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A Descriptive Case Study of the Challenges of Drug and Alcohol Counselors

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A Descriptive Case Study of the Challenges of Drug and Alcohol Counselors

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by

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Abstract

Substance abuse is the number one public health problem in Oklahoma and nationally. Annual related expenses of substance abuse in Oklahoma are nearly $2 billion. This qualitative descriptive case study asks the question what are the challenges of substance-abuse counseling? The researcher will be describing in detail the history of drug and alcohol treatment and counseling in America. Using interviews, observations and document collection which will allow the interviews voices to be heard.

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Dedication

This dissertation is dedicated to my wife and children, parents, brothers and sisters and grandparents. And to all the professors and teachers that helped me reach my goal.

Special thanks to all of my ancestors that did not have the chance to accomplish their own goals due to the laws at that time, but gave me all they had.

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Chapter 1

Introduction

Organization of the Chapter

Chapter 1 commences with an introduction that describes the organization of the chapter, the background of drug and alcohol use in the United States, and how such use has affected some parts of the population. The literature maintains the importance of understanding the history of substance-abuse counseling, and the skills, knowledge, and attitudes needed to become a substance-abuse counselor (SAC). The statement of the problem, purpose of the study, and the research questions comprise the next three sections, laying the groundwork for the research study. The significance of the study is the next section. The objective of the research study is to describe the challenges SACs face. The importance of this study coincides with the current opioid crisis and the importance of having qualified SACs who can meet the needs U.S. communities.

The next section in Chapter 1 is the research-study conceptual-design outline that helps define the limits of the research study. Theoretical sensitivity, as defined by Mills, Bonner, and Francis (2006), in the next section, expounds on the researcher's role as the research instrument. In this study, the researcher was the interviewer, observer, and data collector. The end of Chapter 1 includes parameters of the study, definitions of all pertinent terms, limitations, a summary, and the organization of the dissertation.

Introduction and Background

Alcohol and drug use in the United States have serious consequences not only in social costs, approximately $151.4 billion in 2016 and long-term individual consequences such as legal, medical, and family challenges (Barry, Epstein, Fiellin, Fraenkel, & Busch, 2016). Substance

abuse continues to be one of the most prevalent public health issues in United States. Substance abuse does not discriminate with respect to profession, income, geography, ethnicity, religion, income, or age (Chandler, Balkin, & Perepiczka, 2011). According to the Oklahoma Department of Mental Health and Substance-Abuse-Services (2019) webpage,

> Substance abuse is the number one public health problem in Oklahoma and nationally. The economic cost is staggering, estimated at nearly $7 billion annually in Oklahoma and $414 billion nationwide. Annual costs of substance abuse in Oklahoma are nearly $2 billion for expenses related to health care, public safety, social services, costs to business, and property loss. Another $5 billion in costs is related to lost productivity. In Oklahoma, drug and alcohol addiction contributes to 85 percent of all homicides, 80 percent of all prison incarcerations, 75 percent of all divorces, 65 percent of all child abuse cases, 55 percent of all domestic assaults, 50 percent of all traffic fatalities, 35 percent of all rapes, and 33 percent of all suicides. (p. 1)

Beginning and engaging in drug and alcohol treatment involves various decisions. Many times, substance use has affected people's health and social functioning, with many individuals receiving some sort of formal or informal pressure to attend treatment (Weisner, Mertens, Tam, & Moore, 2001). Identifying factors that may predict failure to begin treatment has important clinical relevance. People with higher levels of drug severity had worse outcome rates than alcohol abusers, making it important to understand the differing characteristics of drug-dependent and alcohol-dependent clients (Weisner et al., 2001).

Treatment involves four enrollment barriers (Appel & Oldak, 2007): the first barrier is individual client issues that involve fear of treatment, being unready for treatment, shame from revealing addiction, and the belief that treatment does not work. The second barrier is access to treatment such as the bureaucracy involved in accessing medical treatment, mental health clearance, and how treatment will be paid for if the person has no insurance or other source of income. The third barrier is the availability of treatment, such as whether treatment is available in the immediate area, whether space is available in those treatment centers, and whether the available beds are appropriate for the person's current needs. The fourth barrier is the

acceptability of clients, based on discrimination and stigmatization in many public institutions and the general public (Appel & Oldak, 2007).

SACs provide the majority of care in the current system (Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001). Most addiction counselors enter the field lacking the skills to use psychosocial evidence-based practices (Olmstead, Abraham, Martino, & Roman, 2012). Counselor self-efficacy (CSE) is counselors' judgment about their capabilities to effectively council a client in the near future (Chandler et al., 2011). Understanding how people behave, think, feel and motivate themselves is also an important part of CSE. A documented need persists for adequate substance-abuse training among licensed counselors (Chandler et al., 2011). Many counseling students are not taught the theories and philosophies that explain the causes and continued misuse of substances. Also, students are not taught necessary skills such as screening, diagnosis, education and counseling of substance abusers, determining appropriate and effective professional-treatment levels, and using referrals for services to help people receive services (Carroll, 2000).

The 12 core functions of an SAC have served as a guide for students and counseling professionals (Taleff & Swisher, 1997). These functions comprise skills in screening, intake procedures, orientation of clients, assessment, treatment planning, client education, referral, reporting, record keeping, and consultation with other professionals (Taleff & Swisher, 1997). The Technical Assistance Publication series (TAP) 21 lists 124 competencies in four transdisciplinary foundations and 13 practiced dimensions/CSE of dimensions (Scheidt, 2001). This publication addresses the following questions: What knowledge, skills, and attitudes (KSAs) should all substance-abuse-treatment professionals have in common? What professional standards should guide substance-abuse-treatment counselors? What is an appropriate scope of

practice for the field? Which competencies align with positive outcomes (Center for Substance Abuse Treatment, 2006)?

Currently, substance abuse counselor must work not only with substance abuse but with dual disorders, family dynamics, and cultural and gender issues (Mustaine, West, & Wyrick 2003). Development of minimum-preparation standards for counseling professionals and the substance-abuse-counseling profession have taken separate but corresponding courses. Substance-abuse counseling emerged as a specialty, due to professional groups such as physicians, social workers, and psychologists avoiding this population (Mustaine et al., 2003). Providing therapy may be challenging because an SAC needs to understand the process of change and the forces that act to stop that change (Rasmussen & Johnson-Migalski, 2014).

Statement of the Problem

The problem of this research study is fundamental: too little is known about the challenges of being an SAC. With the current opioid-addiction crisis and continued use of alcohol and other addictive substances, the need for qualified SACs and the need for continued research in the substance-abuse field is the current problem. Finally, these themes should be investigated to close the many gaps in knowledge. The results of this study can be used to the increase the knowledge of future and current counselors and counselor educators, thereby continuing to close gaps in the research and help the people served by those in this specialty.

Purpose of the study

The purpose of the study is to study and describe the challenges SACs face.

Research Question

What are the challenges facing SACs?

Significance of the Research

The significance of this research study is to allow current licensed SACs' voices to be heard concerning the challenges of being an SAC. In gaining insight from the observations and interviews, a focused picture emerged, which will help researchers, students, future and current counselors, and administrators further the profession and continue to create the necessary work force for the future.

Conceptual Design

Due to the nature of qualitative research, I have provided a framework of the methods used to answer the research question. A conceptual framework helps focus a research study, allowing the reader to follow the data to reach reasonable conclusions to help answer the research question (Ramey, 2008). Figure 1 shows the conceptual design. The outline will help readers identify the steps used to complete the research study.

The seven stages used to complete this research study include the beginning of the study, wherein the researcher identified and formulated the problem. Second, using a qualitative descriptive case study helped determine the research design of this research study. Identifying the site and participant sample and method of data collection comprised Step 3 of this conceptual design. Gathering all the data—interviews, observations, and documents—is the fourth step of the conceptual design, using closed ended interview questions for basic demographic information and then using standardized open-ended questions to complete the interviews. Step 5 outlines how the researcher analyzed the data using three levels of coding: open, axial, and selective, as explained in Chapter 3. Interpreting, discussing, and presenting the data is the sixth step in this conceptual design. In the final step in this conceptual design, the researcher followed up with participants to ensure the data collected are accurate and truthful.

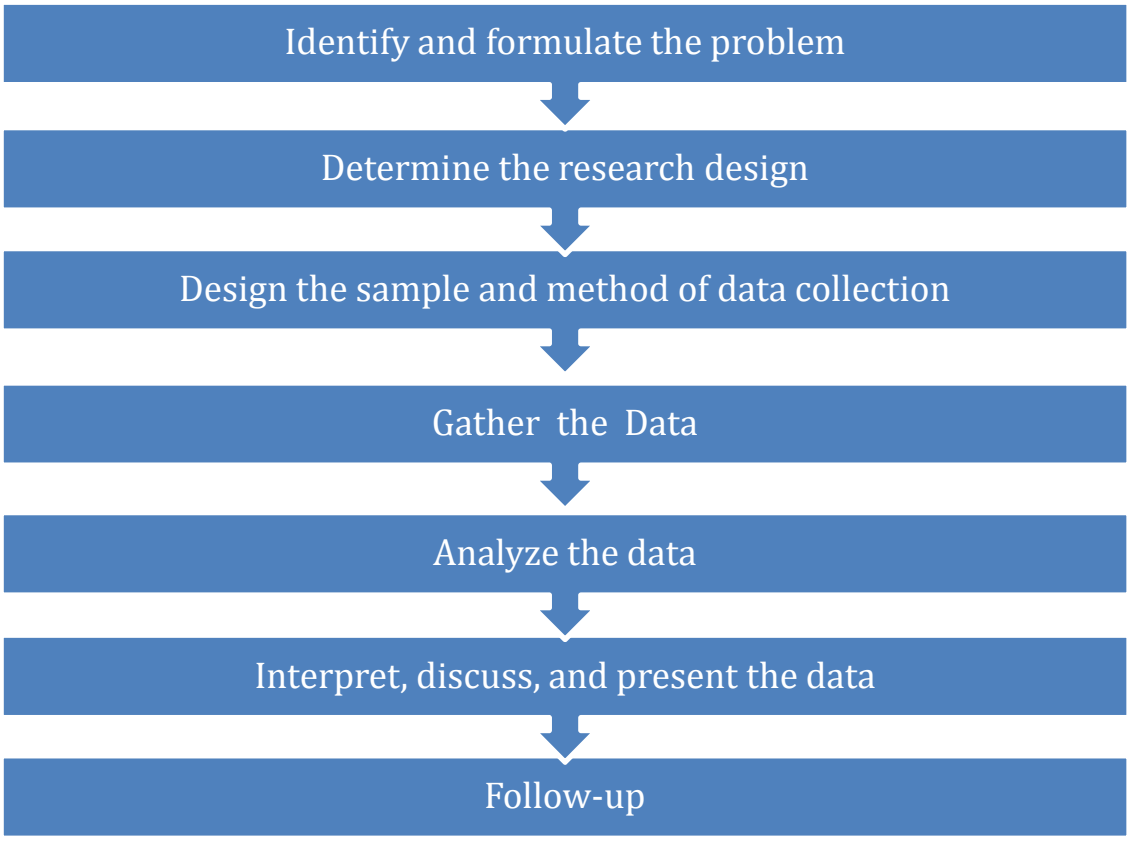

Figure 1. Conceptual design outline identifying the stages of the research study.

Theoretical Sensitivity

Theoretical sensitivity is the quality of the researcher to manage "objectivity and sensitivity" (Ramey, 2008, p. 22) throughout the research study. Also, theoretical sensitivity is a multidimensional concept that includes the level of insight, attention to detail, and a capacity to "separate the pertinent from that which isn't" (Mills et al., 2006, p. 28). The four parts of theoretical sensitivity are (a) personal experiences, (b) professional experience, (c) personal and knowledge of the literature, and (d) analytic rigor (Ramey, 2008).

Professional Experience

Counseling can help people, but person require much courage to enter the doors of a drug- and alcohol-treatment center. Many people have been mandated to attend outpatient treatment and are unhappy about this requirement. No matter why a person enters treatment,

substance-abuse counseling must provide considerable passion, life experience, and education, offering options to help them create the change they seek.

Personal Experience

I am a licensed professional counselor (LPC), certified rehabilitation counselor, and instructor at a local university teaching rehabilitation counseling. My knowledge of the effects of drugs and alcohol started after I received a Bad Conduct Discharge (BCD) from the military in 1981. I realize now that this incident was one of the main factors in my own individual substance use for almost 2 decades. I felt so unworthy following my BCD that my self-esteem and self-image were quite low for almost 18 years. In 1996, I went to the Oklahoma State Penitentiary for selling cannabis. I had received a 5-year sentence and spent 2.3 years locked up. I was released in November of 1998. Going to the penitentiary was a positive experience in that I learned I was never going back, so I had some serious decisions to make.

Due to my BCD and other issues, I usually found hard-labor jobs because employers did not ask many questions as long as employees showed up and worked. Thankfully, my grandfather had taught me to use a shovel and wheelbarrow. My grandfather said, “I hope you never have to use these as your job, but just in case.” All I had was work. Most of my jobs were outdoors jobs, with the exception of my most recent work.

In 2004, I had a positive urine analysis for cannabis to keep my job; I had to see a counselor. It was the best experience I had ever had. Also, I realized that if I did not find a way to look inside and find those thoughts that were disturbing me, I would be unable to manage myself in a kinder, softer, positive, kind way.

Personal Knowledge of the Literature

I recommend that the Statue of Liberty be supplemented by a Statue of Responsibility on the west coast.

—Viktor E. Frankl

The greatest discovery of all time is that a person can change his future by merely changing his attitude

—Oprah Winfrey

Every great dream begins with a dreamer. Always remember, you have within you the strength, the patience, and the passion to reach for the stars to change the world.

—Harriet Tubman

Over the past 35 years, directly or indirectly I have been involved in substance use, changing from a substance abuser to a licensed SAC. I learned a great deal in the process of learning how to help myself. I want to determine if new and beginning counselors can learn particular KSAs to help garner some necessary basic skills in substance-abuse counseling. I believe that people are unique individual beings and their problems are also individual.

Analytic Rigor

Social constructivism is the approach to be used for this research study (as suggested by Creswell, 2014). Social constructivist researchers focus on the detailed context in which people work and live to understand the cultural and historical settings of participants (Creswell, 2014). The objective of the study is to rely largely on participants' views of the circumstances being studied while developing collaboration among individuals (Creswell, 2014).

Parameters of the Study

This is a qualitative descriptive case study. I interviewed five current SACs (three women) with approximately 20 years of total experience. All were from a Midwestern city or surrounding areas and were licensed SACs in Oklahoma, carrying at least one of two substance-abuse licenses: LPC, which requires a master's degree, and meeting the state license requirements. The basic requirements for an LPC are listed in Appendix I.

I interviewed each SAC over 2 sessions using 2 closed-ended questions for demographics and then the research question. Appendix J identifies the open-ended question that allow the interviewees to follow their thoughts, and the closed-ended questions to gain necessary demographic information. I coded and reviewed the information received for any noted themes.

Definition of Terms

Counselor in Recovery (CiR): A current LPC that is in self-described recovery.

Drug- and alcohol-use dependency: Drug and alcohol use occurs across U.S. society. Due to the individual nature of drug and alcohol use and dependency, a person may not understand how they became dependent on drugs and alcohol.

Licensed Professional Counselor (LPC): A licensed professional is passionate about helping people through education, learned skills, research, and empathy. The goal is to help people who come for help to find or create options and learn to manage their situation.

Drug and alcohol counseling: An LPC works to understand the individual nature of drug and alcohol abuse through dependency, relapse prevention, and recovery. SACs require specific knowledge and a basic understanding of the possible consequences of drug and alcohol abuse. A person may receive drug and alcohol counseling in different formats from the acute

stage, when a person may need medically supervised detoxification, to residential treatment, outpatient treatment, and continuing care.

Lay counselor: People who work in the drug and alcohol field, helping other alcoholics and drug addicts. Lay counselors do not usually have graduate degrees or advanced licenses in drug-abuse counseling. People continue to perform function, now called Peer Recovery Support specialists (PRSS).

Minnesota model: An early treatment model that incorporated a comprehensive style of drug and alcohol treatment and recovery, using doctors, counselors, case managers, lay counselors, and incorporated self-help programs. The Minnesota model became a worldwide treatment system.

Roles and functions of a drug and alcohol counselor: Counselors work from an initial warm greeting through the assessment and treatment-planning stages, then the working stage of treatment, outpatient care, and the possible continuing care.

Recovery: Due to the individual nature of alcohol and drug use/dependency, the term recovery may have different meanings. Some define total abstinence from all intoxicating substances for a period of time to define recovery. Others may define recovery as continuing to use drugs or alcohol but without the problems they experienced in the past. For many people recovery occurs in stages and some stages may need to be revisited on the path to recovery.

Limitations

During this research study I need to be cognizant of biases or assumptions. Understanding my role as the research instrument is an important part of this research study. I understand that the population size of this study is a potential weakness, mitigated by using available research methods to create a descriptive research study.

Summary of Chapter 1

Substance use is a large problem in the United States and SACs are at the forefront of efforts to help mitigate problems that substance abuse creates. Chapter 1 began with the introduction and background of the research study, followed by the problem statement, purpose of the study, and research question. The significance of the study, conceptual design outline, and theoretical sensitivity included subsections of professional experience, personal experiences, knowledge of the literature, and analytic rigor. Finally, I described the parameters of the study, definition of terms, and limitations of the study.

Organization of the Dissertation

This research study has five chapters. Chapter 2 consists of the literature review and provides an outline that starts with a history of substance abuse in the United States and ends with treatment outcomes. Chapter 3 provides a detailed description of the methodology used to develop this research study. Results of the interviews, observations, and data collection are described in Chapter 4. Chapter five includes the results of the research, recommendations for further research, and the conclusion of the research study.

Chapter 2

Literature Review

Organization of the Chapter

This chapter is organized so the reader can gain an understanding of the history of substance-abuse counseling in the United States. The literature review starts with the approach to the literature, describing the purpose and action plan used to gather and disseminate the information needed to complete the literature review. The history of alcoholic counseling began with the landing of the pilgrims in Plymouth, MA, and continues to the earliest descriptions of pervasive use of alcohol in colonial times. History leads through native people's exploitation through the use of alcohol and the resulting response from early native helpers, the African American use of alcohol, and the African American societies built on temperance, concluding with Fredrick Douglass's pledge of abstinence.

Chapter 2 continues by describing the beginning of addiction treatment in the United States and the emergence of the first clinic specializing in the treatment of alcohol. I describe the lay-counselor movement from 1911 through the first-known job code for alcoholic counselors in 1954. Then the literature review includes the role of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as they pertain to the substance-abuse counseling. The role of the counselor starts with the definition of counseling and substance-abuse counseling; then I provide a review of the KSAs and attitudes of substance counselors on the 12 core functions of counseling, describing in detail the functions of a counselor from assessment through professional and ethical standards.

The final part of Chapter 2 explains the steps in treatment: entering treatment and identifying the most appropriate, cost-effective treatment. The next section of the literature

review recounts evidence-based treatment, including the importance of using the research evidence and understanding the effectiveness of substance-abuse treatment. The final section of the literature review is the evaluation and outcomes of treatment, describing the effort to evaluate treatment and why determining the outcomes is important in today's health care discussions.

Approach to the Literature Review

The purpose of this literature review is to provide current and past concepts and foundations in the description of a drug and alcohol counselor through current and past articles and books. I used various search engines such as Tulsa Public Library, University of Arkansas Library, Ebsco*host,* ProQuest, ProQuest dissertations, and Google scholar. Using only peer-reviewed and cited articles for my literature review, I used key search words such as alcohol, lay-counselor, alcoholic counselor, AA, NA, and the 12 core functions of counseling to help define my search.

I used many combinations of descriptors to gather literature from important areas of this literature review. The main focuses of the literature were the history of alcohol and drug counseling, the history of alcoholism in the United States, alcoholism, the history of treatment for alcoholism in the United States, the roles and functions of drug and alcohol counselors, substance-abuse-treatment outcomes, and evidence-based practices.

History of Alcoholic Counseling

After the pilgrims landed at Plymouth, MA, the place to meet for politics, business, and trade was the local tavern in early colonial times. At many festive occasions, house warmings, weddings, or the ordination of a clergyman, spirits, cider, wine, and beer were consumed copiously. Drunkenness is better reported In Puritan New England than in the South. In 1776 a speaker declared,

> Many gross immoralities shockingly abound, which RB, so fashionable that in the estimation of many that almost ceased to be vices. Of this kind we may reckon intemperance. How many wallow in the more than bestial sin of drunkenness and seek every opportunity by the immoderate use of strong drink to deprive themselves of the reason, that distinguishable badge of humanity, and reduce themselves to a level with the brutes! Almost beyond account had been the quantities of strong drink annually consumed in this colony; and the mournful complaints under the present scarcity show what a wretched implements it hath acquired over us. (Keller, 1979, p. 2825)

Alcohol use and occasional drunkenness became pervasive in the colonial United States. Benjamin Rush's 1784 quotation referred to "habitual uses of ardent spirts" as an "odious disease" which are from Rush's paper "An Inquiry into the effects of ardent spirits" (as cited in White, 2014, p. 1). Rush used early treatments for the treatment of alcohol ranging from the practice of bleeding and blistering to aversion therapy, cold baths, and vomiting (Henninger & Sung, 2014). The first use of the word *alcoholism* was by Dr. Magnus Huss in 1849, characterizing the state of chronic alcohol intoxication distinguished by severe physical pathology and disruption in social functioning (White, 2014). By 1830, alcohol had become affordable and easily accessible to most people, thereby affecting society, especially families (Henninger & Sung, 2014).

The use of alcohol as a tool of sexual, political, and economic exploitation of native peoples is well documented (White, 2000a, 2000b). Some responses to increased alcohol-related problems among native people were lobbying for a ban on alcohol, using native healing practices, and organizing Native American temperance societies. Tribal leaders led sustained campaigns against alcohol during the last decades of the 18th century. From 1772, with Samson Occom's anti-alcohol pamphlet titled "Mr. Occom's address to his Indian brethren through 1847 with Kah-ge-gah-bowh," the Ojibway temperance reformer detailed his father's and his own addiction the "Devils Spittle" (as cited in White, 2000a, p. 3). These stories and others show a hidden picture of native people recovering and then helping other native people recover from alcoholism (White, 2000a).

In precolonial Africa, alcohol misuse was rare in tribal African communities. Wine and beer primarily were restricted to religious and secular ceremonies fostering a sense of community solidarity. Among some tribes, being drunk was seen as weakness and moderation was ideal. During slavery, alcohol use was limited among African Americans due to control and external pressure (Zapolski, Pedersen, McCarthy, & Smith, 2014). A problem with alcohol increased after the Civil War and into the Reconstruction era due to greater access to alcohol. As early as 1833, African American alcoholics were recovering in local temperance organizations such as the African Temperance Society and the Colored American Temperance Society. In 1845, Fredrick Douglass took a pledge of abstinence. By advocating for abstinence based on personal and cultural survival and needing to prepare African Americans leaders during the temperance and abolition movements, Douglas said, "To keep sober was to strike a blow to slavery" (as cited in Zapolski et al., 2014, p. 9). During this time the African American church significantly influenced the drinking patterns and behaviors of African Americans by promoting moderate drinking patterns and abstinence (Zapolski et al., 2014).

Treatment of addiction in the United States began with alcohol addiction. Between 1819 and 1831 Dr. Walter Channing and Dr. John provided the first documentation of delirium tremens (the DTs) and the associated symptoms: loss of appetite, vomiting, hallucinations, and hand tremors. The American Association for the Cure of Inebriation in 1870 was the original attempt at the professionalization of treatment services. The wealthy were attended in private sanitaria. The term "continuum of care" wherein the patient would go from detoxification to residential outpatient and continuing aftercare was also in use at addiction faculties. By 1902, 100 facilities treated alcoholism (Henninger & Sung, 2014).

Congress passed a national prohibition during World War One, soon followed by the 18th amendment to the Constitution and the Volstead Act of 1920. The alcohol problem sank precipitously but immediately started to rise again. Illegal businesses sprang up across the country supplying alcohol during prohibition. In 1933, after the repeal of prohibition, increasing problems and puzzlement over how drinking might be brought under control was a major question. Drinking and its associated problems have not been thwarted by legislation, the fear of disease, or the promise of hellfire. Keller (1979) wondered if the power of science could be brought to bear on these problems.

In the late 1800s to the early 19th century, recovered and recovering alcoholics devoted themselves with a message of hope, experience, and strength that led to a process of addiction recovery and an effort to spread the hope of recovery to others still afflicted. White (2000a) stated Drunkards "fully understand each other's language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause" (p. 6).

The therapeutic temperance movement started the first alcoholic mutual aid societies and addiction-treatment institutions. Inevitably, recovering and recovering alcoholics started moving from their roles in the temperance movement and started seeking employment with the new addiction-treatment institutions (White, 2000a). An impulse to heal others is characteristic of almost every recovering alcoholic. The defiant and excessive need for attention, importance, and praise is transformed during and after recovery (Anderson, 1944).

> I have no doubt that a man who has cured himself of the lust or alcohol has a far greater power for curing alcoholism then has a Doctor who has never been afflicted by the same curse. No matter how sympathetic and patient the, doctor may be in the approach to his patient, the patient is sure to feel, or to imagine, be there condescension to himself, or get the notion that he is being hectored by one of the minor prophets. (Anderson, 1944, p. 3)

Since 1906, the Emmanuel clinic had been advancing the specialized treatment of alcoholism that includes medical assessment, psychological counseling, attendance in support groups, and acts of service to other alcoholics. Many counseling services were delivered by lay therapists' former patients from the Emmanuel clinic. In 1911, Courtenay Baylor sought help for alcoholism at the clinic in the Emmanuel Church clinic in Boston. Two years later Baylor was hired as possibly the first U.S. paid lay psychotherapist specializing in alcoholism (White, 2000a).

The ideal arrangement for lay therapy is when a lay therapist works and has easy access to a psychiatrist. The knowledgeable lay therapist should have deeper insight due to personal recovery from alcoholism, which should offer insight and inspiration toward other alcoholics' readjustment (Anderson, 1944). Anderson (1944) also stated,

> His qualification should be a two-year period of abstinence, during which time he has adjusted satisfactorily, in his social life and vocational field. If after a two year of abstinence, he wishes to become an associate in therapy, he should have at least a year special training. This training should include courses in a reeducational treatment plan. The lay psychotherapist attends lectures on psychiatry, such as are given to the third-year students of medicine at the University of Pennsylvania by Dr. Strecker. You should attend lectures given by psychologist so that he would have an appreciation and understanding of psychometric testing. A period of nursing would be an invaluable experience in order to familiarize him with the difficulties of alcohol withdrawal symptoms. He said a tent select in the medical lecture as so that he would have an appreciation of the medical aspects of the problem. If he progresses a satisfactory, he said be permitted to work with a certain number of alcoholic patients under the supervision of an experienced therapist. When undertaking a re-educational treatment plan, he should consider himself staff an assistant to the psychiatrist in charge, and make use of the psychologists report. They should also be familiar with the facilities offered by the laboratory. (p. 5)

One of the many different approaches to the treatment of alcohol has come to be known as the Minnesota model of chemical dependency treatment (White, 2000a). The Minnesota model was a pioneering method, advocating the use of a multi-professional or comprehensive approach to substance-abuse treatment. The Minnesota model advocates actively engaging

clients in their own treatment and learning to manage all aspects of their medical, social, psychological, and spiritual problems, past and future (Cook, 1988). The Minnesota model demonstrates that the goal of abstinence is achievable for some patients (Cook, 1988). Cook (1988) concluded,

> The Minnesota model is a treatment program for alcoholism and drug dependence, which has a specific Ideology related to the 12 steps of AA and N.A. It includes a comprehensive and multi professional approach, but the emphasis is that of a self-help therapeutic community, using lay therapists who are themselves in recovery from alcoholism or drug dependence. (p. 746)

This approach was the result of collaboration among three organizations: Willmar State Hospital, Pioneer House, and Hazelden (White, 2000a). The first use of the job term alcohol counselor was created by the Minnesota Civil Service Commission in 1954, allowing recovering alcoholics to receive payment for working with alcoholics entering treatment (White, 2008a).

The federal government organized, then expanded addiction and alcohol treatment services in the early 1970s. Newly created agencies—National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism—created partnerships to plan, operate, staff, and evaluate alcohol and drug-treatment programs in U.S. communities. Problems in the military concerning alcohol and drugs led to a formalization and expansion of treatment in veterans' hospitals, local service centers, and the U.S. military (White, 2000b) Addiction counselors attended to the large number of substance abusers and, because no specific credentials had been established, recovering substance abusers with at least 1 year in recovery were hired and given on-the-job training (Doukas & Cullen, 2011). From 1965 to 1975, recovered addicts and alcoholics took on a wide variety of helping roles in the newly emerging drug- and alcohol-treatment programs, although many times their roles were poorly defined (White, 2000b).

The Role of AA and NA

On December 11, 1934 Bill Wilson was in the Charles B. Towns Hospital in New York City for alcohol detoxification again. Some days later, Bill underwent a profound spiritual experience:

> The last vestige of my proudest obstinacy was crushed. All that once I found myself crying out, "if there is a god let him show himself I am ready to do anything, anything" suddenly the room lit up with a great white light. I was caught up in tool and ecstasy which there are no words to describe. … And then it burst upon me that I was a free man. … All about me there was a wonderful feeling of Presence, and I thought to myself, "So this is the god of the preachers!" (White & Kurtz, 2008, p. 5)

Counselors use Bill Wilsons "hot flash" to convey a life-changing event or experience or a sudden idea of great value, that a spiritual experience could open a pathway to long-term recovery. Having a personal transformation character and identity that is positive, vivid, and unplanned is what psychologists describe as quantum or transformational change (White & Kurtz, 2008). AA was first established in 1935 by cofounders Bill Wilson and Dr. Robert Smith, both alcoholics who met and started helping each other (White & Kurtz, 2008). AA rests on simplicity, no use of any alcohol, and incorporating the 12 steps (see Appendix A for a complete list) and 12 traditions (see Appendix B for a complete list) of AA in a person's life. Without government grants or trained professionals, many find the success of AA to be wondrous (Guydish, 1982).

NA is the largest and best known of the 12-step fellowships addressing recovery from drug addiction. In 1947, a group of drug addicts formed a group in Lexington Federal Prison in Lexington, Kentucky. The group called itself NARCO or Addicts Anonymous. Officially founded in 1953 in September of the same year, AA granted the group permission to use the AA steps and traditions (Laudet, 2008). The primary reason for establishing NA was that AA did not necessarily want to address the problems addicts faced. The originators of NA decided to phrase the problem of NA members as a personality trait: addiction (Peyrot, 1985). The 12 steps (see

Appendices A and B for a full list) and 12 traditions (see Appendix D for a full list) are the foundational principles of NA. All members and representatives must adhere to these principles, which state the purpose of NA and provide policies to guide NA activities. A crucial element of any peer-support group approach is its ideology or belief system (Peyrot, 1985).

The Role of the Counselor

The following definition of counseling was developed by Kaplan, Tarvydas, and Gladding (2014): "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 368) another definition of counseling is from Gustad (1953):

> Counseling is a learning-oriented process, carried on in a simple, one-to-one social environment, in which a counselor, professionally competent in relevant psychological skills and knowledge, seeks to assist the client, by methods appropriate to the latter's needs and within the context of the total personnel program, to learn more about himself and to accept himself, to learn how to put such understanding into effect in relation to more clearly perceived, realistically defined goals to the end that the client may become a happier and more productive member of his society. (Gustad, 1953, pp. 3–19)

When used as a conceptual tool for classification, most approaches to substance-abuse treatment can be understood in the context of four models—traditional, emergent/behavior, legal, and medical—described below (Guydish, 1982). the traditional model explains, "Alcoholism is a disease which manifests itself chiefly by the uncontrollable drinking of the victim, who is known as an alcoholic, it is a progressive disease, which … grows more virulent year by year" (Guydish, 1982, pp. 398–399). Advocates of the emergent/behavior model view addiction as a pattern of behaviors learned through some set of continued actions or events, with the addiction being maintained with the same or other actions or events. The legal model criminalizes addicts. For example, the Harrison Act of 1914 was the means to regulate opium use and prohibition, which restricted the manufacture and sale of alcohol from 1920 to 1932. The ongoing war on drugs

followed, from 1970 to 2019. Finally, 1957, the American Medical Association recognized the medical model of addiction (Guydish, 1982).

According to the Center for Substance Abuse Treatment (2006), counselors who work with people who have substance-use disorders do life-changing work on a daily basis. Difficult circumstances include high turnover, staff shortages, and low salaries. The diversity of backgrounds and types of preparation can be a strength, provided counselors share common foundations from which to work. Counselors come to this important work by different paths and with various skills and experiences.

In 1998, the Substance Abuse and Mental Health Services Administration and the Center for Substance Abuse Treatment published *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice (The Competencies)* as TAP 21. Developed by the National Curriculum Committee of the Addiction Technology Transfer Center Network, "TAP 21 identifies 123 competencies that are essential to the effective practice of counseling for psychoactive substance use disorders. The TAP 21 also presents the "knowledge, skills, and attitudes (KSAs) counselors need to become fully proficient in each competency" (Center for Substance Abuse Treatment, 2006, p. 1).

This publication addresses the following questions: What KSAs should all substance-abuse treatment professionals have in common? What professional standards should guide substance-abuse-treatment counselors? What is an appropriate scope of practice for the field? Which competencies are associated with positive outcomes (Center for Substance Abuse Treatment, 2006)? The National Curriculum Committee emphasizes three components of competency: KSAs (Center for Substance Abuse, 2006).

Knowledge: Clinical knowledge is an ongoing process. Through developing clinical knowledge, SACs gain understanding of the full continuum of complications that may be involved in substance use. Knowledge of the different substances encountered in a clinical practice, understanding withdrawal syndromes, and how addiction develops enables identification and possible management (Crockford et al., 2015). Knowledge of the differences and similarities between substance-related and behavioral addictions could help shape decisions when choosing strategies in the continuum of addictive and substance-related disorders (Crockford et al., 2015).

Skills: Skilled supervisor can provide ongoing supervision, coaching, and training. Supervision is an established technique for counselors to improving skills and performance (Miller, Sorensen, Selzer, & Brigham, 2006). Developing counselor gain competency by developing counseling skills such as reflection statements, probes, interpretations, and counseling attending skills (Allen & Stebnicki, 1995). The communicating of attentiveness plays an important role in the establishment of relationships and is a potent reinforcer in the client–counselor relationship. Counselors use verbal and nonverbal skills for effective interpersonal relationships in a counseling interview (Ivey, Normington, Miller, Morrill, & Haase, 1968). Conceptualization skills (e.g., choosing appropriate interventions or identifying an initial diagnosis) are also effective skills for counselors (Allen & Stebnicki, 1995). According to Sperry in 2005,

> Case conceptualizations is a method and process of summarizing seemingly diverse case information into a brief, coherent statement or maps that elucidates the client's basic pattern of behavior. The purpose of a well-articulated case conceptualizations is to better understand and more effectively treat a client or client system namely the couple or a family in short a case conceptualizations is a clinicians theory of a particular case. (p. 2)

Gaining skills in offering the basic helping conditions that promote the working alliance, client bond, and relationship building are as important as the acquisition of critical self-examination;

technical skills and a more centralized locus of personal identity and evaluation are also important aspects of developing counselor competency (Hays, Dean, & Chang, 2007). Many invisible minority groups (e.g., transgendered, bisexual, gay, and lesbian clients; Hays et al., 2007) require the ability to practice culturally competent counseling with the substance-use-disorder population. Clients with addictions represent various cultural identities (Jones & Welfare, 2017). The multicultural perspective is a defining part of professional counseling. In the preamble to the American Counseling Association Code of Ethics (2014), the second core professional value is "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (American Counseling Association Code of Ethics, 2014, p. 3).

The willingness to have open dialogue with clients is important in counselor training (Hays et al., 2007). Learning to build authentic connections, create understanding, and use active listening are skills effective in connecting with diverse populations. SACs must recognize that clients are experts on themselves. SACs must understand the complexity of clients' particular situation and not judge them on their current situation (Mulvaney-Day, Earl, Diaz-Linhart, & Alegría, 2011).

Attitudes: Counselors need to have continuing self-awareness trainings focused on multiculturalism in counseling. By acknowledging group differences, cultural-group counselor training can continue to improve. Failure to explore personal biases may result in a misunderstanding or misinterpretation of a client's actions or perspective. Exploration of personal biases fosters professional growth and personal introspection (Hays et al., 2007). Counselors' attitudes in developing appropriate optimism for improvement and change over time in people with substance-related and addictive disorders, while understanding that addiction,

may require an approach similar to a chronic disease (Crockford et al., 2015). The training that master's level counselors receive at colleges and universities in the United States is comprehensive and should provide beginning counselors with the basic competencies and knowledge to work as counselors in the field. The requirements for SACs vary; graduate-level counselors with added training in the field of substance abuse are well equipped to perform as SACs (Page & Baily, 1995). Many additional competencies may be desirable for counselors in specific settings (Center for Substance Abuse Treatment, 2006). The transdisciplinary-foundations model describes the skills and knowledge needed by those in the field of substance-abuse treatment. Professional practice for SACs rests on eight learned dimensions (Center for Substance Abuse Treatment, 2006).

1. Clinical evaluation, screening and assessment. According to the Center for Substance Abuse Treatment (2006), "The systematic approach to screening and assessment of individuals thought to have a substance use disorder, being considered for admission to addiction-related services, or presenting in a crisis situation" (p. 39).
2. Treatment planning, according to the Center for Substance Abuse Treatment (2006), is a collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and client. At a minimum an individualized treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, potential mental conditions, employment, education, spirituality, health concerns, and social and legal needs (p. 55).

3. Referral according to the Center for Substance Abuse Treatment is "the process of facilitating the client's use of available support systems and community resources to meet needs identified in clinical evaluation or treatment planning" (2006. p. 69).
4. Service coordination requires implementing the treatment plan, consulting, and providing continuing assessment and treatment planning (Center for Substance Abuse Treatment, 2006).

   > Administrative, clinical, and evaluative activities bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a framework of action to enable the client to achieve specified goals. The framework involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed-care systems, client advocacy, and ongoing evaluation of treatment progress and client need (p. 79).

5. Counseling: individual counseling, group counseling, counseling families, and counseling couples and significant others is a collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives. Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built on an understanding of, appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and significant others. (Center for Substance Abuse Treatment, 2006, p. 101)
6. Client, Family, and Community Education is "the process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment, and recovery resources" (Center for Substance Abuse Treatment, 2006, p. 133).

7. Documentation is “the recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data” (Center for Substance Abuse Treatment, 2006, p. 143).
8. Professional and ethical responsibly are described as “the obligations of an addiction counselor to adhere to accepted ethical and that if behavioral standards of conduct and continuing professional development” (Center for Substance Abuse Treatment, 2006, p. 153).

Steps in Treatment

Entering, engaging, and remaining in substance-abuse treatment may require not only the availability of specialized treatment services, but also an array of resources to help with specific issues, especially for women (Ashley, Marsden, & Brady, 2003). Women who abuse substances are more likely to have posttraumatic stress disorder, and high rates of mental health issues such as eating disorders, anxiety, and depression (Ashley et al., 2003). To ensure all people are treated equitably, people go through a screening process before being admitted for services, based on their level of care. To ensure good clinical care, systematic assessment is important (Skinner, 1982a, 1982b). Intake personnel use standardized assessments such as the Addiction Severity Index (ASI). The ASI is a useful evaluation and clinical multidimensional tool (Alterman et al., 1998). The ASI was developed to provide comprehensive assessments of patient functioning across seven problem areas: medical condition, employment, alcohol use, drug use, family/social relations, legal problems, and psychiatric/emotional functioning. Counselors use the ASI and associated scores for intake evaluations, treatment planning, and client referral decision-making (Cacciola, Koppenhaver, McKay, & Alterman, 1999).

The Michigan Alcohol Screening Test (MAST) is an accurate, inexpensive tool to measure alcoholism (Moore, 1972). The "MAST contains 25 items that converge on symptoms of problem drinking and negative consequences associated with the use of alcohol. Items are answered either yes or no higher scores are indicative to alcohol problem" (Shields, Howell, Potter, & Weiss, 2007, p. 1778). The MAST can be used in either a paper-and-pencil or interview format. Assessors divided MAST scores into three categories: a score of five and above of indicates alcoholism, a score of 3 or more suggests alcoholism, and those scoring 0 to 3 are not alcoholics (Teplin, Raz, Daiter, Varenbut, & Tyrrell, 2006).

Another clinical assessment used is the Drug Abuse Screening Test -28; (DAST), a simple yes or no questionnaire scored by adding items found to be in congruence with substance-abuse problems. All items except Questions 4, 5, and 7 are scored according to a "yes" answer. Scores range from 0 to 28 with higher score suggesting more severe problem with substances. The cutoff score for abuse/dependence is generally 6 or above; however, different cutoff scores are recommended for different populations (Yudko, Lozhkina, & Fouts, 2007, p. 190).

Integrated treatments address two or more chronic interwoven disorders simultaneously; a team of clinicians develops together integrated treatments for people with dual-disorder substance abuse and mental health problems to create a coherent plan for treatment (Drake, Mercer-McFadden, Muesser, McHugo, & Bond, 1998). According to Sobell and Sobell (2000),

1. Treatment should be individualized, not only for the presenting problems but also for other factors such as client beliefs and resources and available treatment resources.
2. Selected treatments should be consistent with the contemporary research literature. Research is more advanced in some areas than others but whatever the level of knowledge, the clinician should be familiar with and use state-of-the-art information.

3. The recommended treatment should be the least restrictive but still likely to work. Restrictive, as used here, refers not only to the physical effects of treatment on the client, but also to restrictions on the client's lifestyle and resources (i.e., the total cost of the treatment to the client, personally as well as financially). One result of adhering to this guideline is that more intensive treatments are reserved for more extreme problems (p. 573).

Comprehensive treatment programs incorporate several components to help meet the needs of the people being served. Examples are detoxification, residential, dual, intensive outpatient, outpatient, and continuing care. Continuing care may include medication monitoring, support services, case management, family services, and individual substance-abuse counseling (Drake et al., 1998).

Evidence-Based Treatment

Evidenced based treatment is "The integration of best research evidence with clinical expertise and patient values" (Glasner-Edwards & Rawson, 2010, P. 2). Research on best practices for disseminating evidence-based substance-abuse treatments is still in its infancy (Miller et al., 2006). Knowledge of the most important active ingredients of evidence-based treatment can help focus examination of those elements that are essential to clinical practice (Miller et al., 2006). When an individual is seeking clinical services, the individual treatment builds on the determination of clinical judgment and the present knowledge base. Understanding the relative efficacy of available treatments is important to being a competent professional. Experienced clinicians should make clinical judgments and provide sensitivity to the various problematic issues caused by substance-abuse-treatment decisions (Sobell & Sobell, 2000). Critical expertise may constitute various elements including awareness of one's clinical skills set,

awareness of individual patient characteristics concerning treatment needs, interpersonal abilities, clinical decision-making, and scientific expertise. Experienced clinicians guide evaluations and use of research evidence (Glasner-Edwards & Rawson, 2010).

Evaluation and Outcomes in Treatment

Jaffe (1983) stated,

> As the effort to evaluate treatment, has evolved the fundamental questions have always been the same. What are the relevant variables about patients, treatments, and environments that we need to measure, how can they be measured reliably, and what conceptual and analytic frameworks are best suited to understanding the relationship among variables. (p. 16)

Illegal drug abuse and continued overuse of alcohol have created substantial health problems, but also contribute or cause other problems such as liver and heart disease in alcoholics, HIV/AIDS, or Hepatitis C in drug-injection users. Treatment of substance-abuse disorders occurs largely in separate specialty services, mainly in drug and alcohol treatment or rehabilitation centers. Most of the population seeking drug and alcohol treatment attends non-profit operated facilities or stand-alone for-profit organizations (Buck, 2011). The use of residential or inpatient hospital settings for substance-use treatment is used more widely in the United States, compared to most other nations, due to intense scrutiny on the cost effectiveness of substance-abuse-treatment centers and emphasis on health care and outcomes over the past years (Harrison & Asche, 1999). Cognitive behavioral therapy, 12-step programs, and similar patterns of change can provide continuing care and are important aspects of substance-use outcomes (Johnson, Finney, & Moos, 2006). Treatment evaluation suggests that substance-abuse treatment should continue for at least 3 months to achieve some positive effects (Simpson, 1984). Individual outcome criteria indicate that preadmission baselines and during-treatment measures generally related to posttreatment outcomes. Additional comparisons of the posttreatment

outcome criteria showed no optimal match between client type and treatment type (Simpson, 1984).

Summary of the Literature Review

In this chapter, the research strategies were outlined and search engines used to describe the approach to the literature review. Next was a description of the history of alcoholic counseling in the United States from the landing of the Pilgrims in Plymouth, MA, through the Native American and African American responses to alcohol use. The beginning of alcohol treatment in the United States, the use of lay counselors, and the involvement of AA and NA in substance-abuse counseling followed. Next, I described the role of the counselor and some fundamental KSAs of SACs. The use of evidence-based treatment and treatment evaluation and outcomes were the last sections described in the literature review.

Chapter 3

Research Design

Chapter 3 describes the qualitative descriptive case-study methods to be used to answer the research question. Chapter 3 begins with an introduction, followed by the focus of the study; then the research question, followed by the research design, which includes a conceptual diagram and timeline. Next, I describe the site, sample selection, and participants, followed by research ethics and the methods used to collect the data including interviews, observations, and document collection.

Next are the researcher's role management and the methods used to manage and record the data. Then, I describe reliability, trustworthiness, and transferability in research through the lenses of Baškarada (2014), Lietz, Langer, and Furman (2006), and Shenton (2004). Using methods of prolonged engagement, persistent engagement, triangulation, and member checks helps ensure the study is effective in achieving reliability and trustworthiness. The last stages of Chapter 3 are descriptions of peer debriefing, an audit trail with a table showing the notations used for the research, and data analysis in the research study, described with a table showing the flow of the data analysis. Chapter 3 will close with a summary.

Focus of the Study

The focus of this study described the challenges experienced by SACs through the lens of current LPCs. The study describes substance-abuse counseling from the history of alcohol and drug use in the United States from colonial times, the role of AA and NA, the role of the counselor, steps in treatment in TAP 21 treatment-assistance protocol, KSAs of SACs, and treatment outcomes.

Research Question

What are the challenges facing SACs?

Research Design

I used a qualitative research descriptive case-study design (Figure 2). Case studies allow a researcher to develop an in-depth analysis of one or more individuals (Creswell, 2014, p. 14). In case-study research, researchers summarize claims and interpretations in combination with the researcher's own personal experiences, called "naturalistic generalizations" (Creswell, 2014, p. 66). Using the philosophical worldview of "a basic set of beliefs that guide action" (Creswell, 2014, p. 6), and a constructivist worldview, Creswell (2014) said social constructivists believe individuals seek understanding of the world in which they work and live (Creswell, 2014). In the natural world, multiple realities help create subjective understanding (Denzin & Lincoln, 2008). Researchers use terms such as "credibility, transferability, accountability, and confirmability" in the constructivist's worldview (Denzin & Lincoln, 2008, p. 33). Using the theme of "empathetic neutrality" (Patton, 1990) to guide this study allowed participants' voices to be heard. Patton (1990) stated,

> Complete objectivity is impossible; peer subjectivity undermines credibility; the researcher's passion understands the world in all its complexity—not providing something, not advocating, not advancing personal agendas, but understanding; the researcher includes personal experiences an empathetic insight as part of the relevant data, while taking a neutral non-judgmental stance toward whenever content may emerge. (p. 41)

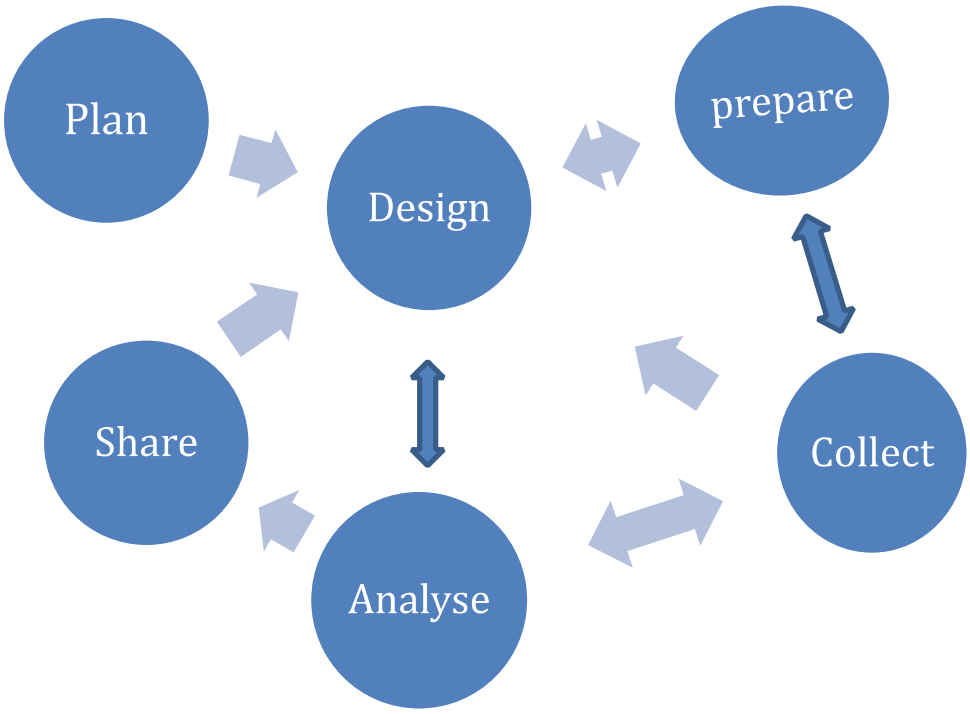

Figure 2. Case study outline, the case study process used for the descriptive case study. *Note*. Adapted from Qualitive Case Study Guidelines, by S. Baškarada, 2014, *The Qualitative Report, ,19*(40), p. 3.

Site and Sample Selection

The site is a local drug and alcohol treatment center that has been in operation since 1985. The site's mission statement is "to offer lifesaving recovery tools for adults suffering with addiction or co-existing mental health and substance use disorders to achieve individualized recoveries" (Appendix A). Many are state-funded consumers who also have contracts with various state and federal entities such as federal and state parole and probation, the Veterans Administration, Native American tribal affiliations, and the Department of Human Services. The treatment center provides all levels of care ranging from medically supervised detoxification to residential, outpatient, and continuing-care treatment. I choose participants for this study using purposeful sampling; that is, selecting participants based on characteristics believed to make them especially good sources of information (Orcher, 2005). Polkinghorne (2005) stated,

> Since you are not interested in "how much" or "how little," random sampling makes little sense instead sense qualitative inquiry seeks to understand the meaning of a phenomenon from the perspective of the participants, it is important to select a sample from which most can be learned. This is called a "purposive or purposeful sample. (p. 140)

Participants

Five participants were chosen all LPCs by a Midwestern state. Table 1 presents a description of the participants and describes the gender, educational level, credentials and the number of years each has been in counseling.

Table 1
Demographics of Participants

	Participant	Gender	Educational level	Credentials	Years in counseling
1	P1	F	Master's Degree	LPC	12
2	P2	F	Master's Degree	LPC	8
3	P3	F	Master's Degree	LPC	4

Research Ethics

The reliability and validity of this research study depends on the ethics of the researcher and on "training, experience, track record, status and presentation of self. "Credibility also involves intellectual rigor, professional integrity and methodological competence" (Merriam, 2009, p. 228). I received signed informed consent from participants, as required by institutional review board (IRB) standards. I did not compensate the participants monetarily for their participation in the research study.

Data Collection

Interviews

In this section the description of the interview process and how the interviews helped answer the research question. Merriam (2009) describe an interview as a "process in which the researcher and participant engage and conversation focused on questions related to a research

study" (Merriam, 2009, p. 87). I used the interview process as shown on Table 2, which was adapted from Baškarada (2014, p. 12).

Table 2
Interview Process for Research Study

Orientation	Orientation: introductions and exchange of contact details. Description of the study and the interview process. Clarification of any expectations regarding non-attribution, sharing of data and any other questions.
Information Gathering	The researcher askes two open-ended questions for demographics and the research question to, all participants interviews will be recorded and then transcribed
Closing	The interviewer reviews the key points, any issues and/or action items as required and confirms accuracy with the participants. The interviewees are invited to provide feedback on the interview process. The researcher thanks the interviewees and seeks permission for any future contact

Note. Adapted from Qualitative Case Study Guidelines, by S. Baškarada, 2014, *The Qualitative Report, 19*(40), p. 3.

Interviews allowed me to find out what the interviewees think, finding those items not directly observable (as in Patton, 1990). Qualitative research questions are open-ended and framed in the spirit of exploration and discovery to address existing knowledge gaps (Wu, Thompson, Aroian, McQuaid, & Deatick, 2016). The qualitative interview is a framework in which standards and practices are not only recorded, but also achieved, challenged, and reinforced (Jamshed, 2014).

Patton (1990) recognized three basic approaches: *the informal conversational interview* is the most open-ended approach to interviewing. The informal-conversational interview relies entirely on the instinctive generation of questions, allowing the interviewer to maintain some pliability and be able to follow information gained from participant observation (Patton, 1990). The second approach used by Patton (1990) is the *general interview guide approach*; the main concepts of this approach are to ensure the same information accrues from the five interviewees

by covering the same material and that the interviewer is using the limited time available as effectively as possible. An interview instrument also allows the interviewer to more deeply discern issues that will help make plain this research study (Patton, 1990). Ramey (2008) stated, "an interview guide is a good tool for staying on track during an interview" (p. 61). Patton's (1990) third approach is the *standardized open-ended interview,* which allows for the interviewer to ask each of the five interviewees the same highly focused questions to maximize the time spent with each interviewee. Two other purposes of the standardized open-ended interview are to minimize interviewer effects by asking the same question to each interviewee and to facilitate data analysis and reduce individual interviewer effects (Patton, 1990). Ramey (2008) identified a fourth approach to interviewing: researchers use *the closed fixed response interview* mainly to gather demographic information by using closed-ended questions such as how long have you been a licensed counselor (Ramey, 2008)?

The researcher scheduled the interviews 2 weeks in advance. The length of the interviews was open; the instrument has 3 total questions to be asked to interviewees (see Appendix H). Then using 2 closed fixed-response interview question to gather the necessary demographic information and use the general-interview-guide approach when asking participants the same questions. I asked the single research question using the informal conversational interview approach where participants can fully describe their answers to the research interview question. All the selected participants are currently licensed by the same Midwestern state to practice as LPCs (see Appendix J). The process for the observation and audiotaping each interviewee involves recording all interviews on a transcriber with digital capabilities and then transcribed word for word. Allowing as long as it takes for the interview, after the first round of data is gathered, the necessity for other interviews will be assessed at that time.

Observations

A *qualitative observation* describes a researcher taking field notes on the activities and behaviors of people at the research site (Creswell, 2014). One major advantage of direct observation is that it provides comprehensive experience in the moment.

> The basic methodological arguments for observation then may be summarized as these: observation … maximizes the inquires ability to grasp motives,, beliefs, concerns, interests, and conscious behaviors, customs, and the like; observation … allows the Enquirer to see the world as his subjects it, to live in their time frames, to capture the phenomenon in and on its own terms, and to grasp the culture in its own natural, ongoing environment; observation … provides the inquirer with access to the emotional reactions of the group into respectively—that is, in a real sense it permits bob server to use *himself* as a data source; and observation … allows the observer to build on tacit knowledge, both on his own and that of members of the group. (Lincoln & Guba, 1985, p. 273).

Using observation as part of the data collection will help increase the quality of data collection and interpretation and will help me to gain a better understanding of the phenomenon and the context under study (Kawulich, 2005). Observation methods are also useful for checking any nonverbal stimuli, checking definitions of terms used in the interviews, and increasing the validity of a research study (Kawulich, 2005). Using the *observer as participant* role will allow me to "observe and interact closely enough with the members to establish an insider's identity without participating in those activities constituting the core of group membership" (Kawulich, 2005, p. 6). Observations will be one part of data collection. The interviewees being observed will know they are being studied, but the importance will be on collecting data to answer the research question.

Document Collection

One large benefit of collecting all documentation used in a research study is its solidness. Documents and the data they hold are considered unbiased compared to other forms of data (Merriam, 2009). Also, documents are rich sources of information and can be analyzed and reanalyzed without undergoing changes (Lincoln & Guba, 1985). Research, literature, readings,

issues, and objectives provide an overview of the research study, sources of information and access to field sites that Yin called "field procedures," and case-study questions asked to investigators (Yin, 1994, p. 3). The end result will be collection all the aforementioned data and necessary evidence to answer the research question. Data collected include a brochure from the treatment center, documentation of licensure from participants, informed consent from the treatment center, and all IRB documentation. All data will be properly copied, numbered, collected, and stored in a manner appropriate for a research study.

Researcher's Role Management

My role was that of an observer of the interviewees, allowing me to "observe and interact closely enough with members to establish an insider's identity without participating in those activities constituting the core of group membership" (Kawulich, 2005, p. 7). The goal of research role management is to help the researcher manage a detailed process of interviews, observations, and data collection and to find as truthfully and academically rigorous answer to the research question.

Trustworthiness

Enabling readers of this research study to gain a complete understanding of what the research study is describing includes the research methods and effectiveness. Shenton (2004) explained the "research design and its implementation," describing what was planned and executed on a strategic level; "the operational detail of data gathering," addressing the minutiae of what was done in the field; "reflective appraisal of the project," and evaluating the effectiveness of the process of inquiry undertaken (pp. 71–72). Baškarada (2014) stated,

> Reliability is concerned with Demonstrating that the same results can be obtained by repeating the data collection procedure. In other words, other investigators should in principle be able to follow the same procedures and arrive at the same results. To strategies for ensuring reliability of case studies clued creation of the case-study protocol

> and development of a case-study. The case-study protocol contributes to the reliability by standardizing the investigation. Relevant documents may be included an overview of the project, feel procedures, guiding questions and a report an outline. (p. 9)

Creating trustworthiness through observations and interviews allows data-collection to speak for itself. Building trustworthiness in the research study is important because of its qualitative research style. Lietz et al. (2006) wrote, "Trustworthiness is not something that just naturally occurs, but instead is the result of 'rigorous scholarship' that includes the use of defined procedures" (p. 444).

Threats to trustworthiness can include problems such as reactivity and bias from the researcher and participants. To manage these threats to trustworthiness, qualitative researchers must engage in a variety of strategies to describe research findings in a way that authentically represents the meanings described by the participants (Lietz et al., 2006). One way to curb bias is through,

> time at your research site, time spent interviewing and time building sound relationships with respondents contributing a trustworthy data. When a large amount of time is spent with our research participants: data less readily faring behavior or feel the need to do so, more ever there are more likely to be frank and comprehensive about what they tell you. (Ramey, 2008, p. 78)

As the data-collection tool for this research study, I need to ensure that the research was credible for qualitative research. Because all of the data will be coming from me and the research participants, I have described what steps were taken to show the credibility or trustworthiness of this research study. Using the terms that Lincoln and Guba (1985) used to describe trustworthiness of the data in the research study such as "Transferability," "credibility," "dependability," and "conformability," which have the four subsets of prolonged engagement, persistent engagement, triangulation, and member checks and peer debriefing (Lincoln & Guba, 1985). Shenton (2004) noted that in conveying the boundaries of the study to the readers, all additional information must be discussed before the researcher makes any attempts at

transference. Thus, Shenton (2004) suggests information on the following issues should be given at the outset:

1. The number of organizations taking part in the study and where they are based,
2. Any restrictions in the type of people, who contributed data,
3. The number of participants involved in the fieldwork,
4. The data collection methods employed,
5. The number and length of the data-collection sessions, and
6. The time period over which the data were collected (Shenton, 2004, p. 70).

Transferability

> A young man, traveling to a new country, heard a great Mulla, a Sufi guru, also traveling in that region, with an unequaled insight into the mysteries of the world. The young man determined to become his disciple. He found his way to the wise man and said, "I wish to place my education in your hands that I might learn to interpret what I see as I travel to the world." After 6 months of traveling from village to village with a great teacher, the young man was confused and disheartened. He decided to reveal his frustration to the Mulla.
>
> Over 6 months I have observed the services you provide to the people on our route. In one village you tell the hungry that they must work harder in their fields. In another village you tell the hungry to give up their preoccupation with food. In yet another village you tell the people to pray for a richer harvest. In each village the problem is the same but always your message is different. I can find no pattern of truth in your teachings.
>
> The Mulla looked piercingly at the young man. Truth? When you came here you did not tell me you wanted to learn truth. Truth is like the Buddha. When met on the road, it should be killed. If there were only one truth to be applied to all villages there would be no need of Mullas travelling from village to village. When you first came to me you said you wanted to learn how to interpret what you see as you travel through the world. Your confusion is simple: to interpret and to state truths are two quite different things. (Patton, 1990, p. 460)

External validity "is concerned with the extent to which the findings of one study can be applied to other situations" (Shenton, 2004, p. 69). The provision of rich, thick, detailed descriptions is a primary strategy used to ensure external validity, thereby providing a solid framework for comparison or transferability of "shared experiences" (Creswell, 2014, p. 202).

Descriptive characteristics of study participants and explanations of how the sample was selected are other strategies for transferability (Wu et al., 2016). Shenton in 2004 wrote, "How congruent are the findings with reality" (Shenton, 2004, p. 64)? "Credibility refers to the degree to which a study's findings represent the meanings of the research participants. … interpretations must be authentic and accurate to the descriptions of the primary participants" (Lietz & Zayas, 2010, p. 191). Lietz and Zayas (2010) went on to explain,

> The purpose of thick description is that it creates verisimilitude, statements that produce, or the readers of feeling is that they have experienced, or could experience the events of being described in the study thus credibility is established through the lens of readers who read and narrative account and are transported into a setting or situation. (p. 194)

Fundamental to qualitative research is to demonstrate the truth of the individual experience. The researcher presents a truthful representation of participants' experiences and voice (Bradshaw, Atkinson, & Doody, 2017). Trustworthiness in a qualitative case study requires prolonged engagement, persistent engagement, triangulation; member checks, an audit trail, and peer debriefing, concluding with an answer the research question (Lincoln & Guba, 1985).

Prolonged Engagement

The more experience a researcher has with participants in their settings, the more valid or precise the findings will be (Creswell, 2014). Prolonged engagement for this research study has been occurring for the past 15 years, since I started working as an employee at the substance-abuse-treatment center. I believe prolonged engagement also involves the number of years participants in the research study bring to the overall content and understanding of this research question: What are the challenges of an SAC?

Total length of time with participants during the study was 3 months, with 2 45–60 minute interviews that ensured ample amounts of data. It was imperative that the amount of time

spent in the field is appropriate for this research study to ensure that the interviews, observations, and data collection can be used to address the research question.

Persistent engagement

As the researcher, I questioned the data persistently and appropriately throughout this research study. By remaining skeptical, by looking at all the data, even the data that do not fit, I needed to become aware of any problems that may occur based on the qualitative nature of this research study (as described by Ramey, 2008). The more engagement a researcher has with participants in pursuing all of the data in their settings, the more accurate or valid the findings will be (Creswell, 2014). Engagement with participants in their social worlds is essential to the understanding of subjective meanings (Fossey, Harvey, McDermott, & Davidson, 2002).

Extensive engagement means researchers are placed well to conduct research in a manner that is responsive to participants and settings (Fossey et al., 2002, p. 728). "Reflexive reporting," described as informing readers about the actions, experiences, and interest in research studies, allows the reader to measure the researcher's role in the conduct of the study, and the understandings gained from engaging with the research study setting, data, and participants (Fossey et al., 2002, p. 728).

Negative Case Analysis

It is important that all information is presented including any negative or discrepant information. Negative case analysis is a process to refine and make the data more credible (Lincoln & Guba, 1985). It is important to manage Erickson's (1985) five major types of evidentiary inadequacies. "Erickson's work is often cited as a way to show how quality was maintained during the data collection and analysis process" (Ramey, 2008, p. 83). The first type

of evidentiary inadequacy is inadequate amounts of evidence (Erickson, 1985); I addressed this issue by being in the field for 2 months in active and purposeful data collection.

The second type of evidentiary inadequacy is inadequate variety in kinds of evidence (Erickson, 1985). I managed this evidentiary inadequacy by using interviews, observations, and data collection collectively, in the process called triangulation. Peer debriefing will help curb biases concerning interpretation of data (Ramey, 2008) and member checks will ensure the data are accurate, managing inadequate variety in kinds of evidence (Erickson, 1985).

Erickson's (1985) third evidentiary inadequacy is faulty interpretation of evidence in the data. By the continuous use of member checks to ensure interviewees read and comment on the accuracy of the translation of the data. Having persistent engagement allows for all data to be accounted for. Maintaining extensive contact with the participants and the site is another way to manage faulty interpretations of evidence in the data (Ramey, 2008).

The fourth type of evidentiary inadequacy stated by Erickson (1985) is inadequate disconfirming evidence by continually showing evidence of persistent and prolonged engagement by collecting, analyzing, and using all data in a genuine manner (Ramey, 2008). Finally, Erickson's (1985) fifth type of evidentiary inadequacy is inadequate discrepant case-analysis evidence. Each LPC and I have gone through the rigorous process of becoming an LPC and are bound by federal and state laws and professional ethics. By interviewing these participants for this research study, the goal is to produce meticulous, conformable, adequate, and illuminating data (Erickson, 1985).

Triangulation

Triangulation will be managed by using the interviews, observations, and data collection to answer the research question (Lietz et al., 2006). Triangulation can be an important strategy in

establishing rigor in qualitative work in that opposing perspectives can bring increased understanding of the data (Lietz et al., 2006). Triangulation is a validity procedure where researchers search for merging among multiple and different sources of information to form themes or categories in a study (Creswell & Miller, 2000). Shenton (2004) stated,

> This is one way of triangulation via data sources. Here individual viewpoints and experiences can be verified against others and, ultimately, a rich picture of the attitudes, needs or behaviors of those under scrutiny may be constructed based on the contributions of a range of people. (p. 66)

Member Checks

According to Creswell (2014), "member checking to determine the accuracy of the qualitative findings through taking the final report or specific descriptions or themes back to participants and determining whether these participants feel that they are accurate" (p. 201). As the researcher I conducting follow-up interviews and cross checks as needed with all participants to ensure this research study is accurate, viewed through as many lenses as possible. It will be important to make the data accessible to all concerned participants so participants can make any changes or clarifications and to ensure participants believe what they stated is true to the best of our combined knowledge. Lincoln and Guba (1985) stated,

> Member checking is both informal and formal, and it occurs continuously. Many opportunities for member checks arise daily in the course of the investigation. A summary of an interview can be "played back" to the person who provided for reaction; the output of one interview can be "played" for another respondent who can be asked to comment; Insights gleaned from one group can be tested with another. Such immediate and informal checking serves a number of purposes. (p. 314)

Peer Debriefing

During the process of observations, interviews, and data collection, having "frequent debriefing sessions" (Shenton, 2004, p. 67) with all concerned parties will ensure the following of correct protocol and helping identity any problems in the observations, interviews, and data collection that may occur. Peer debriefing involves the process of engaging in dialog outside of a

research project with those who have experience with the topic, population, or methods used (Lietz et al., 2006). Peer debriefing addresses whether the researcher or research team has engaged in an ongoing discussion with noncontractually involved peers during the research process (Bitsch, 2005). That is, peer debriefing determines if conclusions have been shared during the research process and all data and information has been verbalized and tested against others' perceptions (Bitsch, 2005).

Researchers use peer debriefing to enhance the correctness of the account so the research study will reverberate with all who read this research study (Creswell, 2014). I identified peers such as doctoral students and LPCs and will use these peers for debriefing, discussing the methods, topics, and populations of the research to help identify any processes or information that may need correction.

Audit Trail

The purpose of the audit trail is so another researcher can see all the data and come to a similar conclusion. Lincoln and Guba (1985) wrote, "An inquiry audit cannot be conducted without a residue of records stemming from the inquiry. … the need to provide an audit trail had innumerable payoffs in helping to systemize, relate, cross reference, and attach priorities to data" (p. 319). By organizing an audit trail, and providing a clear chronicle of all research activities and decisions (as in Creswell & Miller, 2000). Table 3 indicates the notations for the audit trail.

Table 3
Notations for the Audit Trail

Notation	Type	Participant
P-1–5	Interview/conversation	Substance abuse counselor
D-1	Brochure	Treatment Center
J-2	Research Journal	Researcher
O-1	Observations	Researcher I

An audit trail is a method for independent readers to authenticate the results of a research study by following the documents of the researcher (Merriam, 2009). Follow some of the suggestions made by Merriam in 2009. I will keep a journal to take note of any "reflections, questions or problems." I will also keep a running record of any analysis or interpretation that may be noted during the research study (Merriam, 2009, p. 223).

The external auditor examines this documentation with the following questions in mind: Are the findings grounded in the data? Are inferences logical? Is the category structure appropriate? Can inquiry decisions and methodological shifts be justified? What is the degree of researcher bias? What strategies were used to increase credibility (Creswell & Miller, 2000)? Through this process of documenting a study and review of the documentation by an external auditor, the narrative account becomes credible (Creswell & Miller, 2000). I retained this audit trail throughout the study in accordance with University of Arkansas IRB rules and regulations. The research audit trail will consist of my research proposal, journal, all field notes obtained, all data, and the research study final report.

Data Analysis

Data collected and described in Chapter 4 of this research study will be conducted from a "case study" perspective, which involves a detailed description of the setting and individuals, and analysis of the data seeking issues or themes (Creswell, 2014, p. 196). According to Baškarada (2014), "in the context of case studies, data analysis consist of examining, categorizing, tabulating, testing, or otherwise recombining evidence to draw up empirically based conclusions" (p. 15). One strategy for data analysis is creating a case description: a descriptive framework for arranging the case study (Yin, 1994). Data analysis is a process of

making sense of the data through the collection of documents, interviews, and observations (Merriam, 2009).

To accomplish this goal, I used a process called coding. Coding is an iterative and incremental process that researchers may perform at different levels of abstraction, maintaining the quality of addressing ideals rather than events (Baškarada, 2014). Coding enables a researcher to locate and bring together information that has been labeled as similar. Coding also helps identify distinctions among the data, connections, and patterns (Fossey et al., 2002). Coding has three levels: open, axial, and selective (Ramey, 2008). Open coding is a "means for categorizing segments of data with the short name that simultaneously summarizes an accounts for each piece of data. Codes show how data was selected, separated and sorted to begin and analytic accounting" (Ramey, 2008, p. 84). Also, "axial coding is the process of relating categories to their subcategories along the lines of their properties and dimensions. Axial coding helps to link all open codes" (Ramey, 2008, p. 84). Axial coding subcategories help answer questions about what occurred during a research study by helping answer the questions when, where, why, who, and how (Ramey, 2008). Selective coding is a continued focus on particular relationships and links among chosen categories or "the integration of categories" (Benaquisto & Given, 2008, p. 5). In the final stage of data analysis, selective coding validates relationships, fills in categories that need further refinement, and creates relationships among categories (Moghaddam, 2006). Adapted from Creswell (2014), Figure 3 shows data analysis in qualitative research, outlining the steps used to analyze the data.

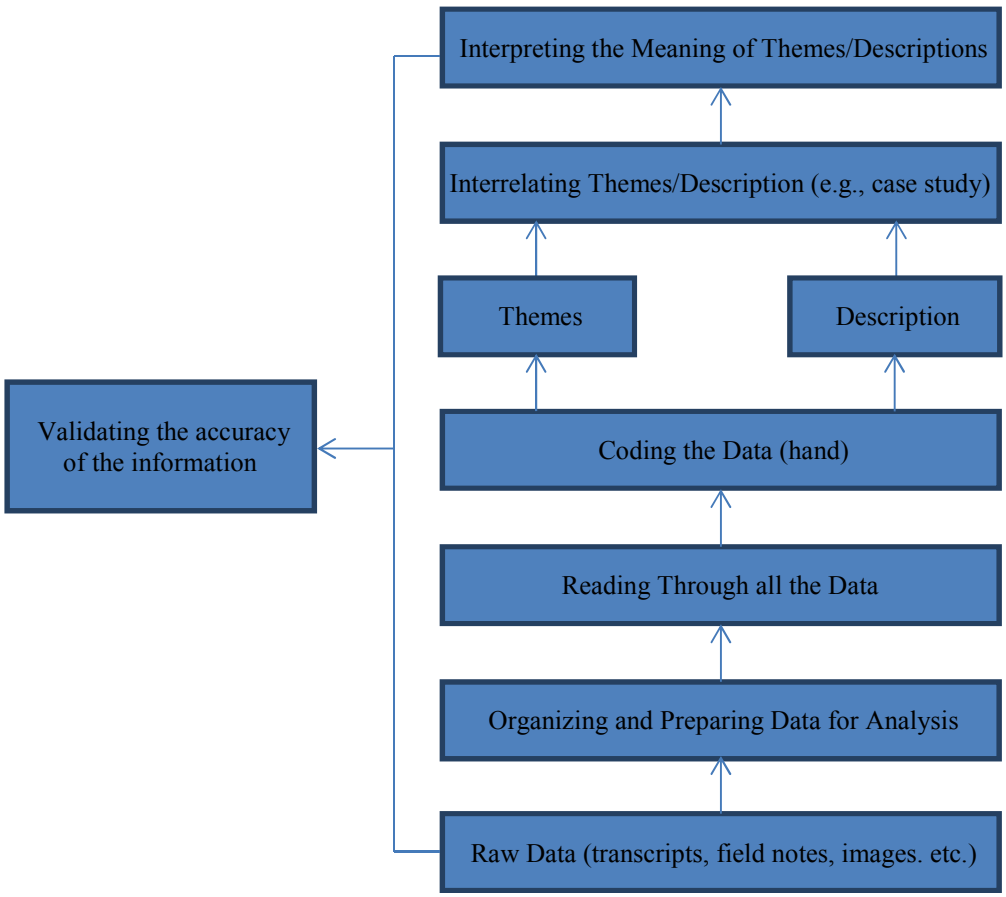

Figure 3. Data analysis in qualitative research.
Note. Adapted from Research Design: Qualitative, Quantitative and Mixed Method Approaches, by J. W. Creswell, 2014, Thousand Oaks, CA, Sage, p. 197.

Summary

In summary, Chapter 3 provided a description of the methods used to answer this research study question. By using a constructivist's worldview for this descriptive case study, maintaining truthfulness and credibility and using the method of triangulation, interviews, observations, and data to help tell the complete story. Prolonged engagement and persistent engagement are methods used to ensure that time spent with the participants is appropriate and that I engaged participants consistently in the research study. I maintained an audit trail so that any concerned parties may recreate this research study. Finally describing the system of data analysis called coding, which will enable me to identify and examine the major themes of this

research study by following the recommendations for Chapter 3. Which is to answer the research question with thick, rich, full, and truthful descriptive data and data analysis, Chapter 4 will tell the story of the participants and Chapter 5 answers the research questions, give future recommendations for research and have final conclusions.

Chapter 4

Organization of the Chapter

Chapter 4 commences with reexamining the introduction and background as outlined in Chapter 1, which describes this descriptive case study focusing on the challenges of SACs. The next section details the interviewee information and describes the interviewee demographics included in Table 4.1. The audit trail section follows and includes Table 4.2, which identifies the notations for the different types of data collected for the research. Next is the data analysis section, which describes the open coding process the researcher used in the study and presents Table 4.3, which identifies the open code samples and themes the researcher identified. The next section presents the open codes and themes that emerged through the coding process. And finally, Chapter 4 concludes with a summary.

Introduction

Substance abuse does not discriminate with respect to profession, income, geography, ethnicity, religion, income, or age (Chandler et al., 2011). Alcohol and drug use in the United States have serious consequences not only in social costs (approximately $151.4 billion in 2016), but in long-term individual consequences such as legal, medical, and family challenges as well (Barry et al., 2016). The purpose of this study was to describe the challenges SACs face. The significance of this study is to allow current licensed SACs' voices to be heard concerning the challenges of being an SAC.

Three interviewees who are LPCs in the state of Oklahoma and current SACs participated in this study. The researcher conducted a total of two interviews; each interview began with two open-ended questions for demographic reasons and then the research question. Each interviewee

received a journal so they could write any extra questions or comments about the research; each journal was labeled according to the interviewee.

Interviewee Information

The interviewees consisted of three female LPCs who are currently SACs. Table 4.1 identifies the demographics of each interviewee. Each interview lasted 1.5 hours, as the researcher followed each line of responses and let the interviewee guide the process, especially for the first interview. The researcher then gave each participant a participant journal (PJ) after the first interview and asked each one to use the journal to write down any additional thoughts about the research question and call within 1 week for the second interview. The researcher conducted the second interview from the notes of each PJ and any extra thoughts the interviewees may have had. The researcher then asked the interviewees to use the PJ for any additional side notes such as comments or observations if needed. The researcher called each interviewee to see if they had any more thoughts about the original research question; each stated there was nothing else for them to say. The researcher digitally recorded each interview, downloaded the recordings to a computer hard drive, and used a flash drive to send the recordings to a transcription service.

Table 4.1
Participants' Demographics

Individual	LPC experience	SAC experience
P-1	12 years	8 years
P-2	8 years	6 years
P-3	4 years	2 years

Audit Trail

The purpose of the audit trail is so another researcher can see all the data and come to a similar conclusion and for any other reader of scholarly articles so they can also follow the data. Lincoln and Guba (1985) wrote, "An inquiry audit cannot be conducted without a residue of records stemming from the inquiry. … the need to provide an audit trail had innumerable payoffs in helping to systemize, relate, cross reference, and attach priorities to data" (p. 319). The audit trail allows future researchers a clear chronicle of all research activities and decisions as in Creswell and Miller (2000). Also, an "audit trail" is a method for independent readers to authenticate the results of a research study by following the researcher's documents (Merriam, 2009).

Table 4.2 displays the audit trail with notations. The notations include participant identification, Interview 1 or 2, the page number, any documents acquired during the research, any observations the researcher noticed, and finally, the PJs. This table offers an example of how the researcher notates the data in the text (ex: Participant 1, Interview 2, page 4 (P1, Interview 2, p.4)).

Table 4.2
Notations for Audit Trail

Notation	Type	Participant
P1	Interview	Participant 1
P2	Interview	Participant 2
P3	Interview	Participant 3
Interview 1	Interview 1	Participant 1, 2, &3
Interview 2	Interview 2	Participant 1, 2, &3
p.	Page number	Interview 1 or 2
D	Documents	Researcher
O	Observations	Researcher
PJ	Participant Journal	Participant

Data Analysis

Coding is the process of organizing the data to generate themes or categories for analysis. The goal of coding is to narrow down the broad descriptions the interviewees provide (Creswell, 2014). Description involves a detailed rendering of information about people, places, or events in a setting (Creswell, 2014). Qualitative researchers start with thorough consideration and analysis of the data and develop theories based on the data (Orcher, 2005).

The coding process begins with a process called open or initial coding. In this beginning process, the researcher reads and examines interviewees' transcripts thoroughly, looking to identify separate, distinct segments (such as the participants' experiences or ideals; Orcher, 2005). Also, using verbatim quotes and words from the participants is called *in vivo*, which is part of the coding process (Birks & Mills, 2015). The coding is open and unfocused at this stage (Moghaddam, 2006). Also, the researcher begins breaking down, comparing, labeling, and categorizing the data during this open-coding stage (Moghaddam, 2006).

According to Moghaddam (2006), theoretical saturation should be reached during this level of coding. This means that no new dimensions, properties, or relationships will emerge during analysis. Saturation is "the state in which the researcher makes the subjective determination that new data will not provide any new information or insights for the developing categories" (Moghaddam, 2006, p. 6). The end result of this process is to find out "what is really going on" in the data (Chun Tie, Birks, & Francis, 2019).

Axial or intermediate coding is the next major stage of data analysis with the intent to fully develop individual categories by connecting the subthemes created in the first stage (Birks & Mills, 2015). Through methodical analysis and constant data comparison, the objective of this stage of the data analysis is to reduce the number of codes and organize them together in a way

that shows the relationship among them (Moghaddam, 2006). The focus of axial coding is to construct a model that details specific conditions that give rise to a phenomenon's occurrence (Moghaddam, 2006). Axial or intermediate coding begins to refine and transform basic data into more abstract concepts (Chun Tie et al., 2019). Chapter 5 describes the third stage: selective coding.

The first step of the data analysis, which is also called the open-coding stage, begins by reading the transcribed interviews line-by-line and page-by-page, identifying words and thoughts utilizing a highlighter and index cards. No concise information emerged during this part of the coding process where the researcher used a stack of index cards with the words and thoughts collected from the pages of the data. Table 4.3 identifies a sample of the open codes identified during the coding process.

Table 4.3
Open-Code Samples and Themes Identified During the Research

Themes	Open Codes
Boundaries	Being in recovery myself, I had to quit cold Turkey, Gambling made me feel better, have my ego in check, Compassion fatigue, and Easy burnout, finding that balance
Time	Lifetime commitment, not a quick fix, don't have clients long enough, it takes time
Why People Use	Externalize their problems, defense mechanisms, lack of support, caught in a cycle, depression.
Treatment	Child care, transportation, geographic location, medications, concentrates on treatment.
Financial	Insurance co-pays, self-pay, a big barrier, no financial means
Training	Know your specific limits, collaboration, thought distortions, being genuine, credentials, training on social media and ethics.

In the second stage of the coding process, the researcher laid out all the index cards with the words and thoughts from the open-coding process. Then, the researcher reread the transcript,

this time looking for context and content, but also comparing how the interviewee used the word or phrase. The researcher organized the index cards by reading each paragraph. This process was the most detailed, as it involved the researcher going back several times to continue to compare and narrow the focus to build the necessary data for the final stage of the coding process.

Peer Debriefing

Researchers use peer debriefing to enhance the correctness of the account so the research study will reverberate with all who read this research study (Creswell, 2014). I identified 2 peers not connected to the study and used these peers for debriefing, discussing the methods, topics, and populations of the research to help identify any processes or information that may need correction. Allowing my peers access to the data so they could ask questions and identify any gaps in the coding process will give 2 other perspectives and should increase additional accuracy in the study.

Presentation of Axial Codes/Themes

Boundaries Theme

The first theme is *boundaries*. The boundaries theme is bound by each participant's words, opinions, and thoughts of their boundary challenges as SACs. Table 4.4 shows a sample of the different open codes that all three participants used for this category. The researcher also framed the boundary category on the interviewees' personal disclosures, which are part of their personal and professional identity, such as their own recovery status or the boundary challenges they identified by using "I" statements.

Table 4.4
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the Boundary Theme

Theme	Sample of Open Codes (Participants 1, 2, & 3)
Boundaries	I didn't go to treatment, Being in recovery myself, I had to quit cold Turkey, stop being human and have my ego in check. Self-care, Easy Burn out, emotionally exhausted, stop being human and dual relationship. Create instances of conflict, compassion fatigue, vicarious trauma and dual relationships

The boundaries theme is connected by the open codes that all three participants brought to the table. The theme begins with one of the major boundary issues all three interviewees discussed, which was the concept of CiRs or those not in recovery. The topic of CiRs has different dynamics as identified by all three interviewees. Some of the different dynamics the interviewees discussed were dual relationships, conflicts of interest, counselor effectiveness, and clients' perceptions of CiRs' effectiveness.

The presentation of data begins with P1 who is in recovery and began with some of the positive and negative aspects of being a CiR:

> And I have had a lot of clients say to me over the years, I don't want a counselor that's not in recovery because they don't understand. And I have a little bit of a prejudice towards that that I don't think they quite do understand if they just went to school. I mean, a lot of people have it in their family; they have a better understanding than a lot of the clients think. But I think it's helpful to have walked that road yourself to really be effective. But that also has it downfalls. What if you relapse and you gotta... I don't know. It's not always a good thing; I don't suppose. (P1, Interview 1, p. 2.)

P2 also explained her perspective about CiRs. P2 began by sharing her feelings about being looked down on for being a SAC not actually in recovery. She also stated that there could be a degree of truth that SACs in recovery may have more "life experience." She also brought up that early in her career one of her coworkers suggested that she go to some recovering meetings, which helped deepen her understanding and create a whole new insight into substance abuse. She explained,

> When I started doing substance abuse, that was the first time I ever felt looked down upon because I wasn't in recovery. Almost as if, well there's no way I could know what I was talking about. And there probably is a degree of that, of truth in that. Until you, if you don't have any family experience or you don't have any kind of information just coming straight out of school. Book smarts is incredible, but so… life experience is a whole 'another education. I was very thankful early on in my career, when one of my coworkers that was in recovery said, you have to go to some meetings. And I'm like, no, I don't feel comfortable. I didn't even know you could go to meetings if you weren't in recovery at that point, you know. So going to those was really eye-opening for me. And I think everybody should go to an open meeting. A few of 'em because I just think it deepens our education and broadens just our whole insight into things. (P2, Interview 2, p. 3)

P3 was not in recovery and also discussed her opinion about CiRs. All 3 interviewees did acknowledge that being a CiR may have some initial benefits, as P3 stated below. P3's opinion was that being a CiR does not make you more effective, although clients may express that they need to have a CiR due to their higher level of understanding. P3 also stated, "…credentials, you know, are credentials regardless of experience" (P3, Interview 1, p. 3).

> I think, and this is my personal opinion, I think that it, a lotta times, I don't think that it makes you more effective to be in recovery. I think that any, that actually can have, that it can have benefits as far as rapport with the client. My clients, a lot of times will express that they need to have a counselor in recovery because they're the only ones that understand. Which I agree that there is a level of understanding that you can't have unless you've been through it, but, you know, I keep going back to, you know, if I had a doctor, if I had a broken leg and I went to the hospital, I'm not gonna care if my doctor had a broken leg too. No. It would be cool if he said, you know, that he did, that he's experienced that because then you know that they're able to relate on that level. But it doesn't make him any less suitable to treat it, because credentials, you know, are credentials regardless of experience. (P3, Interview 1, p. 3)

P2 continued discussing the boundary challenges of dual relationships, especially with counselors in their own recovery programs working in an agency that hires people in recovery, and the challenges of keeping a separation between her personal life and professional career. P3 continued with her thoughts surrounding the possibilities of dual relationships and conflicts of interest among CiRs, especially in a small recovery community, and the importance of making

sure CiRs have other outlets so they can support their own recovery and do their best not to become involved in dual relationships or conflicts of interest.

> Something else that came up was dual relationships. In particular, I've seen a number of counselors struggle with having their own recovery program, going to their own support group meetings, and clients or former clients showing up there. And then they're involved, that's creating that dual relationship of, you know. The other part is, the agency that I work at, we hire those that are in recovery. And so, a great number of people that are employed there have been my clients or I have had some direct care for them. And so that's very difficult. Now they're a co-worker, but I'm also their counselor, so trying to mesh that is extremely difficult. (P2, Interview 2, p. 2)

> Yeah. I mean that creates additional challenges too, other than just, like I mentioned, the conflict of interest and the dual relationships, it also creates a problem for counselors that are in recovery to maintain their recovery using those same methods. Because I know that for a lot of counselors in recovery, they're not gonna wanna go to a meeting where they know that former clients are going to be, even current clients could be. And then future clients could be too, 'cause it is a pretty small pool. (P3, Interview 1, p. 3)

> And even in our city, which is, you know, like 500,000 people, like it's still a small community in the recovery community. So in a lot of ways, I know that it can prevent counselors from having that access to their resources that they're used to taking advantage of due to that issue. Which can be pretty detrimental for their personal recover if they don't find other outlets, like having a, you know, going to private counseling or utilizing maybe groups in a different city. Or even electronically, like Zoom or doing groups online. (P3, Interview 1, p. 3)

At this point in her interview, P3 discussed her thoughts about the advantages of being a CiR, such as relatability with her clients, and also talked about the downside of being a CiR. P3 felt that a bias exists towards many CiRs in that they may have a mindset about their own recovery and may transfer that same mindset to a client.

> I do think that that relatability is an advantage for counselors to, like I said, be able to connect on a different level. But I've seen counselors in recovery have a downside too. Because there's a bias there that they wanna make the way they got sober, the way to get sober. And so I've seen it actually create a bias as far as being kinda one track, you know, like this is what worked for me so, you know, this is the way. And everybody has their own different ways. And so if a counselor in recovery were to have that mindset, which, you know, sometimes people do, that could actually be a negative as far as, you know, it could turn off people who aren't…who don't want. (P3, Interview 1, p. 3)

Continuing with the boundaries theme, P1's recovery is obviously a big part of her personal identity as an SAC. She described the challenges and thoughts she experienced in her early recovery surrounding not drinking any more. She finally discussed her sobriety and search for "serenity" as stated by her quotes below.

> I just, for me personally, I think recovery can be very hard. And I don't think people realize sometimes what goes into it. And I don't think sometimes, or lots of times, they're often to really take those steps to stay in it. (P1, Interview 1, p. 1)

> I had to quit "cold Turkey" and "And get it out of my body so that I… Cause I can't go out and have one or two drinks. Maybe I can. I won't be very happy about it. And eventually one day I'll go out and I won't have one or two drinks. So I do think some things, cold turkey is cold turkey. (P1, Interview 2, p. 14)

> You know, at 42 is when I got sober, so I had all this experience of happy hours and getting together with friends at the lake. And everything I did was around alcohol. You know, having people over, having parties. We used to have lots of parties. And all that goes away. And I know at first, for me, I wasn't comfortable around my friends when they were drinking, so I didn't go to a lot of stuff. I just… I think it would have been tempting at first, at least the first year or so. So…And I never, for myself, I haven't made a whole lot of friends in sobriety. I just… some people do. Like if they go through treatment, I think sometimes they'll have some core friends that they make. But if you just start going to AA, even if you're really involved with the group, it may be that you won't make a lot of new friends. And you gotta get used to the lack of chaos in your life, and serenity. And I… it was very uncomfortable for me for a while, that serenity business. (P1, Interview 2, p. 3)

P2 began by discussing her efforts not to get frustrated while trying to keep boundaries between her personal life and any behaviors she had with her son. P2 continued to talk about dual relationships, which has been a difficult balancing act for her, especially after she lost her son and quit substance-abuse counseling for 2 years.

> I think there's a variety of challenges. A lot of people in this field are in recovery themselves, and I believe that gives them a different, or additional insight into the substance abuse field. Where perhaps I didn't have that insight and I've had to develop that knowledge myself. But challenges: easy burnout. I find that just about the time I'm ready to stop and just change my career path, something happens, somebody reaches out to me. There's some reason that I'm reminded of I am making a difference. Another challenge is at times I feel like because I'm a counselor, not necessarily mattering what type of counselor, that I'm not a person. Or I shouldn't have the range of emotions other people should have. And so in teaching that to my clients, that just because somebody has

> a particular career or duty, or role in the family, that doesn't make us stop being human. I found that quite interesting that so many people, yes, we should be held to a higher standard, but not a non-human standard. I think, apart from me personally, my personal life bleeding into my career path, with losing my son to his addiction, I instantly wanted to stop doing what I was doing. But having said that, I think it has strengthened me as a counselor. And in particular working with families of those that are addicted. At times it feels as if my responsibility is doing paperwork as I'm supposed, rather than the actual counseling. So I have to consider that also in what position do I wanna be in? Do I wanna work in an agency? Do I wanna work independently? Do I wanna work with children? Do I wanna work with adults? Because of all the differing requirements for all. I absolutely do not wanna work with children. (P2, Interview 1, p. 1)

One of the most important things P2 learned is that there is a healthy way of handling things, which she thinks could be a teaching tool for everybody, but she feels she will always have a degree of caution throughout her career. She also brought up keeping a boundary between her work and home life. She described being physically, emotionally, and mentally exhausted and the challenge of managing all the things counselors hear—both good and bad—and how carrying all this weight may create second-hand trauma.

> Challenges for me, not getting frustrated, trying to hold a line between my personal life and my behaviors that I had with my son, in particular. And not keeping those same enabling behaviors. Not holding somebody accountable because—for whatever reason. Going home and leaving things at the office, and keep a boundary of work. Work happens at work; I don't bring it home. And just being exhausted and tired. And when I say exhausted, every sense of the word, physically, emotionally, mentally. Carrying the weight because you hear a lot of things, good and bad. The bad, in particular. Working with the veterans right now. Some of them have shared some extremely difficult things, so it's hard to keep that in the compartment and not think about those things and have that secondhand trauma. (P2, Interview 1, p. 3)

P2 continued with her thoughts on boundary challenges by comparing the price of earning her master's degree to the pay rate of a counselor, which has had personal financial implications for her. She also reiterated the concept of personal and professional balance and self-care. P2 also identified a boundary challenge of working during a global pandemic caused by COVID-19. P2 also disclosed her own recovery status and the guilt and feeling that she must be cautious when out in a public setting due to her status as an SAC.

> Financial. You know we spend a great deal of money going to school. I personally have a lot of loans, and the income almost isn't worth it. So the financial piece of it.Then, I think I mentioned last time like self-care and burnout can happen really easily. The past couple of weeks it's been with the Covid-19 and everything, it seems to be even more important to taking care of ourselves because it seems as if the clients that I'm working with have become much more in need of services also. (P2, Interview 2, p. 1)

> For me, and part of my hanging out with my friends and that selfcare stuff, is I do occasionally have a drink. It may be like a piña colada or something, but I feel guilty as a Substance Abuse Counselor. I am not in recovery and I don't normally drink a lot, but I feel very cautious about who's gonna see me, or who's around, or my goodness don't take any pictures and put 'em on social media, that type of situation. So that's a challenge for me also. (P2, Interview 2, p. 3)

> But again, that falls back into that potential dual relationship. It feels like it's a pile of matches and if you take one out, the whole thing is going to collapse. Or a deck of cards, or something. So I think it's a balancing act for sure". Definitely. That's definitely been a struggle for me personally. And maybe it's not for other people. But it is for me, because, even now, I don't talk about, you know, things I do or… And I left for two years. After I lost my son, I left for two years before going back to this agency. And it was a whole different environment. Completely different. It was a physician's office where the whole team going out for drinks after work was a weekly thing. And I still was like, no, I'm not comfortable going. I don't think that's right, you know? So it's just something you definitely have to work through and gauge what you're willing to put out there. Right. I think I will have a degree of concern throughout my career. I also think it can be a teaching tool for everybody, whether you're in recovery or not, for the clients or the staff that there is a healthy way of handling things. There's a healthy way of… It's just like food and people that are trainers in the gym, do they eat cake? It's kinda that sort of thing. (P2, Interview 2, p. 3)

P2's final thoughts about her personal boundary challenges included finding balance, understanding what her boundaries are, and being able to say no when necessary for her own self-care.

> But then I also, I think it's really, really important to find balance. In my position, I'm on call 24 hours a day. So knowing when I need to put down the phone and have my supervisor cover for me is really important. Really important. (P2, Interview 2, p. 1)

> Having a schedule and sticking to it, number one. Knowing that no matter how much we want for somebody, they may not want it for themselves. And that's a hard thing for me. But also, I mean, just knowing, knowing what your boundaries are. And when I say boundaries in this sense, I'm talking about your time boundaries. How much on-call you're willing to take. How much, in an agency setting in particular, things can be asked of you and asked of you and asked of you, and you need to be able to say no. This is too much. To be able to have your voice. And the second part of that is being comfortable to

> know that if I use my voice, am I going to have backlash from that? Am I okay with that? (P2, Interview 2, p. 2)

P3's open codes that were used in the boundary theme had to do with social media privacy and P3's thoughts about the importance for her to maintain privacy and secure her personal social media identity. Finally, P3 discussed the importance of minimizing the occurrence of dual relationships as a clinician.

> I would suggest privacy. Like doing anything that you can to ensure that if you have social media accounts, that the settings on your end are extremely private. I actually just attended a couple of weeks ago, a training on social media and ethics. And there were discussions in that class about counselors who had been submitted to the Ethics Board due to just information about. (P3, Interview 1, p. 1)

> …about them that their clients were able to find about them on social media. So basically, it wasn't anything the counselor had done, other than not have their privacy settings. So there was information that was used against a counselor by a client from things that they found on their social media. (P3, Interview 1, p. 2)

> So those are things that I know I wasn't thinking about in the beginning. You know, I wasn't thinking of securing my social media identity, so I actually… They had recommended people even changing their name on social media to where it was non-identifying. (P3, Interview 1, p. 2)

> But I know in our state, our Board says that we have to do everything possible to minimize the occurrence of dual relationships. And they recently, like I know the LPC just recently changed even the amount of time in between a last session to even greater than what it was. They used to say no dual relationships, no friendships, no business relationships for two years, and they changed that now to five years. (P3, Interview 1, p. 2)

P3's open codes have to do with her thoughts of counselors being held to a higher standard professionally and that our conduct and professionalism should be higher than those people who are not counselors.

> I think that professionally, we are held to a higher standard, yeah. And that actually came up in the training that I was at a couple of weeks ago, that social media training. As they were saying, you know, like there was a lot of discussion back and forth about how we're still people, you know, and we have lives outside of our profession. And the instructor made it a point to say, you know, we, when we became counselors, basically we have to adhere to a higher standard than just a person who isn't. And how we are held to a

> manner of professionalism and conduct that is much greater than people who aren't. (P3, Interview 1, p. 3)

P3 also shared her thoughts about compassion fatigue, severe trauma, and burnout because there is a greater prevalence of people who may suffer from severe trauma due to substance abuse. "And it's also common for therapists, helpers in general, to put other people's needs in front of their own too" (P3, Interview 1, p. 8). She also explained that substance-abuse therapists are extremely susceptible to vicarious trauma and such clinicians' workload demands and lack of self-care may cause problems.

> I did think of something just now, which is the compassion fatigue. So that's another huge, I think, problem for people that work in our field is to get so exhausted by the work. Because in substance abuse, we do have a greater prevalence of people who have a severe trauma. And trauma therapists can get burnout really fast due to compassion fatigue and vicarious trauma. (P3, Interview 1, p. 8)

> So substance abuse therapists and trauma therapists are extremely susceptible to vicarious trauma. And then if they don't have the self-care in place, if they don't have the time to debrief, the time to decompress, which is common when you work in an agency where you can be overwhelmed by the amount of work required. And you might not have an appropriate amount of time in order to get what you need. (P2, Interview 1, p. 8)

P3 continued with her thoughts about the importance of her having the correct credentials and specializations to be the most effective counselor she can be. She also mentioned that she feels comfortable enough and able to keep her ego in check so if she does have to refer a client she knows it is the right decision to make so as not to harm the client.

> And so I've kinda taken some other paths due to that too, but I really, for me personally, I feel like that that's kinda the way to go, is to have credentials and specializations so that you can really be the most effective at dealing with those types of issues that happen to occur. The grief specialization is something that I'm looking into getting in the future, along with some other different specializations to be able to treat certain conditions. But I absolutely am comfortable enough with myself and have my ego in check to where if I have somebody that comes in that is needing something that I don't feel like I have the best resources and the best… (P3, Interview 2, p. 2)

> Right. Being able to know where those lines are so that you don't harm the client. Because honestly, that's what I always go back to is, am I gonna help or harm?" (P3, Interview 2, p. 2)

In establishing the boundaries theme, the researcher used the open codes and determined their best fit based on content and context. Each participant shared different types of boundary challenges, but as you have read, some boundary challenges intermingle. P1's boundary challenges have a lot to do with her own recovery challenges and the challenges of being a CiR. P2's boundary challenges stem from the death of her son while she was an SAC and the importance of self-care in her personal and professional life. P2 also discussed the concept of counselors who may or may not be in recovery. P3's boundary challenges have to do with the importance of her social media privacy, the possible dual relationship a CiR may have, and her thoughts about being able to understand when it is time to refer a client elsewhere for the client's best interest. The researcher was surprised that all three interviewees had differing thoughts and opinions about counselors who are or are not in recovery. Also, as you read, some of the boundary challenges the participants shared cross over into other categories, which the researcher believes is part of the individual nature of the participants being linked as SACs. The next section describes the time theme.

Time Theme

The researcher labeled the next theme *time* due to the information gained from the participants' open codes and the researcher's use of the coding process. Table 4.5 gives a sample of the open codes used by Participants 1, 2, and 3.

Table 4.5
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the Time Theme

Theme	Open Codes
Time	Lifetime commitment, not a quick fix, it takes time, timely access, wait time, 2 years, not the end all, be all.

Presenting data for the time theme begins with P1 as she discussed her thoughts and feelings about the time clients may get in treatment in an agency setting. In P1's opinion, clients do not really experience an appropriate amount of time in residential treatment; she felt substance abuse is not a "quick fix" and it takes time to find a "path to recovery." She also believed that the longer you can engage someone in counseling—even with some sort of aftercare—they have a better chance of staying clean and that 28 days in treatment is not enough. P2's open codes specific to the time category are different from the other participants. She stated, "…I have the gift of seeing the people for up to two years in a controlled environment" (P2, Interview 1, p.2). P3 stated "…there's a barrier of wait time. So people don't have access timely a lot of times…" (P3, Interview 1, p. 6). P3 also described the time it may take a person to get treatment: "… again you don't have control over the time it takes to get you there. So you could be late and then cut off. Like there could be a cutoff time, and then you don't make it" (P3, Interview 1, p. 7). P2 and P3 both had concerns about clinicians and the concept of time: P3 stated "…I'm talking about your time boundaries. How much on call are you willing to take…" P3 stated that "…and you may not have an appropriate amount of time in order to get what you need" (P3, Interview 1, p. 8).

P1 continued with her thoughts about a person who thinks all they have to do for their recovery is attend a 28-day treatment program and not change anything else about their lives; therefore, they may not gain the recovery they seek: "I just think if all you do is go to a 28-day treatment, you don't change anything else about your life, it's not gonna work" (P1, Interview 1, p. 3). P1 went on to say the timeliness of admission and lack of immediate access to a treatment center could be fatal to the client. Her final thought for the time theme was that even if people do want to get treatment, many feel they cannot possibly attend a 28-day—or upwards of a 60-

day—treatment program due to having to leave the rest of their lives behind for the duration of treatment. She explained,

> Well, I think there are probably quite a few. One challenge that comes to mind is that in an agency setting, which is where I've worked, we don't really have the clients long enough in like a residential setting to really get very far, I don't think. And then sometimes they just aren't willing to go to outpatient, so they don't continue. You know, it's not a quick fix. It takes time to find the path to recovery and what works for you. (P1, Interview 1, p. 1)

> And I think, sometimes people think 28, 30 days in residential, well okay, I did it so now I'm done. And that's not how it works, you know. It's a lifetime commitment, I believe, to be in recovery. And you're always gonna have to be doing something to stay in recovery. So, I think the longer we can engage someone in counseling, or even some sort of after care, the better chance they're gonna have of staying clean. (P1, Interview 1, p. 1)

> And oftentimes people decide they wanna go into treatment, they wanna go right then. They don't wanna go six months from now; things have changed by then. And maybe they don't wanna go at all. Maybe they're dead, you know. (P1, Interview 1, p. 3)

> It's hard for people just to take this big 28-day chunk, or 30-day or however long, 45, 60, and leave their life to go get treatment. So I think that keeps a lot of people forgoing, because it's like, well how can I possibly? I can't do that. (P1, Interview 1, p. 4)

> …and the time factor when you have them in residential treatment, you really don't have a lot of time to do a lot of counseling. You just have such a limited period of time to help them start thinking about the changes and what they're gonna do. And you don't wanna get into a big ton of trauma, 'cause you're only gonna have them 21 to 60 days at the very most. So I think time is not on our side when we have our clients in residential treatment. (P1, Interview 2, p. 4)

This concludes the time theme where the open codes all connected to time or the concept of time. P1's focus appeared to be the amount of time clients are able to spend in treatment compared to the amount of time they may need to stay in treatment. P1's interview yielded rich information that enhanced the time theme. Also, she had some thoughts about the amount of time it may take to get into a treatment center and that there is not always a seamless transition from one level of care to the next. P2 had a different side to the time theme due to the fact that she can see her client for up to 2 years. P3 discussed the problems of clients' access to and wait time for treatment. P2 and P3 also discussed time from a clinician's perspective.

Treatment Theme

The third theme is *treatment*. Table 4.6 presents the open codes the researcher gained from the participants' interviews. The open codes focused on the challenges of treatment including the barriers, importance of treatment, treatment participation, schedules, and the different levels of treatment (residential or outpatient).

Table 4.6
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the Treatment Theme

Theme	Open Codes
Treatment	Concentrates on treatment, hard to get into treatment, your first step, transportation issues, insight, typical schedule, counseling services and schedule

P1 began with "And a step is going to treatment, and that's your first step." (P1, Interview 2, p. 17). She continued with the most basic barrier: "It's real hard to get into treatment" (P1, Interview 1, p. 3). P1 went on to say, "You know treatment is not the end all, be all" (P1, Interview 1, p. 1). They continued further: "Another challenge I had was that people were often forced into going to counseling by their probation officer, or whoever it may be, and weren't really very happy about being there" (P1, Interview 1, p. 1). P2 felt that "It's not just the counseling services in this session that we have once a month or once a week, whatever the case may be. It's those interactions outside...Kinda going back to I'm a human thing." Also, "they haven't been able to have their regular schedule of going to meeting and all those different things" and "having a schedule and sticking to it, number one" (P2, Interview 2, p. 2). P3 stated, "There's a lot of barriers. In different, among different populations. People in different geographic locations. And also people in different gender groups, too" (P3, Interview 1, p. 6).

P1 continued by discussing the various treatment challenges:

> And I think for some people, it's children. They have children. What are you gonna do with the children while you're in treatment? Do you have anybody to watch them? What happens to your job while you're in treatment? It's hard for people just to take this big 28-day chunk, or 30-day or however long, 45, 60, and leave their life to go get treatment. So I think that keeps a lot of people from going, because it's like, well how can I possibly? I can't do that. I gotta go to work. I gotta make money. I gotta pay my bills. I gotta do this, and even people that get into treatment, I hear that from them a lot. I need to leave. I need to go make money. (P1, Interview 1, p. 4)

P3 felt that females have more barriers to treatment, while P1 discussed the lack of support for women:

> For females, there's also a barrier of childcare. And not saying that men can't have childcare issues too, but more often than not, that is a role that the female is usually more, has to take on that burden more as far as not being able to do things due to children in the house, or not having a sitter. (P3, Interview 1, p. 7)

> So females actually have a greater barrier with entering inpatient due to that. Being away from their children that long in the role that they have. It can also be a barrier for outpatient because of childcare and not having a babysitter even weekly. (P3, Interview 1, p. 7)

> You know, some women when they return home, they don't have the support. So if they want to go to a meeting or go to counseling, then their children come along. And I don't know if you've ever had a session where somebody brought their two-year-old, but it's interesting. And pretty short. (P1, Interview 2, p. 5)

> …so they depend on this husband at home, who may or may not be sober, and can't stand on their own two feet. So, and aren't used to it. Don't even know how, really, to make that step. So that's why the continuation of counseling. You know, when they get into half-way, they can go work. They can start working towards that. And if you can refer 'em to places like VOC rehab, things like that, where they can get some training and get placed in a job that might be, maybe they could support themselves with. (P1, Interview 2, p. 6)

P1 also shared that they think treatment offers a positive opportunity. Meanwhile, P3 explaind her view of "holistic treatment."

> …so that's what I did. But I think treatment gives you some insight into yourself and you can learn some coping skills. There's things that you can learn in treatment that'll be really be helpful to you along your journey. But I don't think you can just go to treatment and that works. There's more that has to be done. (P1, Interview 1, p. 3)

> One of the reasons why I believe in holistic treatment because I do believe that you have to have multiple people on the same page, different professionals, to really figure out the whole picture of what's going on with the client. (P3, Interview 1, p. 7)

P1 continued to identify treatment challenges; she explained that a person still has a long way to go in recovery even after finishing treatment: "Once you get done with the residential, it's… You know, I hate that when we graduate people. You've graduated so you're all good now. I mean that's the barest of beginnings" (P1, Interview 2, p. 5). P1 also stated,

> I don't think people in treatment should have much contact with anybody outside of treatment. Because that certainly is a barrier because, the girlfriend at home is saying, well you gotta come home because blah, blah, blah, blah, blah, and then they go home. Whereas if they didn't talk to their girlfriend, they can concentrate on what they're there for and get it finished and get that good start to recovery. (P1, Interview 1, p. 4)

The treatment theme began with participants identifying barriers to treatment. P1 and P3 both felt that women have greater barriers to treatment such as transportation, childcare, and basic support. P2 focused on the importance of positive interactions during treatment and the importance of scheduling while in treatment. P1 also discussed the positive opportunities of receiving treatment, while P3 explained her view on treatment. Finally, P1 felt that going to treatment is just the start of recovery and detailed the importance of concentration during treatment.

Why People Use Theme

The fourth theme is *why people use* (WPU). This category is bound together by the open and axial codes of all three participants. Some of the open codes that created this category are "just to manage," "no job history," "my hope's gone," "environment," and "denial," just to name a few. Table 4.7 identifies the theme and offers a sample of the open codes.

Table 4.7
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the WPU Theme

Theme	Open Codes
Why People Use	Just to manage, feel better, Loneliness and boredom, Caught in a cycle, feel something different, environment, self-image, denial, many changes, old behaviors and thought distortions

The researcher identified the open codes and narrowed the focus to the WPU theme by reading the interviews and looking for not only content but context in the participants' open codes that fit the axial codes. The participants identified WPU as one of the challenges they encounter as SACs. The data below presents reasons behind WPU such as clients refusing to believe they have a substance abuse problem through blaming their problems on other people.

P1 identified her thoughts about WPU and how they feel: "As far as feelings, if I lived in a crack house basically, I probably wouldn't be feeling very good, so I think that perpetuates the drug use. You don't wanna look around and see where you're at" (P1, Interview 2, p. 16). Similarly, P2 stated "…And sometimes it's self-image, self-esteem stuff too" (P2, Interview 2, p. 8). While P3 thought, "I think that it could be a combination of all those things. And people are different, and we also have different defense mechanisms too" (P3, Interview 1, p. 7). P1 went on to discuss the difficulty of becoming sober by stating the following:

> To feel better. Because their parents did, and they were brought up that way. I think people use substances to change the way they feel. And I think people, whether it's depression, anxiety. I think a lot of times it's mental health issues that we're medicating ourselves for. I think, personally, I used alcohol because I liked the way it made me feel, and I liked that feeling. And I couldn't get it from reading a book. I think that's why they use substances, just to feel. (P1, Interview 1, p. 4)

> And maybe just to manage. I mean, if your life is really difficult, it's an escape, you know. If you can get drunk and not think about it for a while, that's good. Unfortunately it's always there when you sober up, but that's why people, some people don't sober up, because they don't wanna look at it. It's hard. (P1, Interview 1, p. 4)

Similar to P1, P2 also thought a broad range of reasons exists as to WPU. But P2 believed the root of the problem is the individual's feelings about their thoughts, actions, or behaviors in that they want to feel something different and may not want to feel pain or feel a certain way in a given situation.

> I think there can be every excuse, every reason, and I don't discount any of them. But why do they do that? I think the root of it is, I want to feel something different. Whether it's I don't wanna have pain any more. You know, if we think about medications, we don't wanna have pain any more, we use a substance. We don't wanna feel a certain way. We don't like the depression, we use a certain substance. Maybe it's prescribed by the doctor, maybe it's not. I think the root is how we feel. (P2, Interview 1, p. 2)

P3 also described a process of thoughts and feelings the individual may need to rewire and explained that individuals must actively work to retrain their feelings, thoughts, and behavioral process to avoid a downward spiral to substance use. P3 continued to explain WPU by stating that individuals have learned to focus on negative things, thoughts, or expectations that create a false reality, especially during substance abuse.

> Some people have used substances or abused substances in order to not feel a certain way, not feel certain things. So like trauma is really big in people with substance use disorders because people wanna avoid those negative feelings or memories. And so they drink or use to numb themselves. And then when they stop, it can seem really overwhelming. Any feeling, whether it be good or bad. So that can be an issue. (P3, Interview 1, p. 7)

> And then thoughts and feelings, they happen together. A thought can cause a feeling, or a feeling can cause a thought. So if they're not used to training their brain to kinda rewire to, which is an active process. Thoughts can become automatic due to like repetition. (P3, Interview 1, p. 8)

> And so if you have somebody that's not actively working to rewire, to retrain, then that can be something that causes a downward spiral pretty fast with feelings and thoughts and then behaviors. Then the behavior usually follows if you're used to that. If you're used to acting based off of feeling. (P3, Interview 1, p. 8)

> Thoughts can be more of an issue for somebody else. Like somebody may have a learned habit to focus on negative things, or to expect things that are outside of expectation range, like what's actually going to happen. Or a distortion that overgeneralizes things. There can be… (P3, Interview 1, p. 8)

P3 continued describing her challenges by giving her thoughts on the concept of denial, which she feels is very prominent in people with substance-use disorders and it becomes a barrier to the person because they cannot admit that their substance use has become a problem. Another big challenge is that people externalize their problems and blame exterior circumstances.

> …and then also denial. Denial is something that is very prominent in people with substance use disorders. So their own denial is a barrier because they are not willing to admit that they are even, or that their drinking or drug use is problematic. A lot of times they will externalize their problems and blame the issues that are really due to substance use on other people or other circumstances. So that's a big barrier too. (P3, Interview 1, p. 7)

P3 continued with her thoughts on WPU by stating, "So you might have somebody who is avoiding, or drinking or using substances to avoid something. And then there might be somebody drinking or using to gain something" (P3, Interview 1, p. 7). She added, "And then there might be all kinds of different imbalances in place. that has any of those problems or any of those issues as far as thought distortions or feelings" (P3, Interview 1, p. 7). P1's thought was about the concept that substance users previously experienced something that caused them to turn to substances.

> I think it is, yep. And I think, you know, people… They say that most people that are drug abusers or alcoholics have had something happen in their life that they've not gotten through or gotten over. Or they've had something not happen. But there's something it goes back to. (P1, Interview 2, p. 16)

P1 explained how people get caught in a negative behavior pattern and the many changes they may have to make from their environment to employment as part of WPU. Her first thought described the individual's environment: "…so they end up going right back to Watonga or wherever it is, and with the same people, the same house, the same everything" (P1, Interview 2, p. 3). She also shared the following:

> And then I was thinking about how the clients really sometimes are caught in a cycle. Maybe you get someone in that's been making money from selling drugs. And now you want him to go get a job, having no job history, nothing, and having to work minimum

> wage at the Whataburger, which a lot of them did over at 12 and 12, that's kinda… I think that's hard for people. They're used to being the big shot and having the drugs, and having the people all around and to give that lifestyle up is hard. And along with that, those who come in for counseling, they often end up returning to the same environment that they came from. (P1, Interview 2, p. 2)

> And I think that's really hard. And then I touched on this a little bit last time. I think for sobriety to work, many changes have to be made in the person and in the person's social life. I mean, you may have to get different employment if you were a bar tender before you came in. You may have to say goodbye to your spouse who's still shooting up heroin or whatever they're doing that won't let you… that would be way too tempting to live in that environment still. You may have… Well, I don't say may, you probably will have to find new friends and new activities because an addict's life is all around getting the drug. So you take the drug away, now what are they going to do? They don't know. I didn't know. (P1, Interview 2, p. 2)

P1 gave her thoughts about WPU by discussing cross-addiction and clients' resistance to be honest with SACs. Many times the clients feel like they do not have a problem, and in her opinion, a client must be able to see what their problem is before recovery begins, but sometimes she feels the clients are afraid to tell their SAC what is really going on.

> Yeah. But that kinda leads into the next one which is the cross-addiction. How many clients have you heard say, well alcohol has never been a problem for me. Meth is my problem, so I can still drink. Can they? I sincerely doubt it. But maybe? I don't know. I can't say whether you can or not. But I always told them alcohol wasn't a problem 'cause you had the meth. So if you take the meth away and start drinking alcohol, it's very likely that that will become the new problem. (P1, Interview 2, p. 14)

> I was thinking that you've got your clients that are really resistant to being honest with the counselor about their drug use or alcohol use. They don't have a problem, you know. So when you get someone coming in that thinks they don't have a problem, it's a little more difficult to… 'Cause you've got to work around that to maybe help them see the problem before you can even start with the recovery stuff. So sometimes I think they're afraid to tell what's really going on. (P1, Interview 2, p. 8)

P1 continued to describe WPU and clients' lapses or relapses:

> …especially if you're a outpatient counselor and you have a client relapse, then I'm gonna look at what were your feelings. I want you to do an autopsy of that relapse. What was happening? How were you feeling that led… Because we both know it's not just a, I'm gonna drink. You know there's shit that leads up to it. That relapse starts long before you pick up the drink. So what was it that was going on that led to that? (P1, Interview 2, p. 16)

P2 also explained WPU and relapse. Currently, P2 is having some difficulty with her clients going back to their old behaviors due to restrictions and schedule changes stemming from the global COVID-19 pandemic.

> Absolutely. I know in particular, I mentioned the last couple of weeks has been particularly difficult. I've had several of my gentlemen, and I'm working with veterans, all male, homeless veterans. Several of them that haven't been able to see their family because of the restrictions. They haven't been able to have their typical schedule of going to meetings and all these different things, so they're going to, you know, they're relapse thinking. They're behaviors are going back to those old behaviors. (P2, Interview 2, p. 2)

P1's final thoughts on WPU had to do with the concept of hope and the instillation of hope. "…Yeah. My hope's gone" (P1, Interview 2, p. 17). She also stated,

> I think it's difficult a lot of times to instill some hope in some of our clients, 'cause it's such a long climb up. But I also think that people deep down have a hope for a better life. If you can uncover it again by talking about it basically… (P1, Interview 2, p. 17)

> I think it's there somewhere. Maybe for some people it is completely dead, that have been abused and had horrible things happen to them for way too long. But I think for the majority of people, there's always that little spark, you may not be feeling it, but you'll get it back. (P1, Interview 2, p. 17)

> I think it's pretty important. Just being able to show in your life, if you've been an addict or alcoholic, what's changed. I mean why, what's better? And that when I had no hope, really, that things would get better, that if I took some steps, they would. I'm gonna have to do something about it, but it's not just gonna change automatically. (P1, Interview 2, p. 17)

This concludes the WPU category. All three participants shared words and thoughts on this topic, which the researcher coded to create this category. Some of the different words and thoughts that became open codes were "feelings," "caught in a cycle," "anxiety," and "defense mechanisms." The researcher verified the axial codes (the second stage of coding) for this category and covered a wide spectrum of data, which the researcher narrowed down through utilizing the coding steps. The researcher continued to read for context and content in the data during the coding process. The participants each described WPU. P1 thought individuals are caught in a cycle of substance abuse, which encompasses much of their life, and experience a

lack of support, loneliness, and boredom. P2 felt the root of the problem is that the person wants to feel something different and may not want to feel pain. P3 discussed denial as being very prominent in substance abusers. She also outlined the important process of substance abusers actively rewiring their thoughts, feelings, and behaviors. All three participants had thoughts about substance abusers and their thoughts, feelings, and behaviors as they pertain to WPU.

Financial Theme

The fifth theme created by the open and axial coding process is *financial*. Each of the axial codes described revolved around finance challenges in some form or another. The financial category begins with a sample of P1's open codes as shown in Table 4.8.

Table 4.8
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the Financial Theme

Theme	Open Codes
Time	Cost can be a big barrier, no money, insurance co-pays, expensive, and financial means.

P1 stated that "Maybe they don't have any money" (P1, Interview 1, p. 3) and further explained, "And then you've got insurance, co-pays are expensive. You've got the State waiting list. By the time they get a call back, they don't wanna come" (P1, Interview 2, p. 9). These issues present a financial challenge for those seeking to enter residential treatment. P2 also thought that "financial definitely" is a challenge (P2, Interview 1, p. 2). P3 identified her financial challenges as follows:

> What I can think of off the top of my head is obviously cost. Cost can be a big barrier for a lot of people. And even though there are resources in place for people that have limited or no income, there's a barrier of wait time. So people don't have access timely a lot of times when they don't have financial means. (P3, Interview 1, p. 6)

P1 continued describing her thoughts within the financial theme:

> It's real hard to get into treatment if you don't have any money. If you're trying to go on State funding you could be on a waiting list for months. And oftentimes people decide they wanna go into treatment, they wanna go right then. They don't wanna go six months from now; things have changed by then. And maybe they don't wanna go at all. Maybe they're dead, you know. I don't know. I think that's a big barrier is the financial end of it. That just because people would call and, I need to come to detox. And I think they had no idea that they couldn't come to detox that day. It was a big surprise. Well, do you have…Can you pay for detox? Well, no. Well, the State funding, there's a list right now that you're gonna have to get on, and they don't anticipate that when they are ready. So I think that's a barrier for sure. (P1, Interview 1, p. 3)

> Sometimes when you have insurance it's even harder because end up paying a lot more money to get your treatment. Whereas if you have—if you're in an agency and you're State funded, you may pay three dollars for an outpatient visit. But if you have insurance, it may be 25, 30 bucks each time you walk in the door. And if you're going like to intensive outpatient, that's—some people can't afford that. It's a lot of money. So I think money is a big barrier. (P1, Interview 1, p. 3)

This concludes all three participants' words and thoughts for this theme. The financial category used open codes such as "hard to get into treatment when you have no money," "can't work or build up money," and "financial definitely." The researcher developed the financial theme using the broad open codes and then axial codes provided by the interviewee's words and thoughts that were continually narrowed down. All three participants shared thoughts about the financial problems a person may have while seeking recovery. From the upfront price of gaining admission, to a residential treatment center, to the copay and reimbursement rates from insurance companies, finances definitely can be a problem for those with limited or no financial resources.

Training Category

The researcher's coding process created the final theme: *training*. The training theme consists of thoughts and words from all three participant interviews. This theme is bound together by the training challenges or implications the participants identified. Some of the participants' thoughts and words, which became open codes used in the training category, were "client rapport," "multicultural," "gambling's an addiction," "adaptability," and "lack of training." Table 4.9 identifies P1's sample of open codes.

Table 4.9
Sample of Open Codes Used by Participants 1, 2, & 3 to Build the Training Theme

Theme	Open Codes
Training	Rapport with clients, plant a seed, counseling relationship, reflecting skills, adaptable, education, own biases, safety plan and training our clinicians, training, where a client feels safe, assessments, professional training and thought distortions

P3's following statement opens the training theme: "And I often think about the things that we weren't taught in school, you know. The things that I wish we would have been taught in school" (P3, Interview 1, p. 8). P1 stated "And I think that's what keeps us going as counselors, to find that hope in people where they finally think, you know, things could improve (P1, Interview 2, p. 17). P2 also felt "There's some reason that I'm reminded of I am making a difference" (P2, Interview 1, p. 1). P1 went on to say,

> Well I think the most important…to me the most important thing in a counseling relationship has always been the relationship. That that client feels comfortable with you, they feel unafraid to say whatever they need to say, they feel acceptance and hope. And I think you have to be the kind of person that can develop that kind of rapport with the client before they really do anything, get anywhere or start anything. (P1, Interview 1, p. 2)

P2 continued describing the training theme by stating, "And the trust. There's a lot of trust that has to be built, and come easy with most people" (P2, Interview 1, p. 2). P3 also described trust: "…And them knowing that you're trustworthy and that they can give you that picture, and that they can unload what they need to" (P3, Interview 1, p. 4). P2 described the importance of adaptability: "…adaptability for sure. I think it's… The position that I'm in right now, I have the gift of seeing the people for up to two years in a controlled environment…" (P2, Interview 1, p. 2). P2 continued describing training challenges: "Being genuine. Learning from our mistakes. Being willing to listen and hear, and being able to understand. Maybe it's not my

opinion or how I would do things, but maybe there's a reason you do that that way" (P2, Interview 1, p. 2). P3 stated:

> Yeah. I mean, I think a relationship where a client feels safe; where they feel like they're not being judged; where they feel comfortable expressing themselves without having to filter anything or censor anything or leave anything out is extremely important in counseling. Because if they're not comfortable to be able to say anything and know that it is… that they're in a safe place and that they're not being judged, and that they're being helped, then you're not going to get the full story. You're not gonna get the entire picture. And having the entire picture is important because you can't really do what you need to do in therapy to help somebody if you only have a tiny little part of the issue. (P3, Interview 1, p. 4)

P2 explaind, "When I first meet with somebody, we're doing assessments; we're doing a lot of things. They don't know me very well" (P2, Interview 2, p. 7). P3 stated, "For me personally, I love to work to criteria. I love to do assessments. And…starting off my session with asking them what their goal is… And so before I do anything therapy related…" (P3, Interview 1, p. 5). P3 continued: "And that's why I think self-awareness is really important. Because you have to sit down with yourself, I believe, and say here's where my education is, here's where my training is, here's where I've had experience…" and further explained that "…if there's somebody that comes in that's not in those areas where you've had training, experience or other education to be able to properly treat, then it's important that you know where those lines too…" And finally, P3 said, "…Because unfortunately, if you make the decision in a moment without having sat down and figured that out, then you could unintentionally harm a client who comes to you for guidance in a specific area (P3, Interview 2, p. 4).

P1 continued describing her training challenges by discussing the cultural barriers she has had to face as a clinician: "I put down cultural barriers And I didn't explain it 'cause I didn't really know how to explain it" and "I just think there are cultural differences and that we have to work to not let 'em hang us up" (P1, Interview 2, p. 1). She questioned how successful she may have been when working with multi-cultural clients: "…But I know that being a white woman,

and maybe my client is a Native American male, not quite the same culture. And I think I don't know how successful I was with some of them, really" (P1, Interview 2, p 1). P2 stated, "Belief systems" (P2, Interview 1, p. 2) and went on to explain, "I mean, I really felt like I related with my clients because of my substance abuse history. So that kind of superseded the cultural differences, you know what I'm saying?" (P1, Interview 2, p. 1).

P1 continued describing the training challenges of working with clients and the importance of basic counseling skills: "…Reflecting. Yeah… A lot of reflection and just… What you need to look at is what kind of problems does the use of alcohol or drugs cause in your life? I mean, five DUIs, that's a problem" (P1, Interview 2, p. 9). P2 also discussed working with clients: "…working harder than your client on their recovery or on their what they stated as their goals. Just working harder and putting more effort into it than they are" (P2, Interview 2, p. 7). She also stated, "…are you really wanting to be sober? Well no, but the Court's making me. Well that's a whole 'another conversation. You know, then it becomes harm reduction at that point than in trying to help them see different" (P2, Interview 2, p. 7). P1 also made a point about harm reduction: "well, I believe in harm reduction" (P1, Interview 2, p. 14) and relapse prevention:

> …especially if you're a outpatient counselor and you have a client relapse, then I'm gonna look at what were your feelings. I want you to do an autopsy of that relapse. What was happening? How were you feeling that led… Because we both know it's not just a, I'm gonna drink. You know there's shit that leads up to it. That relapse starts long before you pick up the drink. So what was it that was going on that led to that? (P1, Interview 2, p. 16)

P2 continued describing various training challenges: "Carrying the weight because you hear a lot of things, good and bad. The bad, in particular… so it's hard to keep that in the compartment and not think about those things and have that secondhand trauma" (P2, Interview 1, p. 3) P3 also described her thoughts about trauma: "And it's also common for therapists,

helpers in general, to put other people's needs in front of their own too" (P3, Interview 1, p. 8). P3 described trauma and compassion fatigue:

> …compassion fatigue. So that's another huge, I think, problem for people that work in our field is to get so exhausted by the work. Because in substance abuse, we do have a greater prevalence of people who have a severe trauma. And trauma therapists can get burnout really fast due to compassion fatigue and vicarious trauma. (P3, Interview 1, p. 8)

P2 identified additional training challenges: "At times it feels as if my responsibility is doing paperwork as I'm supposed, rather than the actual counseling… Do I wanna work in an agency, work independently…work with children... work with adults?" (P2, Interview 1, p. 1). P3 continued in the training theme by stating, "…there's a coupla different strategies that come to my mind. So one, that's one of the reasons why I'm an integrated therapist…, I have to have training to be competent in multiple different areas which has different strategies" (P3, Interview 1, p. 8). P3 went on to explain further: "…So for me, it kinda reinforces the necessity to have training in multiple different areas to be able to deal with different issues that come along, or different categories even" (P3, Interview 1, p. 9). P2 stated, "You know we all have the ethics class. We all have to go through our, whatever our ethical guidelines are. But I think if we could maybe have some more direct scenarios and things in class…" (P2, Interview 2, p. 5). P3 also discussed ethics in the following two statements: "Yeah. Well, I think ethics training is extremely important. But I also think having like a solid group of people to consult with too should there be any ethical dilemma…A lot of ethics is grey area" (P3, Interview 1, p. 2) and "…to stay on top of that too so that we can better serve anybody" (P3, Interview 1, p. 5).

P1 continued describing treatment challenges: "I think it's difficult a lot of times to instill some hope in some of our clients…If you can uncover it again by talking about it basically…" (P1, Interview 2, p. 17). P1 also stated, "… that's what keeps us going as counselors, to find that hope in people where they finally think, you know, things could improve" (P1, Interview 2, p.

17). P2 felt that "… lack of training… And that's kind of where maybe some of that counter-transference comes in too? We just have to be real cautious of it" (P2, Interview 2, p. 8). She also felt the need for "…safety plans for clients for everything from domestic violence to threatening behavior, to whatever their safety plan might be. We as clinicians need to have a safety plan, and probably several like from different scenarios" (P2, Interview 2, p. 10).

Chapter Summery

Chapter 4 began with a chapter outline. The introduction gave the readers a brief look into the chapter. Next, the audience section identified who the researcher tried to reach. The interviewee information described the process of conducting the participant interviews and gathering their demographics. The next section was the audit trail, which will allow future researchers to follow the data completely. The data analysis section described the process of coding from open codes to theme selection. The final section presented the actual data, which the researcher compiled from the participants' transcribed interviews and identified six themes titled boundaries, time, treatment, WPU, financial, and training. Chapter 5 discusses the six selective codes, answers the research question, makes recommendations, and offers final conclusions.

Chapter 5

Discussion and Recommendations

As stated in Chapter 1, substance abuse is a large problem in the United States and SACs are at the forefront of efforts to help mitigate problems that substance abuse creates. Chapter 1 began with the introduction and background of the research study, followed by the problem statement, purpose of the study, and research question. The significance of the study, conceptual design outline, and theoretical sensitivity included subsections of professional experience, personal experiences, knowledge of the literature, and analytic rigor. Finally, the researcher described the study's parameters, definition of terms, and the study's limitations. Chapter 2 is organized so the reader can gain an understanding of the history of SAC in the United States. The literature review starts with the approach to the literature, describing the purpose and action plan used to gather and disseminate the information needed to complete the literature review. Chapter 3 described the qualitative descriptive case-study methods the researcher used to answer the research question. Chapter 4 began with a chapter outline and an introduction, followed by a review of the intended audience for the current study, details of the transcribed interviews and audit trail, and finally, the data analysis and a presentation of the actual data and themes. Chapter 5 begins with a summary of the chapter and moves on to discuss the selective coding process, answers the research question, identifies recommendations to the field for future research, and offers a conclusion.

The purpose of this descriptive case study was to answer the following research question: What are the challenges facing SACs? The researcher interviewed three LPC's from a Midwestern state who are currently licensed and practicing substance-abuse counseling. Six

themes emerged from the coding processes: boundaries, time, treatment, WPU, financial, and training.

Selective Codes/Themes of the Study

“Selective coding is the process of integrating and refining theory” (Ramey, 2008, p. 142). Chun Tie et al. (2019) stated advanced coding is essential to produce a theory that is grounded in the data and has explanatory power within the context of the research. It is also important to remember that selective codes do not “represent just one person or groups story but represent the stories of many people or groups condensed into conceptual terms” (Ramey, 2008, p. 142). Figure 4 identifies the hierarchy of codes from open to selective.

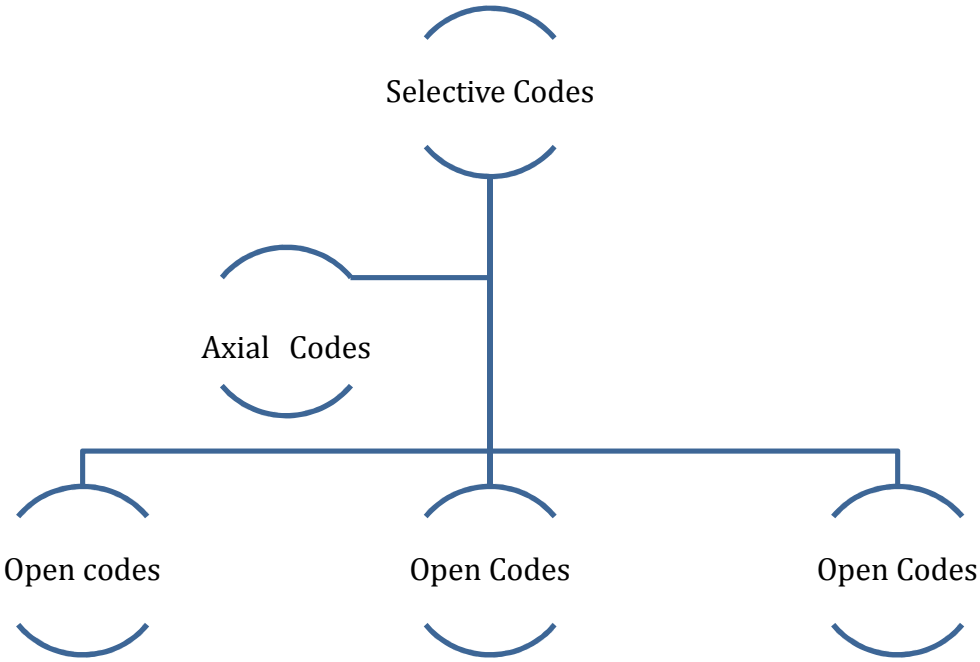

Figure 4. Hierarchy of codes from open to selective

The researcher identified six themes by continuing to narrow down the focus of the research by the process of open, axial, and selective coding to ultimately answer the research

question. The selective codes identified are boundaries, time, treatment, WPU, financial, and training. Table 5.1 presents these codes.

Table 5.1
Selective Codes Identified

Selective codes/themes
Boundaries, time, why people use, treatment, financial, training

Research Question

Ensuring that the researcher clearly identified and followed the process of coding from beginning to end was an important component in answering the research question: What are the challenges facing SACs?

Giving voice to the three participant's data was an important part of this study in answering the research question. The challenges identified are part of a bigger picture, which encompasses not just SACs but the counseling profession as a whole.

Boundaries

The boundaries theme comprised all participants' data. Each participant had a different view on what boundary challenges they experienced, but there were also some similarities in some areas. The researcher included each participant's axial codes that consisted of "I" statements, feelings, and thoughts about personal or ethical boundary challenges. Smith and Fitzpatrick (1995) stated it has long been recognized that boundary violations by health care professionals pose a potential for serious harm to their clients. The Hippocratic Oath, which appeared about 2,200 years ago, obliges physicians to "[keep] far from all intentional ill-doing and all seduction and especially from the pleasures of love with women and men" (Smith & Fitzpatrick, 1995, p. 499). As LPCs, we follow the American Psychological Association's ethical guidelines, plus any applicable local state and federal laws. The APA's ethical guidelines are

located in the appendices section (see Appendix J). It is important to remember this was the researcher's interpretation of what ended up being called the boundary theme.

The participants' boundary challenges range from P1's status in recovery and the challenges involved as a clinician in recovery to P2's challenges like the death of her son and the importance of self-care. Finally, P3 shared thoughts on dual-relationships and vicarious trauma. All three participants had axial codes relating to counselors who are or are not in recovery. Curtis and Eby (2010) stated the substance-abuse treatment workforce is also unique because many clinicians are in recovery from substance abuse themselves. Previous studies have found the percentage of CiRs ranges from 37% to 57% (Curtis & Eby, 2010). Two out of the three participants were not in recovery and the researcher was glad to be able to see both sides. All three participants did agree that being in recovery does give them an extra level of understanding, but it was not the main factor for the two participants not in recovery.

As a CiR, the researcher's understanding of what P1 was talking about when she said "recovery can be hard" is that it is a very real statement. Additionally, it is challenging to separate your recovery from the client's recovery, which is a skill all CiRs must learn. A CiR can bridge the culture gap (drug culture) very quickly once they disclose that they are in recovery themselves. This concept of CiRs also relates to personal disclosure and other possible boundary issues.

P1 continued discussing her boundary challenges by describing her depression and how gambling made her feel better. She also explained that she thinks recovery can be very hard and that she is in recovery herself. She also stated that she quit "cold turkey," which means she suddenly quit drinking at the age of 42. In her experience, clients want a CiR because of their potentially higher level of understanding. P1 also discussed AA as the way she became sober. As

a practicing clinician, any tool, technique, support group, or coping skill that helps a person move forward is the one they must find and use.

"I think there are a variety of challenges," P2 stated as she began discussing her boundary challenges. The first challenge she discussed goes back to the concept of counselors who are in recovery themselves. She acknowledged that being in recovery does give counselors some "additional insight." She also stated that she had to develop that clinical insight herself. She discussed "feeling looked down upon because I wasn't in recovery" when she first began as a clinician. She also stated that during her time as a clinician she has seen clinicians struggle with their own recovery program. P2 also described "dual relationships" as they relate to CiRs. CiRs often attend self-help groups in the community, which creates dual relationships because these recovery programs become part of the counselor's life. Overall, P2 was saying that CiRs may have "additional insight" when it comes to clients but that may also cause boundary challenges due to having "dual relationships."

"Hence, although therapists are professional helpers, it may be their personal characteristics are more important than their professional qualifications in determining their therapeutic capabilities" (Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013, p. 484). P2 described in detail her thoughts about separating her professional and private lives. P2 began by saying, "Another challenge…I feel like because I'm a counselor that I am not a person" and should "…stop being human." She was describing her thought that she "shouldn't have the range of emotions" because she is a clinician. Clinicians often talk about the importance of separating your private and professional lives, especially in a city where you might see or interact with previous or current clients in different public settings. P2 described this issue:

> For me and part of my hanging out with my friends and that self-care stuff, is I do occasionally have to drink it may be like a piña colada or something, but I feel guilty as a

> substance abuse counselor. I am not in recovery and I normally don't drink a lot, but I feel very cautious about who's gonna see me, or whose around, or my goodness don't take any pictures and put them on social media, that type of situation. So that's a challenge for me also.

As an SAC, the researcher very much agrees with this statement. Additionally, many substance-abuse agencies may have specific written moral clauses, although most are unwritten and may still get you terminated.

"Holding the line between my personal life and my behaviors that I had with my son" was another boundary challenge P2 described. Since losing her son to addiction several years ago, P2 also described the importance of self-care in her professional and personal lives. Self-care is truly an important boundary that all clinicians must learn early in their careers, starting in the classroom and continuing throughout our careers. P2 used the word "balance" several times; thus, finding and maintaining some sort of balance is important to enjoy substance-abuse counseling.

P3 also believed that professional counselors are held to a higher standard in professionalism and conduct and that "were still people you know and we have lives outside of our profession." Self-care is also important to P2 as she described compassion fatigue, vicarious trauma, and burnout. Trippany, Kress, and Wilcoxon (2004) stated the following:

> Counselor's reactions to client traumas have historically been characterized as forms of either burnout or countertransference. More recently, the term vicarious trauma has been used to describe counselors' trauma reactions that are secondary to their exposure to client's traumatic experiences. (p. 31)

P2 also discussed the concept of CiRs. She feels CiRs create instances of conflict, which can create dual relationships. Scholars widely recognize that dual relationships may affect a client's ability to build a trusting and open relationship (Scopelliti et al., 2004). And in her opinion, P2 does not think it makes a clinician more effective if they are in recovery. P3 also stated that some CiRs believe they will guide their clients to their own recovery because the

clinician may feel if their method is working for them it will work for the client as well. However, this situation does happen occasionally, especially if the counselor is using AA or NA as part of their own recovery program.

From the researcher's perspective, the boundary theme identified individual aspects of the challenges SACs face. But at the same time, their stories are intertwined. All three interviewees identified their challenges toward the concept of being a CiR and those who are not. The researcher was surprised by how much work it takes to be a CiR. P1, who is a CiR herself, was able to highlight the balance it takes to manage the challenges of being an SAC. P2's challenges had a lot to do with the death of her son, and the importance of personal boundaries, which include her self-care, and that her private life should be hers and not dictated by her profession. P3's boundary challenges also included the importance of self-care to help manage vicarious trauma, compassion fatigue, and burnout. She also felt that self-awareness and creating balance are important boundaries for SACs.

Time

The second selective code the data analysis created was time. The axial codes the researcher identified for this theme are bound together by the interviewees' open codes on time. Previous researchers have also found that the time factor obstructs treatment. According to Carr et al. (2007), "waiting time" refers to the time when clients are looking to enter treatment, which can pose a significant challenge. Carr et al. (2007) also stated that it is crucial to understand the factors that influence the cause and duration of waiting times for treatment programs. P3 also discussed "wait time": "there's a barrier of wait time. So people don't have access timely a lot of times when they don't have financial means."

As seen in Chapter 4, P1's interview yielded rich information that enhanced the time theme. Many of her thoughts had to do with the amount of time clients need to stay in treatment compared to the actual amount of time they may receive treatment. P1 said, "You just have such a limited period of time to help them start thinking about the changes and what they're gonna do." Simpson, Joe, Rowan-Szal, and Greener (1997) also identified that the longer the client spends in treatment, the better their outcomes are following their discharge. P1 followed up by saying, "So I think time is not on our side when we have our clients in residential treatment."

P2 had a different take on time due to the fact that she can see her clients for up to 2 years: "…I have the gift of seeing the people for up to two years in a controlled environment." Manuel et al. (2017) also stated, "…long-term residential substance abuse treatment provides intensive services combined with safe housing and assistance with daily living" (p. 1). P2 also discussed time from a clinician's perspective: "I'm talking about your time boundaries, how much on-call you willing to take." P3 stated, "…if they don't have time to debrief, the time to decompress… you can be overwhelmed by the amount of work required… You might not have an appropriate amount of time in order to get what you need."

The time theme covered different challenges of time based on the data. The amount of time a client spends in treatment is important, but the amount of time, or "wait time," as P2 identified, to begin the treatment process can be just as challenging. P1's open codes focused on the amount of time a person spends in treatment because her recovery is a "lifetime commitment" professionally and personally. P3 had a different perspective about time due to the fact that she can see her client for up to 2 years in her residential program. The amount of time an individual may have to spend accessing treatment and then receiving treatment services is complicated.

Long wait lines, managed health, and a lack of available resources, especially in rural communities, can all play into the challenges SACs face regarding the concept of time.

WPU

"I feel numb on the medication, my hand and hand won't stop shaking, and so I stopped taking what…what I use cocaine I feel live, kicking and buzzing" (Graham, 1998, p. 193). All three participants shared words and thoughts that the researcher coded to create the WPU category. Some of the different open codes that led to the selective codes were "feelings," "caught in a cycle," "anxiety," and "defense mechanisms."

P1 thought that individuals are caught in a cycle of substance abuse, which encompasses much of their life: "To feel better… they were brought up that way… personally, I used alcohol because I liked the way it made me feel, and I liked that feeling. I think that's why they use substances, just to feel" (p. 4). P2 identified various justifications for WPU. She also thought "I think there can be every excuse, every reason, and I don't discount any of them. But why do they do that? I think the root of it is, I want to feel something different." P2 also discussed depression and substance abuse: "We don't like the depression, we use a certain substance. Maybe it's prescribed by the doctor, maybe it's not. I think the root is how we feel." Brady and Sinha (2005) stated the similarities between substance-use disorders and major depression. Much of the problem with WPU is that the person wants to feel something different and/or they may not want to feel pain, which is why P2 felt one of the biggest reasons people use has to do with the individual's feelings about their thoughts, actions, or behaviors. P3 shared her thoughts on the concept of denial, which she feels is very prominent in people with substance-use disorders and it becomes a barrier to the person because they cannot admit that their substance use has become

a problem. Rinn, Desai, Rosenblatt and Gastfriend (2002) also agreed that denial is a shared story of addictive disease.

The researcher believes this theme captures much of the essence of WPU and highlights another challenge SACs face. From the beginning quote to P3 identifying denial as a challenge, this theme shows many possibilities of WPU. At the same time, many of the reasons people use are linked to other challenges identified in this study. The data indicated that people use to feel better, manage pain, self-medicate, when they lack hope, or are in denial that they have a problem or trauma and the challenges is to identify and allow the client to find out why they are using.

Treatment

The third selective code is titled treatment. Some of the open codes included "forced to go into treatment," "treatment gives you some insight into yourself," and "barest of beginnings." The treatment theme is held together by the interviewees' open codes that they identified as treatment challenges. P1 thought treatment offers an opportunity for learning and stated, "And a step is going to treatment, and that's your first step." Rapp et al. (2006) also agreed that …It is important for addicts to enter treatment in the first place—a substantial problem in many situations.

P1 continued describing the challenges of entering treatment: "It's real hard to get into treatment." She also felt that "You know treatment is not the end all, be all." P3 described the challenges of treatment: "There's a lot of barriers. In different, among different populations. People in different geographic locations. And also people in different gender groups too." Pullen and Oser (2014) agreed that challenges to substance-abuse treatment have been well studied, especially as they relate to different treatment contexts.

P2 stated that "It's not just the counseling services in this session that we have once a month or once a week, whatever the case may be. It's those interactions outside, in passing. Kinda going back to that, human thing, you know." P1 and P3 also discussed the difficulties women face when trying to access or enter treatment. P1 stated, "For women in recovery the continuation of counseling will give much needed extra support such as child care, housing, job training than they may be able to support themselves." P3 had similar thoughts: "For females, there's also a barrier of childcare…as far as not being able to do things due to children in the house, or not having a sitter." Brady and Ashley (2005) also stated, it is important to consider the amount of female treatment clients in the framework of gender differences in the causes of addiction.

The concept of treatment is very broad, as shown by the data and other researchers. P1 shared that receiving treatment is just the beginning of a person's steps to recovery, and P1 and P3 identified some of the gender inequalities that people face when trying to access treatment. Those who do not have immediate resources face challenges in gaining access to and entering a treatment facility.

Financial

The researcher identified the fifth selective code as financial. This theme encompasses the financial challenges pertaining to SACs. Meara and Frank (2005) identified that "The low levels of treatment are not surprising when one considers the financial barriers posed to those who need treatment" (p. 5). P1 also described several reasons finances could be a challenge for those seeking treatment: "It's real hard to get into treatment if you don't have any money" and "It's a lot of money. So I think money is a big barrier." P2 also identified financial challenges: "finance definitely is a barrier to treatment." P1 also discussed funding-source challenges: "If

you're trying to go on State funding you could be on a waiting list for months." P3 also discussed many of the same challenges P1 and P2 identified: "Cost can be a big barrier for a lot of people…there's a barrier of wait time. So people don't have access a lot of times when they don't have financial means" (P3, p. 6).

P1 also pointed out that the other option is being placed on the state-funded waiting list for treatment with an unknown wait time. She also shared that people want to go to a treatment facility immediately once they decide they need treatment, but unless they are able to pay the upfront costs or use a credit card, they may have to rely on state-funded resources, and by then, things may have changed; they may not want to go anymore, or they may be dead. Sturm and Sherbourne (2001) said, "The main reason for unmet needs is a concern about costs…" (p. 85). They also added, "…the growth of Managed care, has raised concerns about potentially increased barriers to treatment for mental health and substance abuse disorders" (p. 81). Finally, P1 described that some people still face difficulties in entering a treatment facility, even if they have insurance, due to various financial issues (mainly surrounding the amount of reimbursement insurance companies offer for treatment services). P1 explained that some agencies are state funded and have a $3.00 copay for one unit of outpatient services, whereas insurance copays may be $25–30 for the same service, which is a financial barrier in her eyes.

All three participants had data about the financial challenges a person may experience while seeking recovery. From the upfront price of gaining admission to a residential treatment center, to the copay and reimbursement rates from insurance companies, finances definitely can be a problem for those with limited or no financial resources. Past research also identified financial challenges as a barrier to substance-abuse treatment services.

Training

The researcher identified training as the sixth selective code by identifying the participants' words, thoughts, and statements during the coding and data-analysis process. From the open codes of harm reduction, reflecting, belief systems, transference, lack of training, work to criteria and traumatic experiences all became part of this study.

The identified training challenges covered a broad range of training considerations. The concept of counseling skills as challenges was present in all three interviewees. P1 described how she uses her reflecting skills with clients and how allowing the client to see themselves through the eyes of a skilled clinician may allow the client to have a clear and realistic picture of their problem, which could lead to some new and positive insight: "…Reflecting. Yeah…A lot of reflection and just… 'Cause sometimes if you'll do that, they'll be like, hmm, well, good point there. That is a problem." Bennett-Levy (2006) stated, "Reflexion is…A generic term for those intellectual and affective activities in which individuals engage to explore their experiences ordered to lead to new understandings and appreciations" (p. 60). P3 shared that the therapeutic relationship is very essential: "I think that that's one of the most important things right off the bat is that client-therapist relationship." Amat, Sukor, Johari, and Najib (2020) also noted that the therapeutic partnership is an integral part of completing treatment successfully by helping the therapeutic response among client and counselor.

The concept of trust was important for P2: "And the trust. There's a lot of trust that has to be built, and it doesn't come easy with most people." Mallinckrodt and Nelson (1991) also suggested "an emotional bond of trust and attachment between counselor and client" (p. 133). Hayes et al. (2004) stated "Counselor burnout is a serious problem for workers in substance abuse and behavioral health professions" (p. 3). P3 also described compassion fatigue as a huge

problem for SACs due to the fact that many clients have severe trauma, as shown by her statement: “And trauma therapists can get burnout really fast due to compassion fatigue and vicarious trauma” (p. 8). P2 described the topic of training challenges as it pertains to the concept of countertransference by explaining that, as clinicians, we may get invested in our client’s success for different reasons, but we must be cautious not to cross any ethical lines. P2 also gave her thoughts about clinicians’ on-the-job training and the importance of good clinical supervision: “…But I think it is going to be on-the-job experience, and hopefully they have a really good supervisor that they can work through these things with” (p. 6). P3 also discussed counselor supervision and described the importance of a good LPC clinical supervisor. She felt that finding a supervisor in one’s particular field is beneficial, especially when they are just starting as a clinician. Olmstead et al. (2012) also discussed the importance of competency-based supervision, including individualized coaching and video tape or audio tape feedback.

P1 described clients losing hope and the importance for her as a clinician to reinstall hope in her clients: “and that when I had no hope, really, that things would get better, that if I took some steps, they would. I’m gonna have to do something about it, but it’s not just gonna change automatically.” She felt that most people do not completely lose all of their hope, but many times people put themselves in positions where they might not feel or see hope for the present or future due to substance abuse problems. P2 also described a working scenario that involves her ethical decision-making process and the importance of understanding all federal, state, and local rules and regulations: “You know, we all have the ethics class. We all have to go through our, whatever our ethical guidelines are. But I think if we could maybe have some more direct scenarios and things in class.” She then went on to explain how the global COVID-19 pandemic has created an expanded use of telehealth or telecounseling options. P3 also shared her view on

another aspect of ethics: “Social media may create ethical dilemmas such as dual Relationships if not properly managed. As a beginning clinician having a solid group of other Professionals to consult with if any ethical dilemmas arise is important.”

The training challenges theme covered a lot of different training considerations and each participant gave the wealth of their experience to create this theme. The training theme shows the importance of specialized training for SACs due to some of the specialized challenges that can occur to individuals and families because of substance abuse and other problems associated with the abuse.

Limitations

One of the main limitations of this study was the size of the convenience sample. The researcher interviewed three White female LPC’s from a Midwestern state using the research question and three closed-ended questions for demographics purposes. Gelo, Braakman, and Benetka (2008) stated, “An attempt is usually made to understand a small number of participants’ own frames of reference or worldviews, rather than trying to test hypotheses on a large sample” (p. 268). Using a different or larger sample may have increased the study’s transferability and ability to generalize future studies. Also, the researcher has worked with all three interviewees, two of which were the researcher’s supervisor at different times. Harrell and Bradley (2009) stated “… the actors are observed through the lens of the researcher, who uses his or her own expertise, terminology, and defined categories to describe the actors.” (p. 4.) Gelo et al. (2008) reported, “The aim of scientific investigation is to understand the behavior and the culture of humans and their groups from the point of view of those being studied” (p. 268). As with many qualitative interviews, the main objective of this study was to gather the interviewees’ perspectives rather than facts. Consequently, data collected from the interviews do not

necessarily associate to any place, time, or individual. Any biases that did occur were unintentional; thankfully, the research topic was important to the researcher not only as an SAC, but as a person in recovery, so they felt it was important to complete this dissertation using the best possible research practices to answer the research question.

Recommendations for Future Research

After concluding the data analysis and coding process, the researcher offers the following recommendations for future research in the field of substance-abuse counseling:

1. Continued studies that identify gaps in counselor education and substance-abuse training.
2. Additional research into the differences between SACs in recovery and those substance counselors not in recovery.
3. Additional research on increasing substance-abuse training in Council for accreditation of Counseling and Related Educational Programs (CACREP) counselor programs both at the graduate and doctoral levels.
4. Continued research to identify ways to bridge the gaps in managed care as it pertains to client services.
5. Continued research into the challenges of SACs using different methodologies.

Implications

Implications for counselor educators

The implications for practice based on the results from this research study are based on the challenges of SAC's. This study identified factors associated with the 6 major themes that emerged from the data of the participants all LPC's working as SAC's, which were boundaries, time, why people use, treatment, financial and finally training. This study indicates that

counselor education graduate programs need to offer specialized trainings and increased training opportunities/internships in the education of SAC's to help understand and mitigate the challenges identified by the SAC's.

Implications for research

The 6 challenges identified through the research study may help researchers and interested stakeholders continue to look for solutions to the challenges identified by the participants. Many of the same challenges through various studies have been identified and as a researcher finding solutions to these long identified challenges would benefit our profession and the community at large.

Conclusion

The goal of this study was to answer the following research question: What are the challenges facing SACs? The researcher identified six selective codes/themes that answered the question through the lens of the researcher and the coding process, which allowed the researcher to use the words, thoughts, and statements from the three participants who were all LPCs practicing substance-abuse counseling. The six selective codes identified were labeled as boundaries, time, WPU, treatment, financial, and training.

Clinicians must engage in empirical research to ensure they use the best possible practices available. Chapter 1 introduced and provided background for the study. Chapter 2 presented the literature review, which detailed the history and role of substance abuse in America. Next, the researcher detailed the beginning of the lay-counselor movement, which introduced the first SACs and then the developed of the different self-help groups such as AA and NA. The researcher also identified SACs' KSAs.

Chapter 3 provided a description of the methods the researcher used to answer the research question, detailed the research design, ethics, and data-collection process through the importance of triangulation, and finally, offered a description of the coding process. Chapter 4 began with a continued description of the coding process. Chapter 4 mainly focused on presenting the data through the process of open and axial codes, which the researcher summarized to complete the chapter. Chapter 5 completed the research by answering the research question. The researcher completed the process of identifying and describing the selective codes, identified the study's limitations, outlined future recommendations for research, and finally, offered conclusions for this descriptive case study.

My final thought about concluding this study is did I answer the questions I had about being an SAC? Not really, but as I made my way through the process of getting to this point, I realized that this study is just one drop in the sea of research and if I continue to look for the answers, I will continue to add to the body of research one drop at a time. Therefore, as Sir Isaac Newton said, "If I have seen further than others, it is by standing upon the shoulders of giants" (Isaac Newton Quotes, n.d.).

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Appendix

Appendix A: The 12 steps of Alcoholics Anonymous

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

   The first step encourages people with alcoholism to admit that they cannot control their addictive behaviors.

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

   The second step presents hope, faith and realization. AA believes that people with alcoholism must look to a higher power to https://doi.org/10.1046/j.1360-0443.2001.9657056.x

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

   Through the third step, individuals with alcoholism turn their lives over to their higher power. The individual puts his or her trust in this superior being to eliminate addiction.

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

   People with alcoholism take an honest look at their lives. AA believes the identification of past regret, embarrassment or guilt can help individuals through the recovery process.

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

   This step also incorporates self-evaluation. Sharing past mistakes with their higher

power, themselves and another person can help people with alcoholism build addiction-free lives.

6. We are entirely ready to have god remove all these defects of character.

   This is a step of preparation and reflection. Individuals admit they are willing to have their higher power remove their addictive behaviors.

7. We have humbly asked him to remove our shortcomings.

   Now that they know the root of their addiction, people with alcoholism ask their higher power to help eliminate their character flaws. These individuals must also do their part to separate themselves from influences that build addictive behaviors.

8. We have made a list of all persons we have harmed and are willing to make amends to them all.

   People with alcoholism should make a list of the people they harmed while battling addiction. This strategy allows them to repair the damages done in the past.

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

   Through this step, people with alcoholism make amends with those on their list. making amends could mean sitting down face-to-face with those they've wronged or writing a letter to them.

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

    Monitoring your recovery is integral in sustaining sobriety. this step requires individuals with alcoholism to be vigilant against triggers and addictive behaviors.

11. Sought through prayer and meditation to improve our conscious contact with god as we understood him, praying only for knowledge of his will for us and the power to

carry that out.

Prayer and meditation could help stave off addictive behaviors. Individuals with alcoholism maintain conscious contact with their higher power.

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

    The final step encourages people to help others overcome alcoholism. this step signifies the completion of the cycle of life.

    https://www.drugrehab.com/recovery/alcoholics-anonymous/the-big-book/

Appendix B: The 12 Traditions of AA

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

12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

https://www.drugrehab.com/recovery/alcoholics-anonymous/the-big-book/

Appendix C: The 12 Steps of Narcotics Anonymous

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

   People battling addiction must admit that they have no control over the illness. As a result, they have lost power over many aspects of their lives.

2. We came to believe that a power greater than ourselves could restore us to sanity.

   Whether you're an agnostic, an atheist or a believer, trusting a higher power could help you turn your life around.

3. We made a decision to turn our will and our lives over to the care of god as we understood him.

   It is important to understand the significance of a higher power in overcoming addiction. Through step three, people with addiction turn their loves over to this superior entity.

4. We made a searching and fearless moral inventory of ourselves.

   People with addiction should reflect on their lives, honestly evaluating their past. Evaluating past mistakes could steer people toward recovery.

5. We admitted to god, to ourselves, and to another human being the exact nature of our wrongs.

   After evaluating past mistakes, the next step asks people battling addiction to admit to the root of past wrongdoings. Sharing the nature of these mistakes with oneself, loved ones and a higher power is an important step toward recovery.

6. We were entirely ready to have god remove all these defects of character.

   Individuals with addiction should prepare for their higher power to eliminate their addictive behaviors.

7. We humbly asked him to remove our shortcomings.

   People with addiction allow a higher power to eliminate character flaws. however, it is important that they separate themselves from factors that influence addictive behaviors.

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

   Addiction strains relationships and harms loved ones. The addicted person should make a list of those whom they have wronged and be willing to admit their past transgressions.

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

   Individuals should find time to apologize to those they have wronged in the past, except when doing so would cause further harm. They should tell the truth about past actions and offer a genuine apology.

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

    The 10th step promotes vigilance against triggers. People with addiction must address their addictive behaviors should they arise. Taking a personal inventory should become a daily process.

11. We sought through prayer and meditation to improve our conscious contact with god as we understood him, praying only for knowledge of his will for us and the power to carry that out.

    This step provides daily spiritual maintenance. Maintaining a relationship with a higher power can help a person with addiction reach recovery.

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

    This spiritual awakening allows people in recovery to share their techniques with those suffering from addiction. Helping others through these tough times is a significant aspect of NA's 12-step program.

https://www.drugrehab.com/recovery/narcotics-anonymous/

Appendix D: The 12 Traditions of Narcotics Anonymous

We keep what we have only with vigilance, and just as freedom for the individual comes from the Twelve Steps, so freedom for the group springs from our Traditions. As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.

1. Our common welfare should come first; personal recovery depends on NA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for membership is a desire to stop using.
4. Each group should be autonomous except in matters affecting other groups or NA as a whole.
5. Each group has but one primary purpose—to carry the message to the addict who still suffers.
6. An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose.
7. Every NA group ought to be fully self-supporting, declining outside contributions.
8. Narcotics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. NA, as such, ought never be organized, but we may create service boards or committees directly responsible to those they serve.
10. Narcotics Anonymous has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

Understanding these Traditions comes slowly over a period of time. We pick up information as we talk to members and visit various groups. It usually isn't until we get involved with service that someone points out that "personal recovery depends on NA unity," and that unity depends on how well we follow our Traditions. The Twelve Traditions of NA are not negotiable. They are the guidelines that keep our Fellowship alive and free. By following these guidelines in our dealings with others, and society at large, we avoid many problems. That is not to say that our Traditions eliminate all problems. We still have to face difficulties as they arise: communication problems, differences of opinion, internal controversies, and troubles with individuals and groups outside the Fellowship. However, when we apply these principles, we avoid some of the pitfalls. Many of our problems are like those that our predecessors had to face. Their hard won experience gave birth to the Traditions, and our own experience has shown that these principles are just as valid today as they were when these Traditions were formulated. Our Traditions protect us from the internal and external forces that could destroy us. They are truly the ties that bind us together. It is only through understanding and application that they work.

Appendix E: Substance-Abuse Counselors' Interview Questions

1. How long have you been a Licensed Professional Counselor (LPC)?
2. How long have you practiced substance-abuse counseling?
3. What are the challenges of a Substance abuse Counselor?

Appendix F: Licensed Professional Counselor Academic Requirements

Academic Requirements: Licensed Professional Counselor

Accreditation: All of your graduate course work needed to meet the academic requirements must be awarded by a regionally accredited college or university, recognized by the United States Department of Education.

Degrees: In order to qualify for LPC licensure you must have at least a master's degree in counseling or a mental health degree that is substantially content-equivalent.

At least sixty (60) semester credit hours or ninety (90) quarter credit hours of graduate counseling-related course work, including internship, must be earned.

In order to be considered acceptable, your graduate degree(s) must follow a planned, sequenced mental health program. Your program must be reflected in the university catalog and approved by the governing authority of the college or university. The primary focus of the program must clearly prepare the applicant for a career in counseling. The college or university catalog must also list the core courses from the knowledge areas listed below (at least five (5) of the sixteen (16) knowledge areas must be included).

Core Courses: You must have at least one (1) or more courses of at least three (3) semester credit hours or four (4) quarter credit hours per course in each of the following core counseling areas:

- Human growth and development—at least one (1) course which deals with the process stages of human intellectual, physical, social and emotional development of any of the stages of life from prenatal through old age.
- Abnormal human behavior—at least one (1) course that offers a study of the principles of understanding dysfunction in human behavior or social disorganization.
- Appraisal/assessment techniques—at least two (2) courses which deal with the principles, concepts and procedures of systematic appraisal, assessment, or interpretation of client needs, abilities, and characteristics, which may include the use of both testing and non-testing approaches.
- Counseling theories/methods—at least two (2) courses which survey the major theories and/or techniques of counseling.
- Professional orientation/ethics—at least one (1) course which deals primarily with the objectives of professional counseling organizations, codes of ethics, legal aspects of practice, standards of preparation and the role of persons providing direct counseling services.
- Research—at least one (1) course in the methods of social science or mental health research which includes the study of statistics or a thesis project in an area relevant to the practice of counseling.

- Practicum/internship—at least one (1) course of an organized practicum with at least three hundred (300) clock hours in counseling with planned experiences providing classroom and field experience with clients under the supervision of college or university approved counseling professionals.

Elective Courses:
You must have at least five (5) courses of at least three (3) semester credit hours each or four (4) quarter credit hours each from the knowledge areas.

The knowledge areas are listed below.

- Group dynamics
- Lifestyle and career development
- Social and cultural foundations
- Addictions counseling
- Rehabilitation Counseling
- Counseling with children/adolescents
- Gerontology
- Human sexuality
- Personality theories
- Crisis intervention
- Marriage/family counseling
- Clinical supervision
- Psychopharmacology
- Consultation
- Physical and emotional health
- Grief counseling

Additional courses to reach the 60-hour requirement may be in increments of one (1), two (2) or three (3) semester hour courses or one (1), two (2), three (3) or four (4) quarter hour courses.

Appendix G: IRB Approval

UNIVERSITY OF ARKANSAS

To:	Ruben Oscar Herron
From:	Douglas James Adams, Chair IRB Committee
Date:	05/05/2020
Action:	**Exemption Granted**
Action Date:	05/05/2020
Protocol #:	2004261332
Study Title:	What are the Challenges of Substance abuse Counselors

The above-referenced protocol has been determined to be exempt.

If you wish to make any modifications in the approved protocol that may affect the level of risk to your participants, you must seek approval prior to implementing those changes. All modifications must provide sufficient detail to assess the impact of the change.

If you have any questions or need any assistance from the IRB, please contact the IRB Coordinator at 109 MLKG Building, 5-2208, or irb@uark.edu.