMHSA, 2011).

Also important is building a therapeutic relationship and alliance with the client using an empathetic style not confrontational (Baker, et al., 2002). Compassion communicates a nonjudgmental acceptance of the client and their feelings and helps to build a collaborative relationship in which the therapist listens rather than tells, showing
empathy rather than contempt, and provides support throughout the therapeutic relationship (SAMSHA, 2011). The relationship also rests on cultural competency of the therapist and using culturally appropriate treatment methods. Cultural context is a significant factor in the assessment, diagnosis and treatment of clients of various groups, cultures or countries (CMHS, 2001). The therapist must recognize the importance of culture by acknowledging the client’s cultural strengths, a different value system, and the need to work on stigma reduction of mental illness and substance dependence with a culturally sensitive approach. More often than not, the maladaptive behavioral changes that occur in both substance abuse and dependence are considered highly undesirable in many cultures (SAMSHA).

It is essential for mental health therapists to recognize and deal with their clients’ chemical dependency problems and be prepared to offer a full range of treatment options, including support groups and 12-step programs (Kelly & Yeterian, 2009). Ideally, the therapist is aware of all the resources available in the client’s community: self-help groups, social services, case management, economic assistance, housing, vocational training, and any other resources helpful to the client’s wellbeing (Clear, et al., 2004).

Much of the information the researcher found for the treatment for co-occurring disorders is primarily applicable to organizational and agency systems of care as opposed to individual clinicians in a private practice venue. The author is going to present tools, strategies and guidelines for the treatment of co-occurring disorders.

DDRC Dual Diagnosis Recovery Counseling (DDRC) is considered an integrative approach that focuses on both psychiatric and substance use issues and the
interaction between these different types of disorders (Daley & Moss, 2002). The objective of this dual focused treatment is to reduce the chance of an untreated diagnosis increasing the vulnerability to relapse one another. DDRC can be applied to both individual and group settings and includes educational, motivational, cognitive and behavioral strategies. In the first stages of DDRC, the therapist helps the client accept both diagnoses and develop motivation to change.

Educating the client about COD and their specific mental health diagnosis is a part of the conversation. Discussing treatment, recovery and relapse from the perspective of the recovery model is another educational element which applies to both SUD and COD diagnoses. Part of the DDRC treatment modality is the client working towards achieving and maintaining abstinence from substance(s). For the client who is either unwilling or unable to work towards abstinence, harm reduction is indicated to reduce substance use and the exacerbation of issues impacted by SUD (Drake, Essock & Shaner, 2001).

The stabilization of acute psychiatric symptoms or a reduction in the severity of symptoms is secondary to maintaining SUD abstinence or harm reduction practices (Hendrickson, Schmal & Ekleberry, 2004). When the client has demonstrated stability with both the SUD diagnoses the therapist focuses on improving cognitive, behavioral and interpersonal coping skills and the ability of the client to manage the symptoms of both diagnoses as well as the problems contributing to or as a result of the COD. These skills give the client a foundation for positive lifestyle changes and insight into the
process of relapse, and the tools to recognize and prevent relapse for either the SUD or the mental health diagnosis (McGovern & McLellan, 2008).

Dialectical Behavioral Therapy (DBT), originally developed in 1993 by Marsha M. Linehan, Ph. D. for treating Borderline Personality Disorder, has been a recommended treatment modality for COD clients (Dexter-Mazza, Murray, Comtois & Linehan, 2008). DBT is a comprehensive outpatient program of individual and group skills training developed to enhance the client’s capability and motivation to change and teach skills that generalize to the social environment. The overall goals of DBT are to decrease the client’s interpersonal chaos, labile emotions, impulsivity, confusion about self, and cognitive dissonance (Koener & Linehan, 2000).

Teaching and increasing core mindfulness skills, interpersonal effectiveness, emotion regulation, and distress tolerance are also goals to be reached with DBT by teaching the client learn specific types of skills (McKay, Wood & Brantley, 2007). In the context of DBT, mindfulness skills are to help the client notice, define and become a part of their experience by doing this nonjudgmentally, and to recognize both the helpful and harmful aspects of a situation or behaviors. The focus is on the present not the past, and concentrating on what has worked, not on what is fair or right. Interpersonal skills are taught in hope of the client ending hopeless relationships, and resolving conflict early with others and self. An example of conflicts with self would be balancing priorities and demands and working on their communication skills so the client can obtain what she or he wants, but maintains self-respect (McKay, Wood & Brantley, 2007).
Emotional regulation skills help the client see, define, understand and manage their emotions (Koener & Linehan, 2000). Much of the focus of emotional regulation is on decreasing the client’s vulnerability to negative emotions by taking care of their physical health, taking their medication(s) as prescribed, eating a balanced diet, and staying off of drugs and alcohol. The final piece to emotional regulation is the client observing their emotions, not avoiding them, and realizing they are not defined by their emotions (McKay, Wood & Brantley, 2007).

Distress tolerance skills are integrated to help the client cope with painful events and emotions by distraction, self-soothing activities, and improving the moment with reflection (Dimeff & Lineham, 2001). Distraction is defined as using activities, thoughts, opposite emotions, helping others, and acknowledging that there are others worse off than self. Self-soothing activities are using the five senses such as listening to relaxing music, spending time outdoors and taking in the sights and smells. Improving the moment means to use imagery, prayer, reflection, etc. to focus on meaning (McKay, Wood & Brantley, 2007).

Cognitive Behavioral Therapy (CBT) is a therapeutic approach that has been used in the treatment of COD (SAMHSA, 2011). CBT seeks to modify negative or self-defeating thoughts and behaviors and works most effectively with individuals who are stabilized in the acute phase of their substance use and mental disorders. An underlying assumption of CBT is that the client systematically and negatively distorts her or his view of the self, environment and the future. Consequently, a major premise of CBT is that an individual’s thinking creates behavioral problems; therefore the clinician educates the
client about cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. CBT therapy is primarily oriented toward cognition and behavior, and it stresses the role of thinking, deciding, questioning, and re-deciding (Corey, 2009). CBT is a psychoeducational model which emphasizes therapy as a learning process, including acquiring and practicing new skills, learning new ways. CBT also prescribes new behavior for the client to practice. The approach is educational in nature, active, problem-focused, and time-limited (Corey).

The client is an active participant in CBT and the role of the clinician is primarily that of an educator (Hepworth, Rooney, Rooney, Strom-Gottfried & Larson, 2010). The clinician collaborates with the client or group to identify goals, the setting if applicable, and an agenda for each session. The clinician guides the client by explaining how thinking affects mood and behavior. For CBT to be effective, the client and clinician must develop rapport and a working alliance. The premise that underlies CBT is that behaviors associated with addictive behaviors are related to a person’s basic beliefs and automatic thoughts. At the most basic level, this can be seen in the immediate response that individuals have to the idea of a drink. The goal of CBT is to help people recognize their automatic faulty thought patterns, minimize them and replace them with effective beliefs (Corey, 2009).

As distortions in thinking are generally more severe in people with COD than SUD alone, individuals with COD need to learn specific coping skills to overcome the combined challenges of their SUD and mental health diagnosis (Naeem, Kingdon & Turkington, 2005). Coping Skills Training include teaching the client specific behavioral
and cognitive strategies. Cognitive strategies are used to manage urges and cravings, to identify early warning signs, and to reframe a client’s reaction to an initial relapse (Naeem, D’Arcy, Keegan & Senthilselvan, 2006).

12-Step Programs

Many mental health therapists and treatment programs have recommended 12-step programs as an adjunct to clinical treatment (Bogenschutz, Geppert & George, 2006). Alcoholics Anonymous (AA) is the most well-known and largest self-help program which has been the model for other 12-step programs. In the context of AA, the 12-steps are not a passive process, action is required. Although the goals of each individual may widely vary, simple abstinence to adopting a whole new way of life is the end of the continuum (Bogenschutz, Geppert & George). The 12-Steps of AA (Appendix B) provide a framework for achieving a productive life without the reliance on mood-altering drugs. The 12-Traditions of AA (Appendix C) define the principles of the organization as a whole, the purpose of the fellowship, and the code of conduct.

From AA’s perspective, people recover from alcohol dependence through a “spiritual awakening,” or “psychic change” as a result of a combination of various factors (Timko, Sutkowi & Moos, 2010). Some of these factors include working the 12-steps, having a sponsor, believing in a higher power and helping others (AA, 2001). Other elements may be at work such as the implied social component of AA meetings which may promote therapeutic elements through group dynamics, such as the installation of hope, vicarious living and modeling, and altruism (Yalom, 2005). In addition, empirical research on the mechanisms of change in AA highlights important cognitive, behavioral
and social factors associated with SUD remission (Kelly & Yeterian, 2009). Twelve-step programs similarly appear to activate the same change processes that are mobilized by many different types of professionally led treatment groups: coping, motivation, and self-efficacy.

Individuals with COD face a number of issues that complicate their participation in traditional 12-step programs (Bogenschutz, Geppert & George, 2006). For example, 12-step involvement for those who experience paranoia or social anxiety may make it very difficult for individuals with COD to participate in groups/meetings, especially when a confrontational style of interaction in used in many 12-step groups and vice-versa. These individuals may feel they have little in common with the non-mentally ill members of the groups. There is also much controversy in AA in particularly pertaining to prescription medication, mostly psychopharmacologic medication. Many AA groups and/or members view these drugs as mind altering and therefore not a part of sobriety. Unless an individual is abstinent from all mind altering substances, they are not considered sober or practicing sobriety (Timko, Sutkowi & Moos, 2010).

Mental Health Therapists Beliefs and Attitudes towards Clients with Co-occurring Disorders

A therapist’s attitude and perceptions are critical influences on the process and outcome of clinical interventions with individuals diagnosed with COD. Individuals with COD in pre-treatment circumstances can result in high levels of social and psychological impairment, non-adherence to medication (Richmond & Foster, 2003; (Gafoor & Rassool, 1998); relapse and hospital admissions (Rush & Koegl, 2008). In addition, there
is increased contact with the criminal justice system, high rates of suicide, homelessness, and aggression and violence (Richmond & Foster, 2003; Mueser, Drake & Wallach, 1998). As a result of these realities, many mental health providers’ view substance dependent clients by the negative stereotypes given throughout the history of alcoholism and addiction. Negative professional attitudes towards individuals with a SUD, has a direct impact on the efficacy of the care provided (Briggs, Magnus, Lassiter, Patterson & Smith, 2011).

The need for constructive professional attitudes is essential in building a therapeutic relationship and alliance with the client (Adams, 2008). Self-destructive behavior, such as substance dependence can provoke moralistic and stereotyping attitudes resulting in punitive, rejecting responses and interaction characterized by suspicion, mistrust and avoidance from the therapist as well as the client. Therapists need to be aware of any perceptions, attitudes and beliefs regarding mental illness and chemical dependency which can be an obstacle to providing the client with the appropriate care. Evidence indicates that professionals who hold negative attitudes towards substance abuse/dependent individuals often overlook the SUD and fail to initiate or refer that person to the appropriate treatment (Briggs, Magnus, Lassiter, Patterson & Smith, 2011).

Negative professional attitudes can originate from various sources, including a therapist’s lack of knowledge on SUD, frustration, and a sense of inadequacy in managing the difficulties presented by treating individuals with COD. Mental health therapists tend to regard clients with SUD less sympathetically than those clients with a psychiatric disorder (Daley & Moss, 2002). Academic programs for mental health
professions, Associate Clinical Social Workers (ACSW), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapists (MFT), Licensed Psychologists (Ph.D.) must move towards integrating SUD education and an understanding of the stages of addiction: experimental, recreational, use, abuse, and addiction. With a better understanding of addiction, mental health therapists may be able to view those with a SUD through a more positive lens.

Understanding the pathophysiological and psychosocial needs of addicted individuals and the role of stigma, myths, and misconceptions about addiction is an integral part the learning process. This insight would allow students the opportunity to become aware of their own attitudes, biases, and fears and to possibly address these in supervision. Managing countertransference is another consideration for a clinician: to be aware of a strong personal reaction and biases toward the client. The clinician should obtain further supervision where countertransference is suspected and may be interfering with therapy.

In order for an applicant to qualify for their license, The California State Board of Behavioral Health Sciences requires specific educational requirements in various areas, one of which is substance abuse and dependency. For example, an ACSW/LCSW applicant must have at least 15 hours of education in substance abuse and dependency; and MFT must have at least 10 hours, and a psychologist/Ph. D. are not required to have any hours of education in substance abuse and dependency (http://www.bbs.ca.gov/app-reg/lcs_requirement.shtml.).
Gaps in Literature

Limitations of mental health therapists’ knowledge and approaches to treating substance dependent clients generally revolve around the lack of the implementation of education standards and guidelines for assessing, diagnosing, and treating co-occurring disorders. This information if primarily targeted towards primary care health professionals rather than mental health therapists (Perron, Bunger, Bender, Vaughn & Howard, 2010). Consequently, the lack of implementation and education across disciplines can lead to inconsistent treatment guidelines and efficacy in treating substance dependence. In addition, mental health clinicians do not pay specific attention to socio-demographic and clinical indicators presented by the client (Rush & Koegl, 2008).

Since mental illness is significantly increased among people with substance dependence, many of these individuals seek treatment in a mental health venue (Petrakis, Gonzalez, Rosenheck & Krystal, 2002), it is imperative for mental health professionals to have clinical knowledge of substance dependence in order to integrate treatment for clients with both diagnoses in COD. COD are considered to be the rule rather than the exception when treating patients with a mental illness or substance dependence (Thylstrup & Schepelern-Johansen, 2009). Although there appears to be a large quantity of literature on treatment modalities for COD, because evidenced based research on COD is complicated due to inconsistency in research design and the quality of research procedures and data collection. There are no standardization of interventions (Thylstrup & Schepelern-Johansen).
According to Briggs, Magnus, Lassiter, Patterson & Smith (2011), given the substance misuse, abuse and dependence problems in mental health populations, mental health therapists require increased training and research. Both the American Counseling Association and the Mental Health Counselors Code of Ethics address the need of professionals to keep current with scientific and professional information (AMHCA, 2000). The Code of Ethics requests clinicians to be open to new procedures and maintain competence in the treatment of SUD (Briggs, et al.; Dar, 2006; Simoni, Wastila & Yang, 2006), and in 2009, the Council for Accreditation of Counseling & Related Educational Programs (CACREP) placed increased emphasis on addiction throughout its standards (Briggs, et al.).

Limitations were found in several areas one of which was psychosocial treatment of COD is being insufficient attributed to lack of retention in studies, small sample sizes and the small number of studies for COD (Hess, 2009). There are also limitations related to treatment and study attrition, outcome measurement, and treatment fidelity (Thylstrup & Schepelern Johansen, 2009). Although psychotherapeutic treatment for COD is a promising approach, there is not enough empirical evidence (Grant, et al, 2004). The types of substances used, settings and interventions were also found to be limitations. Additional limitations were lack of new treatment options for treating COD, and on-going studies (Conrod, 2005). Sample populations may not be representative of people with COD, therefore limiting generalizability (Bride, MacMaster & Webb-Robbins, 2006). Many of the populations studied are exclusively homeless individuals and individuals in state and or federally funded programs.
Another limitation is the validity of self-report data provided from individuals with severe mental illness (Hess, 2009). Validity can be affected by an individual’s denial or minimization of substance use, not seeing substance use related to poor judgment, and/or distortions from cognitive, psychotic and affective disorders (Bride, MacMaster & Webb-Robbins, 2006). Evidenced based research on COD treatment is often complicated due to inconsistency in research design and the quality of research procedure and data collection (Thyłtrup, Schelpelern Johansen, 2009). There is a lack of standardization of treatment modalities as there are many challenges by variety of treatment intervention and the lack of general consensus on specific treatment approaches such as treatment manuals and fidelity measures (Thyłtrup, Schelpelern Johansen, 2009). Mixed methods may produce data that highlights central issues such as using qualitative data to interpret statistical data and placing them in a social context (Flynn & Brown 2008). A more pronounced contextual focus on COD and treatment needs could add to the assessment and evaluation of current and needed treatment interventions, and further contextual insight in treatment dynamic sand their relation to treatment and efficacy (Thyłtrup, Schelpelern Johansen, 2009). Limitations are research strategies that do not encompass both quantitative and qualitative measures may add substantial information to further the development of existing and new treatment services (Flynn & Brown, 2008).

Although “emphasis” on SUDs was requested to mental health therapists’ associations, there has yet to be national educational requirements for masters’ mental health programs or licensure requirements. It is for this reason the author of this research
wishes to explore mental health therapists’ knowledge and approaches to treat clients with substance dependence.

Summary

In this section, the author discussed guidelines in assessing and diagnosing substance dependence, recommendations for treatment, including 12-step programs, and mental health therapists’ beliefs and attitudes towards clients with substance dependence. Gaps in literature were also presented. In the next chapter, the methodology is discussed.
Chapter 3

METHODOLOGY

In this chapter, the author explains the methodology utilized in this study. The following areas are addressed: the Research Question, Study Design, Variables, Study Population, Sample Population, Instrumentation, Data Gathering Procedures, and Data Analysis. Additionally, the procedures for the Protection of Human Subjects were reviewed.

Research Question

This study seeks to explore the knowledge mental health therapists have in determining and treating substance dependence. Therefore, the study investigates the following: What knowledge do mental health therapists have of substance dependence and treatment approaches to treat their clients with chemical dependence?

Mental health therapists’ knowledge and approaches to treat clients with substance dependence.

Study Design

This study design is a qualitative, utilizing content analysis methodology methods components were: qualitative content analysis interview.

Qualitative Content Analysis Approach

This approach is employed when the researcher intends to gain understanding and knowledge of the human experience. The qualitative research method attempts to tap the deeper meanings of particular human experiences and is meant to produce theoretically richer observations that are not easily reduced to numbers (Rubin & Babbie, 2008).
Generally employed methods for collecting data include unstructured or intensive interviewing, direct observation, and/or participant observation (Leedy & Ormrod, 2010).

Qualitative research is not standardized. The data is in the form of words, phrases, and text; therefore data analysis requires an interpretation on non-numerical research data in order to develop patterns of relationships, themes, or categories (Leedy & Ormrod, 2010). These patterns of relationships, themes, or categories derive from the research question, concepts found in the literature, verbiage utilized by participants, and ideas arising in the review of research data. Accordingly, qualitative researchers study their subjects in their natural settings, attempting to interpret phenomena in terms of the meaning people bring to them (Denzin & Lincoln, 2011).

Qualitative Interviewing

Qualitative research is a matter of going where the action is and to simply watch and listen. A lot can be learned by purely being attentive to what is taking place (Rubin & Babbie, 2010). Yet, qualitative research has the ability to have a more active inquiry, by asking participants questions when appropriate. Qualitative interviewing generally refers to in-depth, loosely or semi-structured interviews. This qualitative tool is used to encourage an interviewee to talk about a particular issue or a range of topics. This distinguishes it from survey-based interviews that tend to ask closed-ended questions and follow a more structured format to prompt specific information from the interview subjects (Creswell, 1998).

There are many advantages to using a qualitative interviewing research approach. Qualitative interviewing is particularly useful as a research method for accessing
individuals' attitudes and values—things that cannot necessarily be observed or accommodated in a formal questionnaire (Kvale & Brinkmann, 2008). Open-ended questions and flexible questions are likely to get a thought-out response than a closed question, thus providing better access to interviewees’ views, interpretations of events, experiences, understandings, and opinions. Additionally, social cues, such as voice, intonation, body language, and reactions of the interviewee can give a lot of additional information that can be added to the verbal answer of the question. Qualitative interviewing is especially a suitable method for accessing complex issues such as values by allowing interviewees to speak in their own voice and with their own language (Kvale & Brinkmann, 2008).

When done well, qualitative interviewing is able to achieve a level of depth and complexity that is not available to other methods, such as surveys. The non-standardized interview enables the researcher to become attuned to subtle differences in people's positions and to be able to respond accordingly (Kvale & Brinkmann, 2008). Thus, the researcher is able to use relevant follow-up questions or ask for clarification when found necessary. The information acquired from the qualitative interviews generally produces thorough comprehensive data.

There are also disadvantages to consider when using a qualitative interviewing approach. When using this approach, fewer participants are sampled; consequently, the input regarding the subject being studied is limited and not able to generalize the findings to the population being studied. The data collection process can be very labor intensive
and costly. Furthermore, the bias of the researcher can affect the design of the study, data collection, and interpretation of the research (Leedy & Ormond, 2010).

Content analysis is used as the particular method to report on the data obtained by means of interviewing. In basic terms the method is a coding process in which oral, written or other communication sources are organized according to some theoretical framework (Kvale & Brinkmann, 2008). Within the content analysis method there are two basic techniques. There is the latent analysis which categorizes the deeper meaning found within the content, and then there is the manifest analysis which categorizes the structure or surface data (Leedy & Ormrod, 2010). The content analysis method allows for qualitative data to be interpreted into a quantifiable form (Rubin & Babbie, 2008). The latent content analysis method in general works through an inductive approach in which an understanding emerges by organizing the content into themes (Creswell, 2008).

The application of content analysis to the data collected by qualitative interviewing presents the phenomena (Rubin & Babbie, 2008). Furthermore, it tends to offers a more efficient utilization in terms of money and time (Daniel, 2012). These advantages lend themselves due to the fact that content analysis can generally be performed without a lot of specialized training and can be recreated without having to acquire any new data (Leedy & Ormrod, 2010). One major disadvantage, according to Rubin and Babbie (2008), is the reliability of this method. An example of this is two researchers may arise with distinct themes even analyzing the same data.
Study Population

The study participants consisted of 10 individuals. The criterion was that participants were licensed mental health therapists, i.e.; Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), and Psychologist (PhD). All participants were licensed and practiced in the state of California. The actual population for this study consisted of 1 male and 9 females. The levels of education were 8 masters’ degrees: 2 LCSWs, 6 MFTs, and 2 PhDs. Participants ranged in age from 44 to 58. Years of experience in the field of mental health ranged from 2 years to over 25 years. Training level specific to substance dependence was inconsistent. The clinicians newest to the field had to have 10 -15 hours of specific instruction on substance dependence as a Requirement for licensure (California Board of Behavioral Sciences, 2012). The 2 psychologists had no requirement to satisfy prior to licensure.

Sample Population

The study used the purposive sampling method. Purposive sampling is called for when selecting study participants in the following three circumstances: 1) when it is necessary to interview difficult to reach and/or specialized population; 2) when the researcher wishes to study informative participants; and 3) when the researcher wants to identify interviewees linked to particular types of cases (Daniel, 2012; Tashakkori and Teddle, 2003). For this study, it was important to interview mental health therapists who were currently in practice in order to ensure that the facts attained were current and relevant.
The 10 individuals studied were either approached in person or sent a letter both which offered a flyer explaining the type of research study being conducted, its purpose, the prerequisites and request for participation. The 10 participants either approached the author in person or by phone to indicate their interest to participate in this study. Participation in this study was strictly voluntary. After being given information about the study, 10 of the 17 participants agreed to participate.

Instrumentation

The author used a single method design. The qualitative interviews were conducted as standardized, face-to-face, open-ended interviews with ten mental health therapists practicing in the state of California. The interviews lasted between 35 minutes to 55 minutes in length. The interviews were conducted at the convenience of the participants. The participants had the option to be interviewed either in their private office, over-the-phone or a location of their preference.

In preparation for the interviews, the author designed a standardized questionnaire consisting of ten questions. There was a dual purpose for utilizing the same four questions for all the interviews. First, to ensure all 10 interviews were conducted in the same manner ascertaining consistency and a thorough process. According to Denzin and Lincoln (2011), this consistency and thoroughness is useful when coding data, as it guarantees that complete data is collected from each subject. Furthermore, using the same order of questions assists the researcher with the organization and analysis of the data (Creswell, 2008). Second, a structured set of questions helped reduce biases on the part of the researcher. Using a standardized approach—in this case the same set of
questions—can restrict the natural conversation between the researcher and the subject and the researcher’s flexibility. Yet, because the questions are being asked in the form of an interview, the subject has the ability to add to their answers and the researcher has the flexibility to ask natural follow-up questions.

There are many advantages to using open-ended questions: the researcher is likely to get a more well-considered response; the questions allow for an unlimited number of different answers to the same questions; respondents are able to express their perspective using their own words; respondents are able to make inquiries for clarification (Lohr, 2010). Simultaneously, there are disadvantages to open-ended questions. Respondents differ in the amount of articulation they give to questions. Also, the responses gathered must be transcribed verbatim. Responses to questions may be very detailed, yet may not address the question. Finally, comparing the data can be difficult to fully comprehend the meaning or intent respondents may have had when discussing the issues (Creswell, 2008).

The interview process is particularly useful as a research method for accessing individuals' attitudes and values—things that cannot necessarily be observed or accommodated in a formal questionnaire. This interview process mimics a social relationship involving social norms and expectations. Rubin and Babbie (2012) offer some guidelines for conducting an effective interview. First, the researcher's appearance and demeanor. Dress, grooming, and approach are important in order to have the ability to set the tone of the interview. The general rule is that a researcher's attire should be similar to those that are being interviewed. If the researcher is dressed-up noticeably
more than the interviewee, then obtaining cooperation from the participant may be a challenge. Yet, if the researcher is inadequately dressed, the interviewee may not take the interview seriously and may not treat him/her with respect. Thus, it is crucial that the researcher presents himself or herself as clean, neat, and organized. (Leedy & Ormond, 2010; Rubin & Babbie, 2007). The researcher's approach must be pleasant and must convey an interest in listening and understanding what the respondent has to say.

Second, the researcher must be familiar with the format of the interview and the questions being asked. In order for the questions to be asked naturally, it is crucial that the researcher feel very comfortable asking the questions without stumbling on the words. It is equally important for the researcher to conduct the interview at a comfortable pace for the respondent. This will help put the participant at ease and create a more relaxed and, hopefully, enjoyable experience. The researcher must know when there is a need to clarify questions in a natural manner for the respondent or clarify answers for the researcher. Clarification is frequently necessary when a question seems to be unclear to the respondent, when the respondent's answers go astray or are unclear, and in order to gain more insight into a subject or topic matter (Leedy & Ormond, 2010).

Third, the researcher must accurately record the interview. The interview must be recorded continuously and without alterations. This also includes not paraphrasing or summarizing what respondents may have stated during their interview. Finally, the exit is the last guideline. When the interview has ended, the researcher should thank the respondent for their participation in the research interview process.
Data Gathering Procedures

There were two ways in which participation was requested: In person or by mail. Whether in person or by mail, each participant was given a flyer that explained the research being conducted, its purpose, the criteria required to be able to participate in the study, and asked if they would be willing to voluntarily participate. The researcher then set up a mutually convenient time and location for the interview.

All interviews were conducted in the private office of the therapists. Prior to the actual interview, each participant received a description of the research and a list of support resources with contact information. Participants were also told the interview would be digitally recorded, were asked to sign a consent form (see Appendix B), and were provided with a copy of their signed informed consent form. A total of ten standardized questions were posed to each participant in an open-ended interview manner. The meeting with each participant lasted between 35 minutes to 55 minutes in length.

Data Analysis

Following the interviews, all the digital recordings for each interview were transcribed verbatim by the researcher. A content analysis was then conducted on the written version of the responses. The researcher was looking for common themes amongst responses. This classification was useful in summarizing meaningful trends that would provide preliminary answers to the questions posed. Consequently, common themes were then developed and described within the context of the literature and
theoretical frameworks reviewed for this study. Both latent and manifest analyses were conducted.

Protection of Human Subjects

As required by California State University, Sacramento, a human subject application was submitted to the Committee for the Protection of Human Subjects from the Division of Social Work. This committee approved the proposed study and determined the research as "exempt" to the study participants and the approval number is 11-12-024. The approval was received prior to the collection of any research data.

Participation in this research study by mental health therapists was on a strictly voluntary basis. Participants were informed in writing and verbally of their right to decline to answer questions or stop the interview or completion of the questionnaire at any time and for any reason. To protect the identity of the participants, participants were told to not use their name or that of a client used as an example or part of the answer to the question(s). Participants were instructed to use "pseudo" names.

All information received during the interview was confidential. Privacy was maintained through participants using a "pseudo" name and locking all of the completed interviews and consent forms in a safe. All digital recordings and transcribed materials were stored in a locked safe and were immediately destroyed after being transcribed. All interview materials were destroyed by May 25, 2012. This information was described in the participant's consent form (see Appendix B), which was signed prior to the interview taking place.
Summary

This chapter focused on the qualitative research design employed, content analysis, used for this study. A description of the study population and the sampling technique used was also discussed in this chapter. Additionally, this chapter described the methods for collecting, reporting and analyzing the data as well as reviewed the procedure to protect the human subjects.
Chapter 4
DATA ANALYSIS

Introduction

Interviews were conducted with 10 mental health therapists in various locations in Inyo and Mono counties. The ten participants had worked as mental health therapists in the field from as little time as 2.5 years to over 30. All were actively employed as mental health therapists at the time of the interview. The goal of this study was to investigate the following research question: What knowledge does mental health therapists have of substance dependence and treatment approaches for their clients with chemical dependence? The participants were asked a series of ten questions (See Appendix A) regarding their training in substance dependence, assessment, approaches to treatment, including 12-step programs, and collaboration with alcohol and drug (AOD) counselors and primary care physicians.

The interviewees utilized their knowledge and understanding of substance dependence by their experience in the mental health field and their own personal practice techniques. Three primary themes emerged from the interviews: 1) the majority of mental health therapists use the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) to assess substance use disorders (SUD); 2) mental health therapists do not treat the SUD but refer to the AOD department or counselor; and 3) recommending 12-step programs.

This chapter will present demographic information about the study participants. Next, the replies to several of the interview questions will be described in detail. Finally,
each of the four themes will be discussed, including highlight quotes from the interviews illustrating the themes. To protect the identity of the interviewees all study participants were given a fictitious name. The names were: Carrie, Marla, Erica, Deborah, Cindy, Janice, Samantha, Monica, Robert and Justin.

Participant Demographics

There were ten participants in the study: two were male, eight were female, two were non-Caucasian, and eight were Caucasian. All of the participants were licensed to practice in the state of California. Two of the participants were licensed psychologists, Ph. D.s; seven of the participants were MFTs, and one was an LCSW. None of the participants had any additional training or certification in AOD assessment and/or treatment. There was a wide range of length of work experience, ranging from 2.5 to 30 years in the field. Places of current employment included county departments of mental health which included AOD programs and services offered within the department, and private practice. Training in substance dependence consists of the State of California Board of Behavioral Services (BBS) licensure requirements: For a Marriage and Family Therapist (MFT) the requirement is 10 hours, for Licensed Clinical Social Workers (LCSW), 15 hours, and psychologists do not have a requirement (http://www.bbs.ca.gov/app-reg/lcs_requirement.shtml).

The majority of mental health therapists use the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) to assess substance use disorders (SUD). Question four of the interview directly asked, “How do you determine if a client has a substance dependence problem?” Half of the participants indicated they used the criteria in the
DSM-IV as their primary “tool” or “guide” for determining substance abuse or dependence, Robert stated, “You know there are the criteria in the DSM-IV. Uh, so I ask them those questions. What I’m trying to do right now is to memorize those criteria.” It has been recommended that the DSM-IV criteria can be utilized as one of the aids in the assessment process in addition to the Addiction Severity Index (ASI) or the Michigan Alcoholism Screening Test (MAST), or the CAGE questionnaire, to name a few (SAMHSA, 2009).

Strategies that go beyond the DSM-IV are significant in assessing SUD. Using observation and interviews, the therapist, in addition, to assessing a person’s psychological and psychiatric functioning, is also able to gather information regarding any SUD history, current use, relapses, and treatment (Drake & Mueser, 2000). Assessing an individual for a SUD is a process that takes place over time, and new information will arise as treatment continues (Thylstrup, Schepelern Johansen 2009). Monica discusses the assessment process as:

Continually asking them questions related to drinking, in as casual a way as possible. I don’t want them to get too defensive. I’ll as if they’re taking prescription meds, then I’ll as what, how much for how long. Also questions related to drinking, and asking some of the questions from the assessment the AOD department hands out [MAST]. It’s, not about just asking once, but over time.

According to Drake and Mueser (2000), there are three approaches to detecting substance dependence use disorders among the mentally chronically. The first is for the
therapist to ask the individual about their substance use related problems, which was a part of Marla’s assessment. She said:

Basically if they have been using and/or abusing substances, as a result, they typically have problems or consequences in their life such as martial problems, drinking and driving issues, work problems, etc. So you have to look at the big picture. Hopefully you can get a release to get other information from family members, doctors, etc.

Another approach suggested is to maintain a high index of suspicion when clients have characteristics suggesting they are at risk for a SUD. Justin spoke of looking at the client’s history as well as appearance and economic circumstances as indicators of risk. He said:

I might have a client who has had a history of alcoholism, they’ve been through our department before, or in such a small town word travels.

Typically, I’ve seen these clients with red eyes, puffy face, or they haven’t taken a bath in a week, and they’re shaking and can’t stop. So that’s another way, sometimes is observation.

Finally, listening to the client’s history and paying attention to the client’s reports of any regular use of alcohol or other drugs. As Erica stated, ‘When a client says, I only have a couple of glasses a night,’ I’ve found that usually means a bottle.”

It is normal for some clients to deny or minimize substance dependence having a negative impact on their lives, including their family (Kinney, 2009). Therefore, it is imperative that a clinician realizes they need to meet the client where he/she is, what
questions to ask, and how to ask them in an attempt to get to the truth beneath the surface. In order to get to this information, a clinician should not necessarily take a client’s self-reporting at face value. Most likely, the client has been practicing justification, minimization and denial for some time.

Two of the participants, Cindy and Carrie reported they only look for a SUD if the client brings up drinking or using. Cindy reported, “I would say that most of them are pretty forthcoming … also forthcoming about the amount they’re using and what they’re using to soothe themselves emotionally.” Carrie relies on an individual’s self-reporting for determination, “I base the decision and the diagnosis on what the client shares with me.”

A complete assessment is crucial in helping those with COD. These Individuals are more likely to have problems in many areas including medical, psychological, family, educational, occupational, legal, spiritual, social, interpersonal and recreational functioning (Daley & Marlatt, 2005). The assessment should also include a thorough substance use history. Monica discusses the challenge of determining SUD with a mental health diagnosis due to the many aspects the SUD in combination with the mental illness impact every aspect of the individual’s life. She stated:

Well that can be complicated because unfortunately substances can disrupt, turn someone’s life upside-down. Basically, in the initial session, I ask about any problems or negative consequences in their life such as martial problems, economic issues, any other problems, drinking and driving issues [legal], work problems, etc.
There are numerous resources for the determining/assessing an SUD in a client with a mental health diagnosis. Organizations, one of which is SAMHSA, provides examples of assessment tools and the information to access resources such as the Addiction Severity Index (ASI) or the Michigan Alcoholism Screening Test (MAST), or the CAGE (SAMHSA, 2011). Two participants, Marla and Deborah, indicated they have their own questionnaire, which are questions they have found to be useful over the years from their experience in the mental health field. Marla reported, “Well the thing is when I do the initial evaluation; I have a few questions that I use to evaluate the situation. If I feel she or he has substance abuse issues, then I will go from there. Deborah stated, “I have a few standard questions about their current and past substance abuse. If they say they have past use then I try to find out non-confrontationally, if there is any indication of current use, such as symptoms or physical dependency.”

As mental health therapists have different academic credentials, styles, expertise and training in substance dependence, which can be a type of professional labeling (Russell, Davies & Hunter, 2011). Mental health therapists who lack knowledge or skill in substance dependence may enable clients. An example of passive enabling is ignoring a chemical dependency problem or active enabling such as giving inappropriate advice or treatment (Daley & Moss, 2002). Carrie, who is fairly new to the field, demonstrates a lack of assessment skills which can enable clients. She says, “I only ask about it if the client brings it up. Self-reporting seems to more of a non-accusatory way of approaching the topic since there is already stigma of mental illness, why add more when trying to build the relationship.”
Two therapists, Janice and Monica, who had the most years of experience (27-30 years), talked about Motivational Interviewing as their approach. Janice answered, “…then I ask open-ended questions, employ active listening and show empathy. Using this approach helps me see where they are in terms of their stage of change.” Monica spoke of Motivational Interviewing in these terms:

I’m more about a non-confrontational approach. Letting them know I’m not there to judge or whatever they may be thinking to try to put their guard down. Listening with empathy and trying to start building a relationship and a connection. And depending on where they are in, what stage of change their in, meeting them where they are.

The behavioral health disorder can be diagnosed while the substance dependency diagnosis can be missed or misdiagnosed. This often occurs in psychiatric or mental health programs where the clinical staff lacks specialty training in substance dependency (Minkoff, 2006). As the symptoms of substance dependence or withdrawal can be mistaken for a mental health diagnosis, it is an obligation of mental health therapists to be able to distinguish and assess for a SUD (Russell, Davies & Hunter, 2011).

Mental Health Therapists do not Treat the SUD but Refer to the AOD Department or Counselor:

There is increasing literature on the various subgroups of COD and treatment recommendations. For example, treating substance dependence (by drug-of-choice) and the mental health diagnosis; Bi-polar, depression, anxiety, Post Traumatic Stress Disorder (PTSD), panic disorders, schizophrenia, etc. What has been high-lighted is the need for
clinicians to address both diagnoses by integrating treatment (Boyle & Kroon, 2006). As COD have been said to be the rule not the exception (Perron, Bunger, Bender, Vaughn & Howard, 2010), it is essential that a mental health therapist recognize and address the SUD. This includes being prepared to offer the client a full range of options, including treatment for both diagnoses (Hendrickson, Schmal & Ekleberry, 2006). In addition therapists should be aware of all resources available in the client’s community.

Research indicates that effective COD treatment needs to combine mental health and substance dependence interventions tailored for the complex needs of COD patients (Thylstrup, Schepelern Johansen 2009). There is also the realization that to combine appropriate treatment for both disorders, modification of traditional interventions from separate entities need to be resolved. There was a time, in which mental health providers believed they could be of no help to a person with a SUD; however, it is apparent there is the need for education on substance dependence and COD treatment (Moss & Daley, 2002).

Skinner, Roche, Freeman and McKinnon 2009), researched professionals’ attitudes towards their role of adequacy and the role of legitimacy in working with substance dependence clients. Mental health therapists’ role legitimacy is to what extent they perceive their scope of practice has a right to intervene in anything, including assessment and intervention relating to AOD (Skinner, Roche, Freeman & McKinnon). Role adequacy addresses professionals’ confidence in their capacity to respond to AOD issues effectively. This may explain some of the reasons AOD work is referred to other agencies/individuals.
In addition to the therapists’ interpretation of role legitimacy and role adequacy, there is evidence that a large number of mental health therapists’ personal stereotypic or stigmatized attitudes towards individuals who experience problematic substance dependence, has a negative outcome on the individual’s willingness to engage in services (Skinner, Roche, Freeman & McKinnon). To begin discourse on the topic of stereotypes and stigma would be to address these in education or training programs. This may be one way to build the therapists’ perception of legitimacy in treating SUD, as well as giving the therapists a level of confidence.

Eight participants refer the substance dependence treatment to the AOD department or to the one private agency within 250 miles. The primary reasons for the referrals were the therapists own perception of competence. Erica, Robert and Justin reported, the reason for referral was the “. . . lack of (or no) training in graduate school.” Marla, Janice and Cindy correlated their level of knowledge to what they did for licensure: the minimum, Janice reported, “MFTs only need 10 hours.” Marla indicated, “I think it was . . . maybe 10 hours. That’s not enough, and then you’re not required to do anymore on an annual basis or even for renewing your license.”

The two psychologists, Carrie and Samantha, stated they had no substance dependence training requirement as a licensure requirement by the State of California. Carrie stated, “With substance dependence, I do refer them to experts in the field of substance dependence; AOD counselors. I’ve read a couple of books on Borderlines and substance dependence. It seems like that’s what I’ve had the most of.” Samantha spoke
of her lack of knowledge on the subject matter as the reason why she refers to the outside:

   With substance dependence, I do refer them to experts in the field, substance dependence counselors. I am surely not an expert and have been accused by staff of not being able to recognize when a client comes in and they’re high on something.

   Carrie also discussed her discomfort with having to treat both diagnoses when she didn’t have that much experience. She said, “I think it [assessing] was working pretty well; but others in the office noticed the client was coming in high and I didn’t. I had to come to terms that I didn’t know as much as I thought – it wasn’t part of my Ph.D. program.”

   Two other therapists, Robert and Janice, indicated they refer substance dependence services out. Robert reported, “If I get someone with a problem, I refer to either the county for services or the private provider who offers COD treatment as well. Janice responded, “I don’t deal with that part [SUD] of treatment, so I refer out.” If licensure requirements were to go beyond the current minimum hours, in addition to implementing license renewal requirements, there would not only be more knowledge about substance dependence, but perhaps more confidence in treatment planning, and possibly more supervision for mental health therapists in the form of individual or group (Pinikahana, Happell & Carta, 2002).

   Erica and Justin, who had 15 and 17 years of experience in the field, indicated treatment is from on-the-job training. Erica reported, “It’s not a formal education, but
having a relationship with the AOD staff and being able to talk to them about the client
before handing the addiction portion over to them. Justin stated, “Being around people
who are in the field so it makes it easier to transfer a client to them.”

There is knowledge that substance abuse or dependence is a common and
devastating clinical comorbidity in individuals with mental illness, and research offers
evidence that integrated COD treatment is effective; however, it is not clear why there are
not protocols around COD treatment (Drake, Mueser, Brunette & McHugo, 2004). The
effective and destructive patterns of alcohol dependence takes not only the clinical skills,
but special knowledge, including the dynamics of the disease, its effect on others, and
treatment approaches (Drake, 2003).

Recommending 12-step Programs

The 12-steps (see Appendix C) function as the therapeutic framework for many of
the 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous
(NA). Dual-diagnosis 12-step groups sometimes referred to as “Double Trouble
Recovery,” (DTR) are much less common; however, have become more accessible on-
line (Kelly & Yeterian, 2009). It is often questioned whether 12-step groups appeal to
people with COD as they may be taking psychotropic medications or anti-relapse
medications and the 12-step groups focus is on substance and the emphasis is on
abstinence.

Although the inclusion of spiritual or religious based beliefs in addiction
treatment is controversial, the most effective long-term treatments of addiction are the
spiritually based 12-step programs (Inaba & Cohen, 2007; Schuckit, 1994, 2000). Many
other treatment programs in operation base their interventions on the 12-step traditions. A large number of empirical studies demonstrated a 60% to 80% correlation of better addiction treatment outcome to spiritual participation (Sterling, Weinstein, Losardo, et al., 2007). Therefore, it has become essential for programs to at least clarify this issue with their clients and provide appropriate referrals (Inaba & Cohen, 2007; Schuckit, 1994, 2000).

There is also the belief by some that 12-step programs do not resonate with atheists and agnostics because of their spiritual orientation (Kelly & Yeterian, 2009). Spirituality is a difficult concept to study scientifically. Despite differences in conceptualization, and challenges with measurement, scientists have begun to examine spirituality's role in recovery from alcohol and drug dependence (Slaymaker, 2009). Spirituality levels have been shown to increase during the course of treatment for alcohol and drug dependence (Sterling, Weinstein, Losardo, Raively, Hill, et al., 2007).

Spirituality levels and spiritual practices are also related to improved outcomes. Practicing Step 11 (prayer and meditation) and higher spirituality levels among AA members are known to correlate positively with life satisfaction and outcomes (Slaymaker).

Drug and alcohol addiction often bring a person to openness to spiritual experience. As a result, spirituality is a core component of AA's 12-Step philosophy. Spiritual principles include recognition of, willingness to trust, and commitment to maintain "conscious contact" with a power greater than oneself (Sterling, Weinstein,
Losardo, et al., 2007). Carrie referred to the religious or spiritual part of the 12-step program,

My clients, some of them, did not like the religious aspect of it. You know I’m familiar with a 12-step program geared more for atheist. I’ve seen it as an internet resource, but there was a group that was an alternative to AA. It still was a 12-step, but it did not have that spiritual part and more atheists, so I would tell my clients about both, and what their comfort level was.

Twelve-step groups can vary from location to location which can be an obstacle for individuals with COD. In some groups, mental illness is not an accepted topic nor is taking prescribed psychopharmacological medication as they are mind altering drugs: the person is not sober. Other variations can be confrontational, expressed emotions, group cohesiveness and meeting structure which can effect an individual with COD (Bogenschutz, Geppert, & George, 2006).

The majority of participants reported they thought 12-step programs like AA and NA were good for some clients, but not necessarily for all. For example, Carrie, discusses what she has gathered working with individuals who have attended 12-step meetings, “Uh..I think that they work extremely well for some people, but there are an equal number of people who dislike the 12-step community and since we’re in this rural community, it’s too small and selective: there’s a culty kind of feel to it.” Monica stated, If I know my clients have previously had a good experience with a 12-step program, I will recommend that they hook back into the community. But for those who are truly resistant because of previous experiences, I don’t force them but I
may suggest they go to a men only or women only group. This seems to be where newcomers feel more comfortable.

Marla reported “Yea, you know I think that is a good program. I know a lot of people have recovered when they go through that and I would recommend the AA program. I would encourage them to keep going because they have the support and mentoring too.”

It has been documented that 12-step programs can offer a system of belonging; group support and individual support through sponsors and other group members (Daley & Moss, 2002). Robert, indicated:

“I do recommend 12-step programs as an addition to treatment and as another form of support for the client. If the client doesn’t really know, or seems ambivalent, I’ll suggest they go three times. Go to three different meetings and see if there is anything that is helpful, even if it’s one sentence at the end of a meeting.”

Studies have shown that the 12-step approach works by increasing social networks in support of abstinence and by increasing an individual's self-efficacy, or confidence in maintaining sobriety (Slaymaker, 2009) These factors, in turn, lead to improved health and substance use outcomes. Twelve-step programs have been the center of controversy in the substance abuse literature, particularly for the treatment of individuals with COD. Although the program may be beneficial to many those with severe mental illness may feel alienated (Daley & Marlatt, 2005). Therefore, there is a need for caution of emphasizing attendance of an individual with COD at a 12-step meeting. Although this suggestion is meant with good intentions, attendance may be
difficult for the individual with COD to achieve. Individuals with COD may feel they have very little in common with the non-mentally ill members of the group (Bogenschutz, 2005). In addition, due to paranoia, and social anxiety, for example, this may make it difficult for individuals to participate in group, especially when there is a confrontation style of interaction (Bogenschutz).

Many individuals, and to a less obvious extent, therapists, can have resistance to 12-step programs. Some of the mental health therapists are not comfortable expecting their client to go to a 12-step meeting. Cindy indicated she has heard from other clients,

“… how harsh the older (most sobriety) members can be. They can be judgmental and shaming and if someone is in a vulnerable space, which is typically the case, I normally don’t recommend 12-step programs. I don’t say no, but I don’t advertise. If the client mentions it, that’s great. It can also be detrimental to the client’s mental health and overall stability.”

Samantha stated,

“I, to a degree, believe that 12-step programs can be useful; however, I believe that people should be allowed to move on and not have their addiction be their identity, and there’s not a lot of space for that in 12-step programs when you identify yourself as an alcohol, addict, etc. at the beginning of a meeting. There is also not a lot of space for people to be human, and human beings make mistakes. The programs I am familiar with are extremely rigid and cliquish. Up here, I don’t like to recommend it, especially for clients I know aren’t strong enough to defend themselves.”
Also, mental health therapists who either recommend or disqualify 12-step program as an intervention, do not necessarily have experience working with substance-dependent individuals. They have had little to no experience providing spiritual guidance or any experience with the 12-step program (Daley & Marlatt, 2005). Regardless of a mental health therapist’s personal beliefs, there is evidence that 12-step based programs are effective for those with COD; however, there is no empirical evidence supporting the same outcome for the individual with a COD that includes a severe mental illness (Bogenschutz, 2005). It is however, suggested that DTR 12-step programs become more available to those with COD (Kelly & Yeterian, 2009).

Summary

In this chapter, the data from the study were analyzed and discussed. Chapter 5 is a description of the conclusions and recommendations. The limitations of this study and the implications for social work practice and policy are also discussed.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter will discuss the conclusions reached in this research and recommendations will be given. Also discussed will be the themes that developed during the research, their implication for social work practice and future research. Limitations of the study will also be addressed.

Conclusions

This study asked the research question: What knowledge does mental health therapists have of substance dependence and treatment approaches for their clients with chemical dependence? The answer to the question is extremely limited knowledge. As the study participants discussed the various aspects of all of the questions, the first study theme emerged from the interview questions. The first theme was mental health therapists’ reliance upon the Diagnostic Statistical Manual-IV (DSM-IV) as their primary tool for assessing substance abuse disorders (SUD). For the few therapists that used a different approach, it appeared to be due to their length of time in the field. For therapists who worked in an agency setting, it was indicated there were no protocols in place for mental health therapists as part of the intake process.

In exploring these two different approaches to assessing SUD, it appears that agencies and private practice mental health therapists’ use their own discretion on what type of assessment to employ. The therapists who worked in an agency setting indicated that their agencies did not have a protocol in place for assessing clients for SUD. As a
result, mental health therapists determine an individual’s SUD primarily by the criteria in the DSM-IV. In the private practice setting, the therapists took a more motivational interviewing approach; asking open ended questions, empathetic responses, and clarification to name a few (Miller & Rollnick, 2002).

In addition, a majority of the participants appeared to have concluded that there was not one way of assessing an individual that was better than another. What can occur in this event is the mental health disorder can be diagnosed but the SUD can be either missed completely or misdiagnosed (Conrod, 2005). This often occurs in psychiatric or mental health programs where the clinical staff lacks specialty training in substance dependency (Minkoff, 2006). As the symptoms of substance dependence or withdrawal can be mistaken for a mental health diagnosis, it is an obligation of mental health therapists to be able to distinguish and assess for both mental health diagnoses and SUD diagnoses (Russell, Davies & Hunter, 2011). From the research findings, there appears to be no responsibility placed on mental health therapists or mental health agencies to hold themselves accountable for performing a comprehensive assessment during the intake process.

Furthermore, the majority of the mental health therapists interviewed specified that when confronted with a client who is referred or seeking assistance and there is a SUD suspected or reported by the client, therapists typically refer the SUD treatment to the county department of alcohol and other drug programs (AOD), or to the one private agency within a 250 mile radius. There appears to be a lack of professional responsibility on the part of the mental health therapists of which can partially be attributed to the
academic shortfalls of their master’s or Ph.D. programs. This second theme is two-fold: minimum state education and state licensure requirements; and 2) mental health therapists’ limited knowledge of SUD regardless of their credentials.

The minimum training requirements in substance dependence for licensure in the State of California for an MFT is 10 hours, an LCSW 15 hour, and a Ph.D. requires no hours. As a result of the lack of training/education in post graduate programs, certain participants felt as though they were not qualified to assess or treat SUD/COD. Resulting from these minimal requirements, the therapists can identify the mental health diagnosis and therefore, the SUD is not addressed. Some of the participants which were newer to the field did report having “less than adequate” training/education in their master’s program and therefore had no confidence in treating SUD. There was one participant that stated she would read about SUD on her own time to gain more of an understanding of the disease and of what their clients go through.

The final theme to emerge from the interviews was the mental health therapists’ recommendations and ambivalence of 12-step programs. Overall, mental health therapists’ attitudes towards 12-step programs were positive. Twelve-step programs were viewed as a great source of support, having a positive impact on an individual’s choices, moods, and negating negative behavior (Muesner, Noorsdy, Drake, & Fox, 2003). In their study of the role of mutual-help groups, Kelly & Yeterian, 2009 discuss the positive relationships that are formed in 12-step programs and how the program contributes to greater abstinence, improved self-efficacy and motivation for abstinence.
Several studies have demonstrated how clinicians can make a substantial difference in increasing the likelihood that clients will become and stay engaged in 12-step programs (Slaymaker, 2009). In another study by Timko, Sutkowi & Moos, 2010, it was found that individuals with COD exhibited interpersonal avoidance associated with psychiatric problems which made membership in 12-step programs problematic. Due to the individuals’ difficulty in forming close relationships, it is difficult to trust a sponsor, another group member or a group. Although there is data that consistently indicates individuals with COD benefit from 12-step programs, it has not yet been determined the efficacy of 12-step programs on the seriously mentally ill client with substance dependency (Bogenschutz, Geppert & George, 2006).

A Therapist’s personal beliefs can influence their recommendation of a 12-step program. This research found a high rate of ambivalence around the issue of religion and spirituality in 12-step programs. As research was conducted in rural areas, steps 1-3 of AA were a point of contention between the agencies and the 12-step community. Steps 1-3 tell the member to admit they are powerless over alcohol, that a power greater than themselves can restore them to sanity, and they must turn their will and lives over to God (AA, 2001). From the therapists’ perspective, the let go and let God philosophy of AA (AA) was reinforcing an individual’s feelings of powerlessness and hopelessness, as well as guilt, shame or anger if they did not believe in God. Many of the participants reported they had clients who, after attending one meeting, were not going to attend another. This was primarily due to the program’s religious or spiritual aspect which the client felt was being forced upon them.
Kelly and Yeterian (2009) reported that should a treatment center integrate religious or philosophical values into their program, this aspect of the program can be a significant factor in a client’s spiritual or religious conversion. Similarly, if a therapist were to inadvertently or covertly express particular values, this too could alter a client’s religious or philosophical orientation. Recent studies have examined the impact of spiritual guidance as an add-on to behavioral counseling and have seen positive outcomes with combined mental health and 12-step programs (Slaymaker, 2009). Slaymaker (2009) attributes the positive outcome to the addition of group and peer support, in addition to a sponsor.

Recommendations

The three areas where this study makes recommendations are: future research, individual knowledge and the impact of education limitations have on mental health therapists, and mental health agency policies in assessing SUD and treating COD. The recommendations are presented below.

Future Research

The results of this study illuminate the need for further study into the actual practice approaches and techniques of mental health therapists. There is a need for more studies of what mental health therapists’ need in education and training in SUD and COD and what should be within a clinician’s scope of practice. Skinner, Roche, Freeman and McKinnon (2009) discuss the need to go beyond the traditional context of education in the academic and training programs and examine the relevance of what is and is not being taught and the applicability of what therapists know of substance dependence and
COD. Knowledge of SUD and COD requires a high level of skill and knowledge, which is not currently available. Skinner, Roche, Freeman & McKinnon (2009) concluded that the field of mental health would greatly benefit from further research into mental health therapists’ knowledge of SUD and COD.

Skinner, Roche, Freeman and McKinnon (2009) described a limited number of therapeutic approaches to treatment depending on the treatment modality used by the agency, which in this case was absent. They asserted that there was a need for a consistent measurement across all treatment modalities of mental health therapists’ approach to SUD. This study endorses the development and use of such instruments by individual mental health therapists and AOD counselors collaborating with one other within the agencies they practice.

Mental Health Therapists’ Knowledge

This study points towards several recommendations for practice of individual mental health therapists regardless of their credentials. The recommendation for therapists’ knowledge is for mental health academic programs to review and update their programs to include requirements for substance dependency and co-occurring disorders.

Mental health therapists must consistently review, in a critical manner their practice skills. As called for by the National Association of Social Workers Code of Ethics, Ethical Principals, Competence, social workers should continually strive to develop professional skills (NASW, 2009). What this study recommends is that mental health therapists endeavor to be aware of their individual practice styles, attitudes, and qualifications and how these factors impact each client. Indeed, therapists would also
benefit from the administration of a self-assessment instrument similar to the one developed by Kasarabada, Hser, Parker, Hall, Anglin and Chang (2001).

*Treatment Agencies*

Recommendations for treatment agencies include collaboration between the mental health department and AOD. The objective for this partnership would be to create and implement a protocol for assessing SUD consistency in both departments. This would be an attempt to implement and maintain an agency-wide protocol that is consistently applied to all clients. However, treatment agencies should also put in place procedures to insure mental health therapists are continually reevaluating their knowledge base and practice skills.

*Limitations*

Limitations specific to this study included participants living in rural areas and therefore, their experience of the participant were limited to these geographical areas and populations. Another limitation was the small sample size. In using a qualitative interviewing approach, fewer participants are sampled; consequently, the input regarding the subject being studied is limited and not able to generalize the findings to the larger population being studied. As qualitative studies are subjective, the personal bias of the researcher can affect the design of the study, the data collection process, and interpretation of the research (Leedy & Ormond, 2010). The personal biases of the participants can be a limitation due to personal life experiences, working in specific clinics/agencies, types of supervision, and experience in the field of study.
Implications for Social Work Policy and Practice

The implications of this study will benefit the practice of social workers and other mental health professionals in successful outcomes in the treatment of individuals with COD on micro, mezzo and macro levels. On the micro level, the mental health therapists who participated in the study will have greater insight when examining their knowledge and practice skills with COD. In the participants’ exchanges with clients, other agencies and therapists, the intent of this study may inspire other therapists’ exploration of their baseline knowledge of substance dependence. As the high prevalence of COD has been recognized within the mental health profession (Horsfall, Cleary, Hunt and Walter, 2009), it is hope of this researcher that social workers and other mental health therapists remember the significance of knowledge in this area of diagnosis and the recommended treatment methodologies.

On the mezzo level, agencies involved in the study through the participation of therapists employed at these agencies will benefit by the improvement in individual therapist’s self-awareness, self-examination and self-motivated search for knowledge. Discourse on the topic of COD among mental health therapists and AOD counselors may stimulate positive interaction and a collaboration creating a comprehensive assessment and treatment process. In addition to developing a comprehensive protocol for COD, this study may encourage both disciplines in an agency setting to examine their practices and knowledge in the areas of substance dependence and COD diagnosis. Training and education in COD may be an area in which agencies decide to pursue funding from both state and federal governments.
On a macro level, as there is now greater awareness and recognition of the large number of individuals living with COD, a more integrated system of care can be established. System-wide planning of integrated substance dependence and mental health diagnosis need to be developed to define the nature and scope of an integrated response in providing services (Bride, MacMaster & Webb-Robbins, 2006). Historically, mental health and substance dependence have been treated in separate systems with differing and many times contradictory philosophical orientations (Daley & Moss, 2002). As there is a great need for more extensive and consistent education, training and licensure requirements within mental health academic programs, there is also that need to a certain extent in AOD education and training. In order to produce more positive outcomes in treating individuals with COD, there is a great need to establish a baseline understanding of COD; how to assess, diagnose and treat.

Because of the impact this complex diagnosis has on an individual’s life, social workers need to better understand the prevalence of COD and the socio-demographic and clinical characteristics when screening for COD. In working with this population, it is imperative to be aware of the diagnosis in a bio-psycho-social context will have a positive effect on social workers treatment outcomes with individuals diagnosed with COD.

Conclusion

The purpose of this study was to contribute to the understanding what knowledge mental health therapists have of substance dependence and treatment approaches for their clients with chemical dependence. The answer to the question is the therapists that were
interviewed had extremely limited knowledge of substance dependence: assessing, diagnosing, and treating. The findings from this study advocate for the implementation of substance dependence curriculum into mental health graduate and post graduate programs as well as stricter licensure requirements. With the pervasiveness of COD, the lack of knowledge on the part of the therapist, it would appear the therapist is practicing out of their scope of practice.

This study explored several aspects of the topic including mental health therapists’ SUD assessment process, diagnosing SUD, and their approach to treating a client with COD. There is need for future research on ways in which agencies can effectively train and educate their mental health staff so they are able to successfully assess, diagnose and treat COD.
APPENDICES
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to participate in a research study that will be conducted by Cristina Whitlock, a graduate student in the Division of Social Work at California State University, Sacramento. This study will explore mental health therapists’ knowledge and approaches to treat clients with substance dependence.

Procedures:
After reviewing this form and agreeing to participate you will be given the opportunity to set up a time at your convenience. The interview should last roughly 20-30 minutes. It will be digitally recorded. The voice file will be quickly transcribed and then destroyed.

As a participant in the interview, you can decide at any point not to answer any specific question or to stop the interview.

Risks:
There is a minimal risk to participate in this study because study that will focus solely on mental health therapists and their knowledge in a specific area of substance dependency treatment. The study does not solicit individuals who are substance dependent or have co-morbidity. However, you may experience some emotional distress when you discuss your own knowledge about substance dependency treatment. You may contact Therapy for Therapists, Info@TherapyForTherapists.com, or call (949) 290-4922 or (949) 241-0042 if you feel any distress.

Benefits:
By being a part of this study you may gain insight into the needed advocacy for knowledge of substance dependence in mental health clinicians as well as your own knowledge regarding substance dependence treatment. This research may also help others understand the importance of furthering research in this area.

Confidentiality:
All information is confidential and every effort will be made to protect your anonymity. The responses given on the digital recorder will be kept confidential. The information you provide on the consent form will be stored in a secure location under lock and key at my residence. All digital recordings will be downloaded and transcribed to word files. This researcher’s thesis advisor will have access to these transcriptions for the duration of the project. All drafts as well as the final research report will not include any identifying information. All data will be destroyed upon completion of the project on or before 5/25/12.
Right to Withdraw:

If you decide to participate in this interview, you can withdraw at any point. In addition, during the interview you can choose not to answer any specific question(s).

If you have any concerns throughout this research process, please feel free to contact me at cristinaw@verizon.net or (760) 914-XXXX. Thesis advisor, Maria Dinis, Ph.D., MSW can be reached at (916) 278-XXXX if there are any questions regarding the research and study.

Thank you for your participation in my research. I look forward to contributing to the Social Work profession and to the mental health community.

I have read the descriptive information on the research participation cover letter. I understand that my participation is voluntary. My signature indicates that I have received a copy of the research participation cover letter and I agree to participate in the study.

I __________________________ agree to have my responses digitally recorded.

Signature:_________________________ Date:____________________

If you have any questions you may contact me at (760) 914-XXXX or email me at cristinaw@verizon.net. Or, if you need further information you may contact my thesis advisor:

Maria Dinis, Ph.D., MSW
California State University, Sacramento
(916) 278-XXXX
APPENDIX B

The 12-Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
APPENDIX C

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.
REFERENCES


http://www.omh.state.ny.us


