Uncovering the methadone counseling process among recovering and non recovering chemical dependency counselors

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UNCOVERING THE METHADONE COUNSELING PROCESS AMONG RECOVERING AND NON-RECOVERING CHEMICAL DEPENDENCY COUNSELORS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment of the Requirements for the Degree
Master of Social Work

by
Sara-Amanda McCarthy
Jennifer Ann Palmersheim
June 2007
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ABSTRACT

The purpose of this study was to uncover the methadone counseling process among recovering and non-recovering chemical dependency counselors by examining the concepts and techniques utilized throughout the counseling process. This study examined whether the recovery status of a counselor affected the counselor’s theoretical addiction model and the concepts and techniques that were utilized throughout the counseling process.

To uncover the methadone counseling process this study conducted both quantitative and qualitative examinations of both recovering and non-recovering counselors. To examine the addiction model of both recovering and non-recovering methadone counselors, data was collected using a quantitative, standardized, group administered survey. This study further uncovered the counseling process among recovering and non-recovering counselors by conducting in depth face-to-face exploratory interviews to investigate the following counseling concepts and techniques: self-disclosure, counter-transference, spirituality, motivation, confrontation and evidence-based practice.
This study expected to find that the theoretical addiction model, techniques and concepts of the counseling process would differ among recovering and non-recovering methadone chemical dependency counselors.
ACKNOWLEDGMENTS

To Dr. Thomas Davis for his commitment to completing this project.

Sara-Amanda

I want to gratefully acknowledge Kathleen Rodrigues and CRC Health Group for allowing the researchers to conduct research in their facilities. I would like to give special recognition to all of the methadone chemical dependency counselors who participated in our research, without their help we would have had no research. I would like to give special recognition to the chemical dependency counselors who opened my heart and soul to the chemical dependency field. Thank you Mr. Timothy Thelander for his time and reassurance during the uphill battle to completion. I want to thank Dr. Thomas Davis for his guidance, patience, support, knowledge and most of all his enthusiasm throughout this project. Finally, I would like to acknowledge the support and encouragement of my family.

Jennifer
DEDICATION

To all the men and women who dedicate their lives to the chemical dependency field.

To my family for their endless encouragement and support: Richard Palmersheim, Maru Palmersheim, & Penney Stowe.

To my adorable brother & sister for their understanding and endless hugs: Benjamin Palmersheim & Danica Palmersheim

And finally to all the families & survivors whose lives have been forever affected by addiction.

Jennifer
# TABLE OF CONTENTS

ABSTRACT ........................................................................................................ iii

ACKNOWLEDGMENTS .................................................................................. v

LIST OF TABLES .......................................................................................... ix

CHAPTER ONE: INTRODUCTION

Problem Statement ......................................................................................... 1

Policy Context ............................................................................................... 3

Practice Context ............................................................................................ 4

Purpose of Study ............................................................................................ 7

Significance of the Project for Social Work Practice ....................................... 8

CHAPTER TWO: LITERATURE REVIEW

Introduction .................................................................................................... 11

Background ................................................................................................... 11

Counseling Process and Techniques ............................................................... 14

Self-Disclosure ............................................................................................... 15

Counter-Transference ................................................................................... 16

Spirituality ..................................................................................................... 18

Motivation ...................................................................................................... 20

Confrontation ................................................................................................. 21

Evidence-Based Practice .............................................................................. 23

Models of Addiction ..................................................................................... 24

Theories Guiding Conceptualization ............................................................. 27

Generalist Practice Model ........................................................................... 27
LIST OF TABLES

Table 1. Gender ..................................................... 45
Table 2. Recovery Status ........................................ 46
Table 3. Age ......................................................... 46
Table 4. Ethnicity .................................................... 47
Table 5. Highest Level of Education ......................... 48
Table 6. Years as Counselor ....................................... 49
Table 7. Qualitative Results ................................. 52
CHAPTER ONE
INTRODUCTION

The contents of Chapter One present an overview of the research project. The problem statement concerning policy and practice context are discussed followed by the purpose of the study and context of the problem. Finally, the significance of the project for social work practice is presented.

Problem Statement

According to the Substance Abuse Mental Health Services Administration (SAMHSA) in 2002, more than 6 million people in the United States need treatment for an illegal drug problem (as cited in Fisher & Harrison, 2005). In 2004, the Department of Health and Human Services (HHS), estimated that 22.5 million persons were classified as suffering from chemical dependency or abuse within the past year. According to HHS in 2004 the drug category with the largest number of recent initiates was nonmedical use of pain relievers (2.4 million), followed by marijuana (2.1 million), non-medical use of tranquilizers (1.2 million), and cocaine (1.0 million) (HHS, 2004).
The Office of National Drug Control Policy estimated the number of persons in the United States with an opioid addiction is between 750,000 and 1 million (Stroller & Bigelow, 2006). Opiates include heroin, methadone, oxycodone, hydrocodone, codeine, Dilaudid, morphine, Demerol, opium, and any other drug with morphine-like effects. In 2003, opiates were the primary substance of abuse for 324,000 (18%) of the 1.8 million substance abuse treatment admissions (HHS, 2004). Despite these dire statistics, methadone is the one treatment that has been found to be effective in opioid dependency.

Methadone is a long-acting opioid agonist medication used in a comprehensive treatment for individuals who have an addiction to opioids such as heroin (Kosten & George, 2002). Methadone is a medication that has been found to reduce relapse rates, assist with facilitating behavioral therapy, and enable patients to concentrate on life tasks (Kosten & George, 2002).

Methadone is administered in daily dosages that vary in milligrams (Kosten & George, 2002). Methadone is just one component of the federally regulated methadone treatment programs that administer the medication (Kosten & George, 2002). Along with administering the medication
these programs also provide individual chemical dependency counseling (Kosten & George, 2002).

The focus of research in methadone treatment has been on outcomes, concentrating on issues such as dosage and treatment retention (Lilly, Quirk, Rhodes, & Stimson, 2000). Although, the delivery of counseling services in methadone treatment facilities has been identified as a critical component, research has yet to focus systematically on how such services are delivered and negotiated within the context of the counselor and client relationship (Lilly, Quirk, Rhodes, & Stimson, 2000).

**Policy Context**

The standards for addiction counseling emerged during a time when other professional groups, such as social workers, avoided working with the chemically dependent population (Mustaine, West, & Wyrick, 2003). To meet the demand of this burgeoning treatment population, there was a reliance on substance abuse counselor certification boards, either at the state or national level, to provide qualified practitioners (Mustaine, West, & Wyrick, 2003). According to the Center for Substance Abuse Treatment (1998), “counselors may be nurses, psychologists, social workers, psychiatric
technicians, trained counselors, or others as long as they have training or experience in treating persons with an opiate addiction."

Practice Context

Morgenstern and McCrady (1992) reviewed the literature in the substance abuse treatment field and identified 35 processes used in treatment (as cited in Fisher & Harrison, 2005). Almost every method of therapy has been discussed in relation to changing addictive behavior (Giovazolias & Davis, 2005). However, not one treatment has been shown to be the most effective for all persons with a drug addiction (Giovazolias & Davis, 2005). It has been suggested that there is a need for a model of therapy that would integrate various perspectives and give direction to the addiction intervention efforts (Giovazolias & Davis, 2005). Many chemical dependency treatment programs attempt to provide direction to their counselors by placing emphasis on a particular therapeutic intervention (Fisher & Harrison, 2005). However, the background of an addiction counselor influences their beliefs about the causes and treatment of chemical dependency (Humphreys, Noke, & Moos, 1996). As a result, a chemical dependency counselor may rigidly
advocate a therapeutic intervention when delivering counseling services to their clients (Humphreys, Noke, & Moos, 1996).

In methadone treatment facilities, a vital component of rehabilitation is carried out by chemical dependency counselors with diverse backgrounds (Snyder, 1986). The backgrounds of chemical dependency counselors vary in recovery status, training and experience. The recovery status of chemical dependency counselors can be either: recovering or non-recovering (Aiken, LoSciuoto, & Ausetts, 1984). If the counselor is recovering the counselor has a history of chemical dependency (Aiken, LoSciuoto, & Ausetts, 1984). If the counselor has no history of chemical dependency then they are considered to be non-recovering (Aiken, LoSciuoto, & Ausetts, 1984). The training and experience of counselors can include a professional degree or a certification in addiction counseling (Mustaine, West, & Wyrick, 2003). As of result of these diverse backgrounds, the method each counselor utilizes in the delivery of counseling services differs.

According to Culbreth (2000), a review of past research has revealed distinct differences between recovering and non-recovering counselors, but these
differences have not been found to impact treatment outcome. Client treatment outcomes have been found to be similar regardless of the recovery status of the counselor (Culbreth, 2000). The primary difference between recovery and non-recovery counselors, is the different methods they utilize to achieve the treatment goal (Culbreth, 2000). The difference in treatment method does not seem to have an impact on the treatment outcome. However, it does impact the manner that recovering and non-recovering counselors perceive and work with chemical dependency clients (Culbreth, 2000).

Past research has focused on the examination of the treatment outcome without a clear understanding of the counseling process by which it occurred (Culbreth, 2000). According to Heppner, Kivlighan, and Wampold (1992) understanding how change occurs during the counseling process, specifically the interactions between the counselor and the client, represents a critical level of research that is necessary to clarify and define the change process for clients. A clearer understanding of the counseling process can provide more direction in effective training strategies for social work academic
programs and addiction counselor preparation programs (Culbreth, 2000).

Purpose of Study

This study focused on uncovering the methadone counseling process among recovering and non-recovering chemical dependency counselors by utilizing surveys and conducting face-to-face interviews to examine the concepts and techniques that each counselor utilizes throughout the counseling process. The data that was collected from the surveys was used to assess the counselors' theoretical model to understand addictive behavior. The data collected from the face-to-face interviews was examined to uncover the concepts and techniques that each methadone chemical dependency counselor utilizes throughout the counseling process.

Most of the research on chemical dependency counseling has focused on treatment outcome without examining the concepts and techniques that are utilized throughout the counseling process. By exploring the concepts and techniques utilized by recovering and non-recovering counselors, this study will challenge the belief system that one group of counselors is more
Effective than the other (Culbreth, 2000). The examination of the counseling process also allows the chemical dependency profession to further develop and legitimize research that promotes chemical dependency counseling within the greater professional and treatment community (Culbreth, 2000).

Significance of the Project for Social Work Practice

The significance of this project for social work practice is that it provides insight about the techniques and concepts that are utilized throughout the chemical dependency counseling process. Historically, social workers have avoided assisting individuals with chemical dependency issues, indicating that they prefer to not work with individuals that have a history of chemical dependency (Googins, 1984; Gray, 1995). Ironically, social workers are often the first service professionals to encounter this population within the context of some other social problem such as a financial crisis, homelessness, or domestic violence (Gray, 1995).

Presently, the discipline of social work is taking a larger role in the field of chemical dependency (Fisher & Harrison, 2005). It is critical for social workers to
obtain expertise in the field in order to facilitate the creation of appropriate programs and interventions that directly address chemical dependency as a major social problem (Gray, 1995).

Shaffer and Gambino (1984) stated that "the field of addictions had been in a pre-paradigm stage of development". As a consequence, counselors have been left to develop their own working models and techniques to utilize in the chemical dependency counseling process (Shaffer & Gambino, 1984). According to Freeman (1992), the task of social workers is to integrate their clinical skills into the chemical dependency field (Freeman, 1992). The social work skills that have been found to be effective in other fields of practice can be generalized and modified as needed in the terms of the dynamics of chemical dependency (Freeman, 1992).

This project utilized the social work generalist practice model as a tool to delineate how chemical dependency counselors utilize various techniques and concepts throughout the chemical dependency counseling process. Policymakers and educators/trainers for the social work profession could utilize the findings of this project in the modification of methadone treatment
legislation and the development of educational training programs that enhance the treatment for the chemical dependency population.

Overall, the project may have an impact on the social work practice by providing insight about the concepts and techniques of the methadone counseling process to chemical dependency counselors, treatment programs, educators and social work practitioners.

This study expected to find that the theoretical addiction model, techniques and concepts of counseling process differed among recovering and non-recovering methadone chemical dependency counselors.
CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter consists of an overview of literature relevant and related to uncovering the methadone counseling process of recovering and non-recovering chemical dependency counselors. This chapter reviews counselor background, theoretical models of addiction, counseling techniques and concepts as they pertain to the methadone counseling process.

Background

This study focused on two types of chemical dependency counselors: recovering and non-recovering. Non-recovering counselors are professional counselors who hold a high school diploma or higher and do not have a history of addiction themselves (Aiken, LoSciuto, & Ausetts, 1984). Recovering counselors consist of counselors who are certified addiction specialists who have a high school diploma or higher and have a history of addiction themselves (Aiken, LoSciuto, & Ausetts, 1984).
The employment of individuals with such diversity of training and experience in chemical dependency treatment programs stems from the 1960s (Deitch, 1974). The vast proliferation of substance abuse treatment programs and the deficiency of interest in the field led to the recruitment of individuals who were in recovery themselves (Aiken, LoSciuto, & Ausetts, 1984). In order to recruit individuals, there was a general reliance on chemical dependency counselor certification boards to provide qualified practitioners to meet the needs of this treatment population (Mustaine, West, & Wyrick, 2003).

Historically, the chemical dependency certification boards did not require formal academic graduate preparation as a prerequisite for addiction counseling (Mustaine, West, & Wyrick, 2003). The Code of Federal Regulations (2002) requires that:

Each person engaged in the treatment of opioid addiction must have sufficient education, training, and experience, or any combination thereof, to enable that person to perform the assigned functions. All physicians, nurses, and other licensed professional care providers, including addiction counselors, must comply with the
credentialing requirements of their respective professions. (p. 23)

In the past thirty years, substance abuse treatment research has primarily focused on which group of counselors, recovering or non-recovering, provided more effective counseling to chemical dependency clients (Culbreth, 2000). Two methods have been utilized to examine which group provided more effective counseling. One method has been to explore differences in client perceptions of effectiveness based on the recovery status of the counselor (Culbreth, 2000). The other method has been to compare treatment outcome variables between recovering and non-recovering chemical dependency counselors (Culbreth, 2000).

Previous studies have reported that recovering counselors demonstrate lower levels of autonomy; less flexibility and willingness to accept alternative viewpoints; and were more dependent on conventional treatment methods (Hoffman & Miner, 1973). Thinking patterns among recovering counselors have been classified as tough-minded, confrontational, and rigid in their belief of the disease model (Culbreth, 2000).
Although studies have demonstrated distinct differences between recovering and non-recovering counselors, these differences do not affect their respective effectiveness with their clients. These differences do however have a bearing on how recovering and non-recovering counselors interact with their clients during the counseling process (Culbreth, 2000). Currently, researchers are calling for a shift in research agendas that will explore differences in the actual counseling process (Heppner, Kivlighan, & Wampold, 1992). Hill (1991) indicated that it is not helpful to know a counseling outcome without a clear understanding of the process by which the outcome has occurred.

Counseling Process and Techniques

This study focused on uncovering the methadone counseling process among recovering and non-recovering chemical dependency counselors by examining the concepts and techniques utilized throughout the counseling process. The recovery status and the counselor’s theoretical model to understand addictive behavior have been identified as having an impact on the techniques and concepts the counselor utilizes during the counseling
process. This study focused on the following counseling process techniques and concepts: self-disclosure, countertransference, spirituality, motivation, confrontation and evidence-based practice.

**Self-Disclosure**

One common counseling technique utilized by both recovering and non-recovering methadone chemical dependency counselors is self-disclosure. Self-disclosure is a counseling technique defined as counselor statements that reveal something personal about the counselor (Hill & Knox, 2002). Counselor self-disclosure has been defined broadly in the literature, but one theme that unites the definitions is that counselor self-disclosure involves the counselor’s personal self-revelatory statement, otherwise known as a recovering counselor’s personal narrative (Hill & Knox, 2002).

In order to increase perceived similarity between themselves and their clients, counselors often self-disclose (Hill & Knox, 2002). Self-disclosure by counselors in recovery fosters a therapeutic alliance, normalizes the client’s experiences, and offers alternative ways to think and behave when trying to overcome an addiction (Hill & Knox, 2002). According to
Lilly, Quirk, Rhodes and Stimson (2000), clients in methadone treatment often state that rapport was built when they perceived that their counselor had experienced opiate use or chemical dependency treatment. In order to maximize rapport and understanding, many clients prefer to have a recovering heroin counselor rather than a counselor with only an educational background (Lilly, Quirk, Rhodes, & Stimson, 2000).

Miller and Rollnick (2002) noted that if a counselor self-disclosed their personal addiction history to a client struggling with a similar addiction, the counselor would be at risk for over identification. This could compromise the counselor’s ability to counsel effectively. Recovering counselors have been found to utilize self-disclosure techniques more often than non-recovering counselors (Culbreth, 2000).

**Counter-Transference**

Another common counseling concept that is part of the methadone counseling process is counter-transference. Counter-transference is defined as the counselor’s emotional reactions to the client (Fisher, 2002). According to Imhof (1995), some level of counter-transference is a natural and normal component of
all therapeutic relationships. Healthy counter-transference can contribute to the feelings, cognitions, behaviors and communications throughout the counseling process: therefore, enhancing the chemical dependency counselor’s capacity for empathy, identification and understanding within the counseling relationship (Imhof, 1995).

According to Culbreth (2000), chemical dependency counselor self-disclosure has been found to put counselors at risk for counter-transference (Culbreth, 2000). According to Imhof (1995), the self-disclosure of the counselor’s personal life may be associated with increased vulnerability to counter-transference reactions. Premature and repetitive counselor self-disclosure is usually reflective of unhealthy counter-transference and can negatively impact the client, the therapeutic relationship and eventually the counselor (Imhof, 1995).

Recovering chemical dependency counselors may be especially at risk for experiencing unhealthy counter-transference in their counseling relationships (Imhof, 1995). According to (Imhof, 1995), the risk of counter-transference is higher for recovering counselors
than non-recovering counselors because they are in a position in which they can project their own personal recovery and chemical dependency histories onto the client and consequently turn the counseling sessions into mutual sharing (Imhof, 1995). In the case of mutual sharing, the counselor may repetitively disclose many details of his or her own life, his or her chemical dependency history, and recovery process (Imhof, 1995). Mutual sharing during counseling sessions could actually harm the client and/or limit the effectiveness of the counseling relationship by flooding the client with counter-transference-oriented disclosures (Imhof, 1995). As a result, the counselor indirectly teaches the client that there is only one road to recovery and change, the counselor’s road (Imhof, 1995).

**Spirituality**

For decades, the spiritual component of recovery from addiction has been incorporated into most chemical dependency treatment programs (White, 1998). Despite insufficient evidence for a spiritual dimension in addictions treatment, most chemical dependency treatment programs continue to utilize treatment modalities based on the Alcoholics Anonymous (AA) 12-step recovery
treatment (Brooks & Clifford, 2000). This perspective stresses that spirituality is absolutely inherent and integral to all levels of chemical dependency treatment. To a certain degree, spirituality even transcends each level of treatment, and is difficult to define in objective, behavioral and measurable terms (Brooks & Clifford, 2000).

Many counselors currently working in the chemical dependency field, regardless of educational background, do not have a personal recovery experience or a clear understanding of the 12-step philosophy. As a result, these counselors find themselves working in chemical dependency treatment programs with an established treatment model that includes a spiritual component (Brooks & Clifford, 2000). Without a clear understanding of the 12-step philosophy, these counselors may fail to comprehend or may be skeptical of the spiritual nature of chemical dependency treatment (Sebenick, 1997).

Academically trained counselors have difficulty reconciling their assumptions about the nature of addiction with their assumptions about AA (Brooks & Clifford, 2000). Many academically trained counselors view the 12-steps of AA as not representative or
consistent with the methodology taught in academic programs (Brooks & Clifford, 2000). White (1998) indicated that both recovering and non-recovering chemical dependency counselors believed that when spirituality is applied to an individual it contributes to creating a moral stigma about addiction.

Motivation

This study also examined how motivation is utilized during the methadone chemical dependency counseling process. Motivation is operationally defined as the client’s willingness to become actively involved in treatment with the determination to change and a preparedness to make sacrifices to obtain a sober lifestyle (Saunders, Wilkinson, & Towers, 1996). In the chemical dependency field, motivation has long been viewed as a matter of importance in the counseling process (Saunders, Wilkinson, & Towers, 1996). However, there are different viewpoints in regards to the most effective technique to increase client motivation.

Sterne and Pittman (1965) found that many counselors’ supported the notion that chemically dependent individuals can be divided into two classes, those who have motivation and those who do not. According
to Saunders, Wilkinson, and Towers (1996), chemical dependency counselors reported that if a client entered treatment lacking motivation they would also lack the inclination to change. If a client lacked the inclination to change, the counselor would be powerless in manipulating the client’s level of motivation (Saunders, Wilkinson & Towers, 1996).

**Confrontation**

Historically, the only effective strategy for dealing with individuals with a chemical dependency, was utilizing the confrontation counseling technique. It was believed that confrontation was necessary to motivate a chemical dependent individual to stop using alcohol or drugs (Fisher & Harrison, 2005). According to Washton (1995), strong confrontation aimed at counteracting denial tends to only intensify the client’s feeling of shame and guilt and may produce alienation rather than cooperation within the counseling relationship (Washton, 1995).

According to Miller and Rollnick (2002), confrontational counseling has been associated with the following: lower client retention rates, an increase in client termination rates and relatively poor treatment
outcomes. Handmaker, Miller, and Manicke (1999) were able to predict a clients’ substance use one year after treatment from the frequency the counselor utilized the confrontation technique. It was found that the more the counselor confronted the client during treatment the more the client would use addictive substances (Handmaker, Miller, & Manicke, 1999).

The traditional chemical dependency counseling approach has been found to utilize confrontation as a means to break through the client’s defenses and provide them with an inside look at the reality of the disease of addiction (De Leon, 1995; Hartel & Glantz, 1999). When utilizing confrontation, the counselor would attempt to remove the client’s defenses and encourage self-effacing in order to rebuild them as a sober person with a sober lifestyle (Futterman, Lorente, & Silverman, 2004). Although a popular method among chemical dependency counselors, harsh confrontation has not been supported in evidence-based practice (Fisher & Harrison, 2005). Miller and Rollnick (2002) found that the use of confrontation methods in the chemical dependency field was a product of the counselor rather than evidence-based practice.
Evidence-Based Practice

This study also examined the type of evidence-based practice utilized by recovering and non-recovering methadone chemical dependency counselors. Evidence-based practices are treatment methods with scientific evidence demonstrating efficacy (Miller, Wilbourne, & Hettema, 2003). Historically, the treatment methods used in the chemical dependency field and those methods found to be effective through scientific evidence have remained separated (Miller, Sorensen, Selzer, & Brigham, 2006). The gap between evidence-based practice and chemical dependency treatment has been attributed to the original development of addiction treatment (Miller, Sorensen, Selzer, & Brigham, 2006). The counseling techniques utilized in the chemical dependency field evolved from practitioners who are in recovery themselves (Miller, Sorensen, Selzer, & Brigham, 2006). As a result chemical dependency counseling techniques continued to be guided by individuals who were in recovery and who followed the perspective of AA and other related 12-step programs (Miller, Sorensen, Selzer, & Brigham, 2006).

Research has shown that counselors in recovery themselves show less interest in utilizing evidence-based
practice techniques and more interest in utilizing techniques that worked in their own recovery experience (McGovern, Fox, Xie, & Drake, 2004). The type of academic degree or years of education does not appear to predict whether a counselor utilizes evidence-based practices (Erickson-Pritchard, 1999). Within the chemical dependency field, there has been the tendency to continue doing what is familiar and comfortable and as a result there is discomfort among counselors in reconsidering long-practiced methods (Miller, Sorensen, Selzer, & Brigham, 2006).

Models of Addiction

Historically, the chemical dependency field has been characterized by a variety of explanations for the same behavior (Fisher & Harrison, 2005). The field has elicited extensive involvement from the legal system, business, government, religious community as well as the medical and mental health fields (Fisher & Harrison, 2005). The differing goals and orientations of these disciplines have resulted in distinct differences in the conceptions of addiction. There are many concepts and theoretical models that have been utilized when
understanding additive behavior. However, this study focused only on two: the disease model and the psychosocial model.

The theoretical disease model of addictive behavior views addiction as the primary disease that is not secondary to some other psychological or behavioral condition (Fisher & Harrison, 2006). In the disease model, addiction is viewed as a disease that is chronic and incurable (Fisher & Harrison, 2006). The underlying rationale that addiction is a disease that is chronic and incurable resulted in the development of the term “recovery” to describe an individual who is maintaining sobriety (Fisher & Harrison, 2006). The disease model of addiction is an implicit component of the Alcoholics Anonymous and Narcotics Anonymous (12-step) programs, as well as many chemical dependency treatment programs (Fisher & Harrison, 2005).

According to Roth (1996), it is normal for individuals to attribute adverse outcomes in their life to factors beyond their personal control. This attribution is congruent with the disease model of addiction. The disease endorsement by recovering counselors may be the result of indoctrination of these
views during their own treatment (Moyer & Miller, 1993). Recovering counselors endorsing the disease model have been found to be more rigid in their belief systems and more inflexible in the treatment process with clients (Moyer & Miller, 1993).

Another theoretical model of addiction is the psychosocial model. The psychosocial model of addiction focuses on factors that are external to the chemically dependent individual such as culture, spirituality, family and peer interactions or psychological conditions (Fisher & Harrison, 2005). The psychosocial model views addiction as the result of multiple combinations of adverse consequences, with multiple prognoses, that may require different types of treatment interventions (Pattison & Kaufman, 1982). According to Fisher and Harrison (2005), it is important for a chemical dependency counselor to consider all variables that may be affecting the client during treatment.

Humphreys, Noke and Moos (1996), found that counselors’ educational backgrounds are positively correlated to the endorsement of the psychosocial model and negatively correlated to the disease model. Various studies have indicated that recovering counselors are
more likely than non-recovering counselors to view chemically dependent clients as a homogenous population and as a result utilize a uniform counseling technique that incorporates the disease model of addiction (Humphreys, Noke, & Moos, 1996).

Theories Guiding Conceptualization

In this study the generalist practice model guided the conceptualization of uncovering the methadone counseling process of recovering and non-recovering chemically dependency counselors. The researchers utilized the steps in the generalist practice model as a tool to delineate how chemical dependency counselors use various techniques and concepts in the methadone counseling process.

Generalist Practice Model

The examination of the techniques and concepts in the methadone counseling process among recovering and non-recovering chemical dependency counselors was guided by the Generalist Practice Model (GPM). The GPM is a problem solving method that provides counselors with clear step-by-step guidelines for working with individual clients (Kirst-Ashman & Hull, 2006). The generalist
practice model is a foundation for relationship-building, interviewing, and problem-solving when working with individual clients (Kirst-Ashman & Hull, 2006). All of the steps of the generalist practice model: engagement, assessment, planning, implementation, evaluation, termination, and follow-up are critical throughout the counseling process (Kirst-Ashman & Hull, 2006). The techniques and concepts of the counseling process that was examined in this study can be utilized at any step of the GPM.

Summary

This chapter presented the literature relevant and related to uncovering the methadone counseling process of recovering and non-recovering chemical dependency counselors. The literature reviewed in this chapter discussed the theoretical models of addiction and identified that the delivery of counseling services is a critical component of chemical dependency treatment. This chapter examined what techniques or concepts the methadone chemical dependency counselors utilize throughout the counseling process. The techniques and concepts were: self-disclosure, countertransference,
spirituality, motivation, confrontation, and evidence-based practice.
CHAPTER THREE

METHODS

Introduction

This chapter will address the study design, sampling strategy, data collection, and instruments. The chapter defines the procedures by which the data was collected and how the data was analyzed. Additionally, this chapter will also address the precautions that were taken to ensure the proper protection of human subjects.

Study Design

The purpose of this study was to uncover the methadone counseling process among recovering and non-recovering chemical dependency counselors. This study examined the counselors' background, theoretical models of addiction, the techniques, and concepts that pertain to the methadone counseling process. In addition, this study delineated the different techniques and concepts utilized by recovering and non-recovering chemical dependency counselors through the Generalist Practice Model.

This study used a combination of quantitative and qualitative methods. The study consisted of a
standardized survey questionnaire to investigate conceptions of addiction and face-to-face exploratory interviews designed to capture the techniques and concepts utilized by methadone counselors throughout the counseling process.

A quantitative, standardized, group-administered survey was used to determine the methadone counselors’ conceptions of addiction based on a revised version of William Miller and Theresa Moyer’s Understanding of Alcoholism Scale.

The qualitative portion of this study included in-depth face-to-face interviews with individual recovering and non-recovering methadone counselors. The qualitative portion of the study employed a non-standardized interview guide as the instrument for data collection. The interview guide was developed by the researchers to examine the concepts and techniques that the counselor utilizes throughout the counseling process.

The data for this study was obtained from six opiate outpatient treatment facilities in the Los Angeles and Inland Empire regions of Southern California that are owned and operated by the Camp Recovery Center Health Group Incorporated (CRC). The data was collected at six
opiate outpatient treatment facilities located in the cities of: Colton, Los Angeles, Montclair, Palm Springs, Riverside and Wilmington. The specific CRC opiate outpatient treatment facilities that the researchers conducted their research in were: WCHS, Inc. in Riverside; Colton Clinical Services in Colton; Jeff Grand Treatment Center in Los Angeles; Desert Treatment Center in Palm Springs, Recovery Treatment Center in Montclair; and Coastal Recovery Center in Wilmington. The regional director of the six facilities in the Los Angeles and Inland Empire regions was contacted by the researchers in person and through e-mail. The following documents were provided to the regional director: a copy of the researchers' research project proposal, an explanation of the purpose of the study, and a request of permission to conduct research at the six specific Los Angeles and Inland Empire opiate outpatient treatment facilities.

The regional director provided the researchers with a letter of approval to conduct research at all CRC facilities on WCHS letterhead, which is one of the six clinics within the Los Angeles and Inland Empire region. Prior to conducting research, the regional director requested that the researchers receive training on how to
sign confidentiality statements and instructions on how to document entering/exiting the clinics. The regional director of the Inland Empire and Los Angeles region contacted each director of the six clinics by email to inform them that they would be contacted by the researchers to schedule an appointment during their weekly meeting to conduct group-administered surveys.

Within two weeks after conducting the quantitative portion of this study each researcher contacted three counselors from the opiate outpatient facility located in Riverside to schedule an appointment to conduct face-to-face interviews.

There are several limitations of this study. The methadone counselors surveyed were employed by CRC and worked within the six clinics mentioned. Therefore, the results of this study cannot be generalized to other populations. In addition, the number of completed surveys and participants in the face-to-face interviews might have been influenced by the researchers' presence. The respondents may have reacted subjectively to the personality of the researchers rather than the content of the survey and interview questions.
Sampling

This study employed purposive sampling to collect the data for both the quantitative and qualitative portions of the study. The participants for the quantitative portion of the study consisted of all the methadone counselors that were present at the weekly staff meetings held at the CRC opiate outpatient facilities in the California cities of Colton, Los Angeles, Montclair, Palm Springs, Riverside and Wilmington. There was a sample size of 41 participants for the quantitative portion of the study.

For the qualitative portion of the study, participants selected consisted of six methadone counselors from the Riverside CRC opiate outpatient treatment facility. The individuals selected to participate had a minimum of six months of experience as a CRC methadone counselor and had volunteered to be interviewed after completing the survey.

The demographics of the participants for this study included both male and female counselors varying in ethnicities, races and educational backgrounds. The age of the participating counselors ranged from 23 to 65. The participants' characteristics were consistent with the
state of California alcohol and drug certification/registration requirements. The counselors were chosen as the primary data source due to their critical role in uncovering the methadone counseling process.

Data Collection and Instruments

The quantitative portion of this study employed a survey that included both open-ended and closed-ended questions. The survey used was a revised version of Miller and Moyer’s Understanding of Alcoholism Scale. A revised measuring instrument was utilized because the standardized measuring instrument found to date only addresses alcoholism and the concern for this study was all addictions. According to Toriello and Leierer (2005), changing the phrase alcoholism to addiction does not change the concepts being measured in the scale.

Other revisions to the survey included removing the questions from the original survey regarding the heterogeneity model of addiction. The questions regarding the heterogeneity model of addiction were removed because this study was not focusing on that particular model of addiction. This reduced the 70-item instrument to a
50-item instrument examining the disease model and psychosocial model of addiction.

The researchers also added a variety of open-ended and closed-ended questions concerning counselor demographics to the beginning of the revised survey. A majority of the demographic data was obtained with closed-ended questions on variables of ethnicity, gender, age, highest level of education, and counselor's recovery status. Open-ended questions included: the length of experience as a chemical dependency counselor with the CRC Corporation, ethnicity and education level if the options provided on the questionnaire were not sufficient. The other 50-closed-ended questions, used a Likert-type scale to assess the counselors' conception of addiction (Appendix A).

Approximately two weeks after administering the survey the qualitative data for this study was collected using in-depth face-to-face interviews. The participants that were interviewed were six methadone counselors at the Riverside Treatment Center who had volunteered to be interviewed after completing the survey. Three of the counselors interviewed identified themselves as being in recovery, while the other three participants identified
themselves as non-recovery counselors. The researchers' asked the following open-ended questions: to what extent are you confrontational with clients who are in denial; to what extent do you use your personal narrative with clients; how do you establish good rapport with a client; to what extent does counter-transference happen to you with your clients; how do you tell if a client is being honest with you about their use of drugs or alcohol; how do you motivate your client to stop using drugs or alcohol; to what extent do you use spirituality to help your clients; and to what extent do you rely on evidence-based practice during your counseling session.

Several limitations of this study were acknowledged. The data obtained from this study was based on the chemical dependency counselor’s self-report; as a result the surveys and interviews of this study are as valid as the truthfulness and accuracy of the counselors’ responses. During this study, counselors may have responded with socially appropriate responses and may have not felt that the alternatives provided were appropriate to their perceptions.

Another limitation is that the sample size for the qualitative portion of this study was small and purposive
rather than a random sample; therefore, the results of this study cannot be generalized to all chemical dependency counselors. In addition, the quantitative portion of this study only examined the disease model and psychosocial model of addiction; therefore, other conceptions of addiction were not examined. Another limitation of this study is that the quantitative and qualitative portions of this study was conducted with a sample that was composed of chemical dependency counselors employed at the specified CRC opioid outpatient treatment programs; therefore, the results may or may not reflect all of the differing responses of recovering and non-recovering chemical dependency counselors.

The independent and dependent variables of this study were determined after the results from both the quantitative and qualitative studies were analyzed.

The appropriate type of statistical analysis that was used was directed by the determination of a variable's level of measurement. The demographic variables of this study were a nominal level of measurement. Variables on the survey that were at the ordinal level of measurement are the questions that will
require the participant to select from the following: 5 (strongly agree), 4 (mostly agree), 3 (unsure), 2 (mostly disagree) and 1 (agree).

Procedures

The researchers' contacted each director of the six CRC opiate outpatient facilities by phone to schedule an appointment to conduct the group-administered survey during their weekly staff meetings. The director of each clinic made an announcement to all the methadone counselors in the clinic about the nature of the study and the date that the researchers would be conducting the survey portion of the study.

The researchers distributed the surveys at the six opiate outpatient facilities during their weekly staff meeting in order to present a limited intrusion on the daily activities of the counselors. During the staff meetings the researchers distributed a packet to all the methadone counselors present. This packet included the informed consent, the revised Understanding Addiction Scale survey, and a five-dollar Starbucks gift card. The informed consent form stated that the study was voluntary and if the counselor did not wish to participate in the
survey, the counselor could return the survey without consequence.

The researchers made an announcement to the counselors present that they were looking for volunteers to participate in face-to-face interviews that would take place at a later date. The researchers were present while the counselors completed the surveys to answer any questions. The survey took each counselor approximately 20 minutes to complete. The researchers collected the completed and placed them in a manila envelope. At the completion of the survey, the researchers provided the counselor with a copy of the debriefing statement that included a description of the purpose of the study (Appendix C). If the counselor was interested in participating in the interview portion of the study they provided the researchers with a business card.

Approximately two weeks after conducting the quantitative portion of the study, each researcher contacted three methadone counselors from the Riverside Treatment Center that volunteered to be interviewed by the researchers. The interviewees consisted of six methadone counselors, who had a minimum of six months of experience as a chemical dependency counselor and had
volunteered to participate in the qualitative portion of the study.

The interviews occurred in the counselors' offices within the Riverside Treatment Center. Conducting the interviews in the counselor's office insured privacy during the interview. Prior to beginning the in-depth face-to-face exploratory interview the researcher provided an informed consent that informed each participant that all their responses would be kept confidential (Appendix D). The researcher also informed each participant that the interview would be audio-recorded; if the participant did not wish to be recorded the interview was hand written by the interviewer (Appendix E). At this time the participant was provided with a ten-dollar Starbucks card for participating in the study. The researcher utilized the eight open-ended questions listed in Appendix E to guide the interview (Appendix E). Each interview took approximately 30-45 minutes to complete. At the conclusion of each interview, the participating counselors were provided with a copy of the debriefing statement with the purpose of the study (Appendix F).
Protection of Human Subjects

Prior to participating in this study the participants were provided informed consent forms, describing the purpose of the study and the nature of their participation. The respondents were informed that they did not have to participate in the study and that they were free to withdraw their consent to participate or discontinue their participation at any time. At the conclusion of the counselors' participation in the study they were provided with debriefing statements with the names of the researchers, their advisor, and a phone number to contact in the event that they have any questions concerning the study.

Participants were informed that all answers would remain confidential. To ensure the confidentiality of the participants, the names and identifying data were not recorded. However, the age, gender, level of education, ethnicity, race, recovery status and years of experience as a chemical dependency counselor were recorded for statistical analysis. To further protect confidentiality, the data collected was kept in a safe deposit box during the study.
At the conclusion of the research project, the researchers destroyed all audio recordings of interviews. A serial research number was assigned to each survey and interview during the data collection process. Therefore, when analyzing data the computer file was only identified by a research number. Survey and interview procedures were designed to ensure that the participants' answers were individual and private.

Data Analysis

Both qualitative and quantitative measures were analyzed. The data from the quantitative portion of the study was statistically analyzed using SPSS. The statistical analysis included: frequencies and t-tests. The qualitative interview responses were transcribed and analyzed by the researchers.

Summary

This study consisted of quantitative and qualitative questions which were nominal and ordinal. This study utilized surveys and in depth face-to-face interviews to collect data to uncover the concepts and techniques utilized by methadone counselors throughout the counseling process. The participants were methadone
counselors selected from six CRC opiate outpatient facilities within the Los Angeles and Inland Empire region. The quantitative portion of the study included a survey that uncovered information on the conceptions of addiction among recovering and non-recovering methadone counselors. The qualitative face-to-face interviews uncovered the techniques and concepts utilized by the methadone counselor throughout the counseling process.

The purpose of this study was to uncover the methadone counseling process among recovering and non-recovering chemical dependency counselors. Specifically, the study focused on methadone counselors' conception of addiction, techniques and concepts utilized throughout the counseling process.

The study was strictly confidential and the researchers conducted all data collection. Informed consents and debriefing statements were provided to all of the participants. The statistical analysis utilized by the researchers included: frequencies and t-tests.
CHAPTER FOUR

RESULTS

Introduction

This section describes the results from surveys and interviews obtained from chemical dependency counselors. The Chapter will conclude with a summary of the results.

Presentation of the Findings

Table 1. Gender

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>22.0</td>
<td>22.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
<td>78.0</td>
<td>78.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 1 identifies that of the 41 participants surveyed, 78% (n = 32) were female (n = 9) and 22% were male.
Table 2. Recovery Status

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Yes-recovery</td>
<td>21</td>
<td>51.2</td>
<td>52.5</td>
<td>52.5</td>
</tr>
<tr>
<td>No-Non-recovery</td>
<td>19</td>
<td>46.3</td>
<td>47.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>97.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Of the 41 participants surveyed, 40 noted their recovery status. Twenty-one participants or 51% identified themselves as being in "recovery" and 46% (n = 19) identify themselves as being non-recovery.

Table 3. Age

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid 23 to 33</td>
<td>11</td>
<td>26.8</td>
<td>26.8</td>
<td>26.8</td>
</tr>
<tr>
<td>34 to 43</td>
<td>13</td>
<td>31.7</td>
<td>31.7</td>
<td>58.5</td>
</tr>
<tr>
<td>44 to 53</td>
<td>13</td>
<td>31.7</td>
<td>31.7</td>
<td>90.2</td>
</tr>
<tr>
<td>54 to 65</td>
<td>4</td>
<td>9.8</td>
<td>9.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 indicates that all 41 participants indicated their age. The age of the participants ranged from 23 to
65, with 31.7% (n = 13) the largest number of participants between the ages of 34 to 43 and 44 to 53.

Table 4. Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian American</td>
<td>1</td>
<td>2.4</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Black/African American</td>
<td>7</td>
<td>17.1</td>
<td>17.5</td>
<td>20.0</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>14</td>
<td>34.1</td>
<td>35.0</td>
<td>55.0</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>4.9</td>
<td>5.0</td>
<td>60.0</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>13</td>
<td>31.7</td>
<td>32.5</td>
<td>92.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>2</td>
<td>4.9</td>
<td>5.0</td>
<td>97.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.4</td>
<td>2.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>97.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 indicates that of the 41 participants, 40 noted ethnicities. Fourteen or 34.1% of the participants were Hispanic/Latino, 31.7% (n = 13) were White/Caucasian, 17.1% (n = 7) were Black/African American, 4.9% (n = 2) were Native American, 2.4% (n = 1)
were Asian American, 4.9% (n = 2) were mixed, and 2.4% (n = 1) were other.

Table 5. Highest Level of Education

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduated from high school</td>
<td>1</td>
<td>2.4</td>
<td>4.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Some college but, did not receive diploma</td>
<td>1</td>
<td>2.4</td>
<td>4.3</td>
<td>8.7</td>
</tr>
<tr>
<td>Certification in substance abuse field</td>
<td>8</td>
<td>19.5</td>
<td>34.8</td>
<td>43.5</td>
</tr>
<tr>
<td>Associate in Arts degree (2 year college diploma)</td>
<td>4</td>
<td>9.8</td>
<td>17.4</td>
<td>60.9</td>
</tr>
<tr>
<td>Bachelor in Arts degree (4 year college diploma)</td>
<td>5</td>
<td>12.2</td>
<td>21.7</td>
<td>82.6</td>
</tr>
<tr>
<td>Master in Arts degree (6 year)</td>
<td>3</td>
<td>7.3</td>
<td>13.0</td>
<td>95.7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.4</td>
<td>4.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>56.1</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>18</td>
<td>43.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participant’s highest level of education was examined. Eighteen participants did not indicate their
highest level of education. Of a possible 41 participants, 23 respondents noted the following: 19.5% (n = 8) reported having certification in the field of substance abuse, 12.2% (n = 5) indicated having a Bachelor's degree, 9.8% (n = 4) had an Associate's degree, 7.3% (n = 3) indicated having a Master's degree, 2.4 (n = 1) reported having a high school diploma, and 2.4% (n = 1) had some college education without obtaining a degree.

Table 6. Years as Counselor

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year and under</td>
<td>9</td>
<td>22.0</td>
<td>25.7</td>
<td>25.7</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td>12</td>
<td>29.3</td>
<td>34.3</td>
<td>60.0</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>9</td>
<td>22.0</td>
<td>25.7</td>
<td>85.7</td>
</tr>
<tr>
<td>11 to 15 years</td>
<td>1</td>
<td>2.4</td>
<td>2.9</td>
<td>88.6</td>
</tr>
<tr>
<td>16 to 20 years</td>
<td>3</td>
<td>7.3</td>
<td>8.6</td>
<td>97.1</td>
</tr>
<tr>
<td>21 years and over</td>
<td>1</td>
<td>2.4</td>
<td>2.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>85.4</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing System</td>
<td>6</td>
<td>14.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The survey included an open-ended question regarding the number of years the participant worked as a counselor in the substance abuse field. For the purposes of data analysis, categories were created from the range of responses received. The reported number of years as a counselor was categorized as 1 year and under, 2 to 5 years, 6 to 10 years, 11 to 15 years, 16 to 20 years, and 21 years and over. Of the 41 participants, only 35 indicated the number of years they worked as a substance abuse counselor. Of the 35, twelve (29.3%) reported working between 2 to 5 years; 22% (n = 9) indicated that they worked 6 to 10 years and 1 year or less; 7.3% (n = 3) reported working as a counselor 16 to 20 years; and only 2.4% (n = 1) worked as a counselor for 11 to 15 years and 21 years or more.

An independent-samples t-test (Appendix G) was conducted to compare the disease model scores for recovery and non-recovery counselors. There was a significant difference in scores for recovery (M = 3.59, SD = .524) and non-recovery [M = 3.19, SD = .401; t(38) = 2.30, p = .03). This finding suggests that recovery counselors were more likely to use a disease model of addiction than were non-recovery counselors.
An independent-samples t-test (Appendix H) was also conducted to compare the psychosocial model scores for recovery and non-recovery counselors. There was no significant difference in scores for recovery ($M = 3.44$, $SD = .529$) and non-recovery counselors [$M = 3.63$, $SD = .444$; $t(38) = -1.23, p = .23$]. This finding suggests that neither recovery nor non-recovery counselors were more or less likely to use a psychosocial model of addiction.
Qualitative Interviews

Table 7. Qualitative Results

<table>
<thead>
<tr>
<th></th>
<th>Recovering</th>
<th>Non-recovering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Field</td>
<td>Own history (3)</td>
<td>Family history (1)</td>
</tr>
<tr>
<td></td>
<td>&quot;Fell into it&quot; (2)</td>
<td></td>
</tr>
<tr>
<td>Confrontation</td>
<td>Yes (3)</td>
<td>Sometimes (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unsure (1)</td>
</tr>
<tr>
<td>Rapport</td>
<td>Self-Disclosure (2)</td>
<td>Commonality (2)</td>
</tr>
<tr>
<td></td>
<td>Supportive (1)</td>
<td>Supportive (1)</td>
</tr>
<tr>
<td>Personal Narrative</td>
<td>Yes (3)</td>
<td>No (3)</td>
</tr>
<tr>
<td>Counter-transference</td>
<td>Yes (3)</td>
<td>No (3)</td>
</tr>
<tr>
<td>Honesty of Client</td>
<td>Behavior (3)</td>
<td>Behavior (3)</td>
</tr>
<tr>
<td>Spirituality</td>
<td>Yes has own (2)</td>
<td>Yes has own (2)</td>
</tr>
<tr>
<td></td>
<td>No doesn't have own (1)</td>
<td>Not sure (1)</td>
</tr>
<tr>
<td>Motivate</td>
<td>Build self-esteem (1)</td>
<td>Build self-esteem (2)</td>
</tr>
<tr>
<td></td>
<td>Effects of drug use (2)</td>
<td></td>
</tr>
<tr>
<td>Evidence Based</td>
<td>Yes (2)</td>
<td>No (3)</td>
</tr>
<tr>
<td></td>
<td>No (1)</td>
<td></td>
</tr>
</tbody>
</table>

Six chemical dependency counselors (three recovery and three non-recovery) participated in the interviews. Differences were evident between the participating recovering and non-recovering chemical dependency counselors in the concepts of (a) confrontation, (b) self-disclosure, (c) personal narrative,
(d) counter-transference, and reason for entering the chemical dependency field (Table 7).

The findings uncovered that recovering chemical dependency counselors' personal history of addiction was important in their decision to enter the chemical dependency field. "I was assisting people with getting off of drugs as I was doing drugs with them" (quote from a recovering chemical dependency counselor). A majority of the participating non-recovering chemical dependency counselors reported that they "fell into" the chemical dependency field.

Counter-transference was a counseling technique that was reported most often utilized by recovering chemical dependency counselors. "I use confrontation a lot if the client comes back with a positive urinalysis" (quote from a recovering chemical dependency counselor). A majority of the non-recovering chemical dependency respondents reported that they are less likely to utilize confrontation throughout the counseling process.

Another significant finding was that a majority of recovering chemical dependency respondents' utilized self-disclosure not only in their personal narrative but throughout the counseling process in order to build
rapport with their clients. "I give them a real fast disclosure and I say this is where I am at and this is where I have been, I have 25 years of addiction myself" (quote from a recovering chemical dependency counselor). Another recovering chemical dependency counselor reported: "I use it to build rapport with my clients." A majority of non-recovering respondents reported that they did not utilize self-disclosure as a counseling technique. "No, not as much as most of them because I am not in recovery" (quote from a non-recovering chemical dependency counselor).

There was a detectable difference between recovering and non-recovering chemical dependency counselors' responses to the interview question concerning counter-transference. All (how many right here? - just say the number instead of all) of the recovering counselors reported that they had experienced counter-transference throughout the counseling process. "I mean everyone has it, especially people who have been through it" (quote from a recovering chemical dependency counselor). All (just spell out number again) of the non-recovering chemical dependency respondents denied experiencing counter-transference throughout the
counseling process. "I have never had that problem" (quote from a non-recovering chemical dependency counselor).

Conclusion

Chapter Four reported survey and interview results. Survey results suggest a statistically significant difference between recovering and non-recovering counselors' use of a theoretical model to understand addictive behavior. When compared to counselors who were not in recovery, the recovering counselors were more likely to prefer a disease model to understand addictive behavior. Face-to-face interviews with six chemical dependency counselors suggested that counselors in recovery are more likely to use confrontation, self-disclose, use personal narrative, and have counter-transference with their clients than counselors who are not in recovery.
CHAPTER FIVE

DISCUSSION

Introduction

This study examined the methadone counseling process among recovering and non-recovering chemical dependency counselors by examining the concepts and techniques utilized throughout the counseling process. Specifically, this study examined whether the recovery status of a counselor affected the counselor's theoretical model to understand addiction as well as the concepts and techniques that were utilized throughout the counseling process. In Chapter Five, the conclusions of this study are discussed; the limitations of the study are presented; and recommendations for social work practice, policy and research are offered. The Chapter concludes with a summary.

Discussion

It was hypothesized that the theoretical addiction model, techniques and concepts of the counseling process would differ among recovering and non-recovering methadone chemical dependency counselors. This study supports this hypothesis: recovering chemical dependency
counselors are indeed more likely to prefer the disease model to explain addictive behaviors. In addition, and consistent with the inherent simplicity in the disease model of addiction, recovering chemical dependency counselors used the techniques and concepts of self-disclosure, personal narrative, counter-transference, and confrontation in their counseling process.

Recovering chemical dependency counselors may well prefer using the disease model of addiction in treatment approaches because it is easy to use, and may well be consistent with the exigencies of everyday clinical practice. In contrast to the natural simplicity built into the disease model, the psychosocial model of addiction may well be more difficult to use in everyday practice because it focuses on a complex web of internal, external, and interactive factors to explain addictive disorders. The psychosocial model may well be simply too comprehensive and complex to use for chemical dependency counselors who face everyday exigencies in clinical practice. Attempting to address the underlying biological, psychological, and social stressors leading to addiction may well prevent the counselor from
providing immediate and effective treatment to the client.

Among substance abuse counselors, the use of a disease model may well be effective because it removes any moral or value-judgment stigma attached to addictive behavior among clients in treatment. In the disease model, recall, clients are regarded as having the 'disease' of addiction, and should be treated as fairly as a diabetic or any other person who happens to have a physical or mental 'disease.' Of particular interest here is the idea that counselors in recovery may well find the disease model useful because it 'de-stigmatizes' not only their own personal narrative of embarrassment, blame, and guilt for having had at one time an 'addictions' disease, but the disease model might also prove useful to chemical dependency counselors because the model offers clients a way to remove the stigma of addictions, which might in turn encourage clients to develop self-sustained attendance during their treatment.

The notion of addiction as a disease (chronic and incurable), and one's own personal experience with its devastating impact, may well prompt the recovering chemical dependency counselor to employ direct and
uncomplicated counseling techniques, including personal narrative and self-disclosure. For the counselor in recovery, the use of self-disclosure may be a way for the recovering counselor to indicate that he or she is an authentic expert in the client's addictive disorder.

Because the client may well use defense mechanisms to conceal their addictive disorder, the recovering chemical dependency counselor may tend to use direct confrontation to address the client's denial.

Limitations

A limitation of this study is that the surveys and interviews occurred at only at CRC Treatment facilities. Therefore, the participants surveyed and interviewed may not reflect the beliefs and techniques of chemical dependency counselors in other treatment facilities. Another limitation of the survey study was that there was not an equal balance of male (22%) and female (78%) participants. In addition, the number of completed surveys may have been influenced by the researchers' presence at the staff meetings. Study participants may have been engaged in socially desirable answers rather than on the substantive content of the survey. Responses
from respondents may also have been influenced by the researcher’s gender or appearance.

In short, the surveys and interviews are as valid as the truthfulness and accuracy of the counselors’ responses. The limitations of this approach include the possibility that chemical dependency counselors may not feel that the alternatives provided were appropriate to their answers.

Recommendations for Social Work Practice, Policy and Research

This research impacts social work on various levels. For the social work practice, this research offers data reflecting the preferred treatment model for understanding addiction currently used in practice among recovering chemical dependency counselors. In addition, this study provided insight about the different concepts and techniques that are considered particularly important by chemical dependency counselors during the methadone counseling process. This information will offer practicing social work professionals areas for training in counseling skills. Social workers can use the information contained in this research to aid them in
making decisions regarding their approach to an individual’s treatment.

This project provides useful information to Camp Recovery Center Health Group Incorporated (CRC) in terms of meeting the needs of future and current clients. The research findings from this study indicate that the chemical dependency counselors at the six clinics surveyed did not use a uniform model to understand addictive behavior when working with clients. In addition, the three non-recovering counselors interviewed indicated that they either did not utilize or were unaware of certain therapeutic processes. This perhaps suggests that CRC needs to conduct a more thorough approach to employment education and supervision in order to provide counselors with a variety of strategies available to use during treatment.

In terms of social work research, this project will contribute to the relatively small body of literature on the therapeutic process that occurs during methadone treatment. Most of the research on chemical dependency counseling has focused on treatment outcome without examining the concepts and techniques that are utilized throughout the counseling process. An examination of the
concepts and techniques of the methadone counseling process can provide a clearer and more comprehensive picture of the social work skills that can be generalized and modified to work in the current treatment environment of chemical dependency.

Conclusions

In summary, results of this study indicated that recovering and non-recovering chemical dependency counselors' use a different theoretical model to understand addictive behavior. Recovering chemical dependency counselors also employ different therapeutic techniques during the therapeutic process. These techniques may be used at different stages of the Generalist Intervention Model in order to undertake the change process. It is hoped that this research project will stimulate interest in this subject and encourage future research.
APPENDIX A

QUANTITATIVE SURVEY
Understanding of Addiction Scale

Questions #1-6 ask you to provide information for statistical purposes.

1. Your gender
   (Circle one number below)
   1. Male
   2. Female

2. Your age:
   (Circle one number below)
   1. 23 to 33
   2. 34 to 43
   3. 44 to 53
   4. 54 to 65

3. Your ethnicity: (Circle one number below)
   1. Asian American
   2. Black/African American
   3. Hispanic/Latino
   4. Native American
   5. White/Caucasian
   6. Mixed (specify): ______________________
   7. Other (specify): ______________________

4. Would you describe yourself as being in “recovery”? (Circle one either yes or no)
   YES or NO

5. What level of education do you have?
   (Circle the number of the one that applies if none apply fill in space provided)
   1. Graduated from high school
   2. Did not graduate high school but, have GED
   3. Some college but, did not receive diploma
   4. Certification in substance abuse field
   5. Associate in Arts degree (2 year college diploma)
   6. Bachelor in Arts degree (4 year college diploma)
   7. Master in Arts degree (6 year)
   8. Other (specify): ______________________

6. How long have you worked as a counselor in the substance abuse field:
   ______________________
For each of the following statements, rate the extent to which you agree or disagree, using the rating scale provided. If you neither agree nor disagree with a statement, answer "3" (unsure).

<table>
<thead>
<tr>
<th>Do you agree?</th>
<th>Strongly Disagree</th>
<th>Mostly Disagree</th>
<th>Unsure</th>
<th>Mostly Agree</th>
<th>Strongly Agree</th>
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<tr>
<td>7. A person’s environment plays an important role in determining whether he or she develops a drug problem.</td>
<td>1</td>
<td>2</td>
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<td>8. If an addict uses a drug, he or she loses control and is unable to stop using more.</td>
<td>1</td>
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<td>9. Anyone can develop an addiction if he or she uses drugs enough.</td>
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<td>10. People can be born drug addicts, even if their mothers have not used drugs.</td>
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<td>11. Drug addicts tend to be weak in morals or character.</td>
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<td>12. Twelve-step groups like NA and AA are the only really successful route to recovery.</td>
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<td>13. Spiritual problems lie at the core of drug addiction.</td>
<td>1</td>
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<td>14. It is important to treat an addict’s psychological problems such as depression and anxiety.</td>
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<td>15. Drug addiction is caused, in part, by growing up in a dysfunctional family.</td>
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<td>2</td>
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<td>16. Sometimes an addict who has been addicted to a drug can go back to using that drug in moderation.</td>
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<td>17. Drug addicts usually lie about how much they are using.</td>
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<td>Do you agree?</td>
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<td>18. The brains of drug addicts are different from those of normal people, which is one reason that they become addicted.</td>
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<td>19. Anyone who uses drugs to get high is an addict.</td>
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<td>2</td>
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<td>20. Drug addiction follows a single predictable path of progressive deterioration as long as the person keeps using.</td>
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<td>21. There are people in the world who are drug addicts but don’t know it, because they haven’t yet found their drug.</td>
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<td>2</td>
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<td>22. The denial of drug addicts is so strong that it is often necessary to use very strong confrontation to get them to accept reality.</td>
<td>1</td>
<td>2</td>
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<td>23. The more a person uses a drug, the greater the chances of becoming addicted.</td>
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<td>24. There is an addictive personality that can be seen as early as adolescence, even before the person starts using drugs.</td>
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<td>25. Some drug addicts wind up using drugs moderately without problems.</td>
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<td>26. It is necessary to treat the drug addict’s family, too, for the addict to recover.</td>
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<td>27. There is no “addictive personality” —addicts differ from each other as much as other people do.</td>
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<td>28. A person’s genes determine whether or not he or she will be a drug addict.</td>
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<td>Do you agree?</td>
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<td>29. Once a person is drug addict, he or she will always be a drug addict.</td>
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<td>30. Drug addiction is, in part, a spiritual deficit.</td>
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<td>31. Drug addicts who are using cannot make good decisions for themselves.</td>
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<td>32. Drug addiction is caused, in part, by what one learns about drugs and</td>
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<td>how drugs are used by one’s family and friends.</td>
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<td>33. Every drug addict must accept that he or she is powerless over their</td>
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<td>drug and can never use it again.</td>
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<td>34. In the long run, most drug addicts recover and live relatively normal</td>
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<td>lives.</td>
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<td>35. Drug addicts are liars and cannot be trusted.</td>
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<td>36. If a drug addict is clean for five years, then starts using again, he or</td>
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<td>she is right back where he or she left off in the development of the</td>
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<td>addiction.</td>
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<td>37. There are only two possibilities for a drug addict: lifelong abstinence</td>
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<td>or death.</td>
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<td>38. Unless the family is also treated, they are likely to undermine the</td>
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<td>addict’s recovery.</td>
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<td>39. The clergy (pastors, priests, rabbis, and/or healers) have an important</td>
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<td>role to play in the recovery of addicts.</td>
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<td>40. Differing kinds of addicts need different kinds of treatment.</td>
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<td>Do you agree?</td>
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<td>41. Unless addicts rely on God or a Higher Power they will not recover.</td>
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<td>42. The society or culture in which one grows up has a significant influence on whether or not one becomes an addict.</td>
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<td>43. The bodies of addicts are different from those of nonaddicts, even when they are not using.</td>
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<td>44. A person can develop drug addiction because of underlying psychological problems.</td>
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<td>45. Most drug addicts relapse after treatment.</td>
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<td>46. In general, recovering addicts are more effective than nonaddicts in treating drug addiction.</td>
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<td>47. Members of addicts’ families need to be treated for codependence.</td>
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<td>5</td>
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<td>48. The development of spiritual faith is crucial for recovery from drug addiction.</td>
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<td>5</td>
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<tr>
<td>49. Every drug addict is one use away from a relapse.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>50. There are no shades of gray; either you are a drug addict or you aren’t.</td>
<td>1</td>
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APPENDIX B

QUANTITATIVE INFORMED CONSENT
INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate the counseling process of methadone chemical dependency counselors. This study is being conducted by Jennifer Palmersheim and Sara-Amanda McCarthy under the supervision of Dr. Thomas Davis, professor of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to several questions developed to assess your conceptions of addiction. The following questionnaire should take about 15 to 20 minutes to complete. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion in June 2007 at the John M. Pfau Library at California State University, San Bernardino.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail and a $5 gift card to Starbucks. In order to ensure to validity of the study, we ask that you not discuss this study with other students or participants.

If you have any questions or concerns about this study, please feel free to contact my faculty supervisor, Dr. Thomas Davis at (909) 537-3839.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at LEAST 18 YEARS OF AGE.

Place a check mark here □               Date: _______________________
APPENDIX C

QUANTITATIVE DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

The study you have just completed was designed to investigate the conceptions of addiction among recovering and non-recovering methadone chemical dependency counselors. In this study two models of addiction were assessed: the disease model and psychosocial model. The model of addiction is based on the conceptions of addiction a chemical dependency counselor utilizes when working with clients. The recovery status of a chemical dependency counselor has been found to influence their model of addiction. We are particularly interested in how the recovery status of a counselor influences their model of addiction.

Thank you for your participation and for not discussing the contents of the survey questions with other counselors in your clinic and in other CRC opioid outpatient treatment programs. In the event that you become uncomfortable as a result of this study, a mental health provider will be offered. If you have any questions about this study, please feel free to contact Jennifer Palmersheim, Sara-Amanda McCarthy or Dr. Thomas Davis at (909) 537-3839. If you would like to obtain a copy of the group results of this study, please contact Dr. Thomas Davis at (909) 537-3839 after June 2007. The results of this study will also be available after June 2007 to view at California State University, San Bernardino in the John M. Pfau Library.
APPENDIX D

QUALITATIVE INTERVIEW GUIDE
Interview Guide

1) To what extent are you confrontational with clients who are in denial?

2) To what extent do you use your personal narrative with clients?

3) How do you establish good rapport with a client?

4) To what extent does countertransference happen to you with your clients?

5) How do you tell if a client is being honest with you about their use of drugs and alcohol?

6) How do you motivate your client to stop using drugs or alcohol?

7) To what extent do you use spirituality to help your clients?

8) To what extent do you rely on evidenced based practice in your counseling session?
APPENDIX E

QUALITATIVE INFORMED CONSENT
INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate the methadone counseling process. This study is being conducted by Jennifer Palmersheim and Sara-Amanda McCarthy under the supervision of Dr. Thomas Davis of professor of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to several questions regarding your counseling process. Participation will consist of an interview that should take about 30 to 45 minutes to complete. With your permission the interview will be audio taped. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion in June 2007 at the following location John M. Pfau Library at California State University, San Bernardino.

There are no foreseeable risks attached to this study, and all information will be kept strictly confidential. Your interview will be given a number and neither your name nor that of the clinic your work for will be connected with the interview. Only the researchers, and our research advisor, will see or hear the information shared. After the research is completed, the tape recording will be destroyed.

Your participation in this study is totally voluntary, and there will be no cost to you except for your time. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the interview with the researcher, you will receive a debriefing statement describing the study in more detail and a $10 gift card. In order to ensure to validity of the study, we ask that you not discuss this study with other students or participants.

If you have any questions or concerns about this study, please feel free to contact my faculty supervisor, Dr. Thomas Davis at (909) 537-3839.

By checking the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least AT LEAST 18 YEARS OF AGE.

Place a check mark here □ Date: _______________
APPENDIX F

QUALITATIVE DEBRIEFING STATEMENT
Debriefing Statement for the face-to-face interviews

The study you have just participated in was designed to investigate the methadone counseling process among recovering and non-recovering chemical dependency counselors by examining the concepts and techniques utilized throughout the counseling process. In this study the following counseling process techniques and concepts: self-disclosure, countertransference, spirituality, motivation, confrontation and evidence-based practice were examined. The recovery status of a counselor has been found to often unconsciously influence the techniques and concepts the counselor utilizes within the methadone counseling process. We are particularly interested in how the recovery status of a counselor influences the techniques and concepts that are utilized throughout the methadone counseling process.

We hope that this study will provide insight concerning the techniques and concepts that a methadone chemical dependency counselor utilizes throughout the counseling process.

Thank you for your participation and for not discussing the contents of the interview questions with other counselors in your clinic and in other CRC opioid outpatient treatment programs. In the event that you become uncomfortable as a result of this study, a mental health provider will be offered. If you have any questions about this study, please feel free to contact Jennifer Palmersheim, Sara-Amanda McCarthy or Dr. Thomas Davis at (909) 537-3839. If you would like to obtain a copy of the group results of this study, please contact Dr. Thomas Davis at (909) 537-3839 after June 2007. The results of this study will also be available after June 2007 to view at California State University, San Bernardino in the John M. Pfau Library.
REFERENCES


This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem

2. Data Entry and Analysis:
   Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem
   b. Methods
      Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem
   c. Results
      Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem
   d. Discussion
      Team Effort: Sara-Amanda McCarthy & Jennifer Palmershiem