THE EFFECTS OF CLIENT AND RESPONDENT VARIABLES ON ADDICTION PROFESSIONALS’ DECISION MAKING: A FACTORIAL SURVEY

A dissertation submitted to the Kent State University College of Education, Health, and Human Services in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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The purpose of the current study was to investigate the effects of 4 client variables and 10 respondent (i.e., participant) variables on two measures of addiction professionals’ decision making. Data were collected using Rossi and Nock’s (1982) factorial survey approach. This approach uses randomly constructed vignettes intended to represent hypothetical and life-like scenarios. Respondents are randomly assigned a predetermined number of vignettes and are then asked to make decisions about those vignettes. The factorial survey approach is inherently hierarchical, meaning that data are simultaneously collected at two levels: (a) the vignette level, and (b) the respondent level.

Chi-square and hierarchical regression analyses were performed on factorial survey data collected from a sample of 124 members of the Association for Addiction Professionals (NAADAC). Results of the current study suggest that particular client and respondent variables influence addiction professionals’ decision making. Notable client variables include the client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal. Notable respondent variables include level of education and addiction-specific training. Results also identified inconsistencies between select client variables and addiction professionals’ decision making. This study highlights the need for increased exposure to, and training
in, addiction theories and individualized treatment approaches among addiction professionals.
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CHAPTER I

INTRODUCTION TO THE STUDY AND REVIEW OF LITERATURE

Problematic substance use continues to represent a leading public health concern in the United States (National Institute on Drug Abuse [NIDA], 2012, 2014), and in 2014 a mere 1% of individuals who needed treatment for problematic substance use received care at a specialized facility (i.e., inpatient hospital care, inpatient or outpatient rehabilitation facility, or mental health center; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). The problem is that 40–60% of individuals who receive care for problematic substance use will relapse (NIDA, 2012). Research suggests that relapse is an indication that treatment needs to be adjusted to reflect personalized care (NIDA, 2012). This “personalized care” means that treatment should (a) differ depending on client variables, (b) address client-identified needs, and (c) evolve according to clients’ levels of change (NIDA, 2012).

Furthermore, treatment planning should reflect a collaborative effort between client and provider (Friedrichs, Spies, Härter, & Buchholz, 2016; NIDA, 2012). Godolphin (2009) noted that this collaboration between patient and provider is known as shared decision making, and has been described as the “crux” of patient-centered care in the medical field. Godolphin also regarded patient-centered care as an integral part of change; however, he noted that its implementation in clinical practice is rare. Friedrichs et al. (2016) noted that shared decision making has been linked to symptom reduction and have suggested that the preferences of individuals receiving treatment for substance use disorders be honored.
Evidence-based practices are intended to promote such personalized care: care that addresses the unique characteristics and needs of clients during treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). There are many evidence-based treatment approaches in the field of addiction counseling, and through scientific investigation, these approaches have been regarded as appropriate for use in addiction treatment (Sorensen, Hettema, & Larios, 2009). Unfortunately, their implementation in clinical practice is limited (Arria & McLellan, 2012; Tuchman & Sarasohn, 2011). In the United States, the dominant treatment approach is abstinence-based group counseling (McLellan, Carise, & Kleber, 2003; NIDA, 2012), a non-evidence-based treatment approach, and this treatment approach is often time-sensitive with the exclusive goal of abstinence (Arria & McLellan, 2012).

The purpose of the current study was to investigate the effects of client variables on addiction professionals’ decision making. Specifically, the current study used a factorial survey to investigate the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective and recommended treatment approach.

**Prevalence of Substance Use in the United States**

The most recent prevalence data of substance use (i.e., illicit substances, alcohol, tobacco, and non-medically used prescriptions) in the United States are from the 2014 National Survey on Drug Use and Health (NSDUH). Although this survey represents only one source of prevalence data, it is the primary source for such information
This survey is conducted yearly and is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey’s findings report the prevalence of substance use among persons 12 years of age and older in the United States. Persons are randomly selected for participation; however, individuals who are institutionalized (i.e., in jail or hospitalized), homeless, or on active duty at the time of the study are excluded from the selection pool.

SAMHSA (2015) reported that 27.0 million Americans (10.2% of the U.S. population) and 139.7 million Americans (52.7% of the U.S. population) were using illicit substances and alcohol, respectively, in 2014. These numbers reflected individuals’ current substance use (i.e., use within one month prior to the survey’s administration). The report noted that an estimated 21.5 million persons (8.1% of the U.S. population) met criteria for SUDs and were in need of some level of treatment assistance. These percentages are similar to those reported by the 2011–2013 data sets. In 2009, the National Center on Addiction and Substance Abuse (CASA) at Columbia University identified the amount of federal, state, and local expenses directly associated with problematic substance use. Results of CASA’s study revealed a total expenditure of $467.7 billion in 2005 (NIDA reported that the United States spends $600 billion annually in response to problematic substance use; NIDA, 2012). Of this total, the amount of funding used for prevention and treatment programs was 1.9 cents per federal and state dollar. The majority of expenses (i.e., 95.6 cents per dollar) targeted the consequences of substance use: (a) accidents, (b) homicide, (c) suicide, (d) domestic violence, (e) child abuse, (f) sexual assault, (g) unplanned pregnancy, (h) homelessness,
(i) forgone education, (j) sexually transmitted diseases, (k) birth defects, and (l) more than 70 illnesses requiring hospitalization.

The prevalence of problematic substance use and its related consequences has remained steady over the years (SAMHSA, 2015) and yet the practice of treating SUDs continues to be stagnant and largely unchanged (Arria & McLellan, 2012; Mee-Lee, McLellan, & Miller, 2010). What continues to be reflected in the federal budget is expenditure for complications-driven or diagnosis- and program-driven treatment modalities (Mee-Lee et al., 2010). These modalities do exactly what 96 cents on the dollar do: treat the consequences of substance use.

Poor success rates (i.e., within six months of receiving treatment for SUDs, more than 50% of individuals return to problematic use) are associated with consequence-driven treatment modalities; therefore, Mee-Lee et al. (2010) recommended the use of empirically-based and efficacious treatments driven by individualized assessment and informed by outcome (e.g., “Are clients getting what they want from treatment?”). The former promotes person-centered care based on client-identified needs or preferences, and the latter elicits feedback from clients to develop treatment planning and delivery. Orford (2006) explained that these treatments,

Give far greater weight to patient choice and far less to professional allocation of rules . . . shift away from a preoccupation with the psychobiological characteristics of individual clients . . . [consider] a person’s treatment-seeking, preferences and expectations . . . [adopt an ideology so that a provider] adjust[s]
continuously what she or he [does] in response to the client and the developing
client-therapist relationship. (pp. 653-654)

To explore the application of individualized assessment and the use of
empirically-based treatments, the current study used a factorial survey approach to
investigate addiction professionals’ decision making. Specifically, how do client
variables effect addiction professionals’ selection of theoretical perspectives and
recommended treatment approaches. Participants were active members of the
Association for Addiction Professionals (NAADAC), and a random sample of 1,274
members participated in an online survey. The research questions guiding the current
study were:

1. What are the effects of a client’s drug of choice, previous treatment
   experience, understanding of substance use, and preferred treatment goal on
   addiction professionals’ selection of a theoretical perspective according to
   their interpretation of a client’s understanding of substance use?
2. What are the effects of a client’s drug of choice, previous treatment
   experience, understanding of substance use, and preferred treatment goal on
   addiction professionals’ recommended treatment approach according to their
   interpretation of a client’s preferred treatment goal?

American Counseling Association (ACA) Code of Ethics

The ACA Code of Ethics (2014) serves six primary purposes (e.g., identifying
ethical considerations, clarifying ethical responsibilities) and underscores nine content
areas. Ethical standards detailed in the nine content areas largely govern the counseling
profession. Several ethical codes highlight the expectation that counseling is to be individually tailored according to client needs.

Section A.1.c of the *ACA Code of Ethics* (2014) states that counselors are to promote client autonomy (i.e., respect their freedom of choice) and collaborate with clients when establishing treatment goals, reviewing or revising treatment plans, and assessing treatment effectiveness. Counselors are prohibited from imposing personal preferences (e.g., moral opinions, attitudes, behaviors) on clients (section A.4.b.) and must be willing to adopt empirically-supported practices (section C.7.a.) that best serve diverse populations (section C.2.f.). Relatedly, counselors must avoid using treatment approaches unsupported by research (i.e., lay or traditional approaches) or approaches that might harm clients (section C.7.c.). Counselors are also required to consider how culture influences client understandings of presenting concerns (section E.5.b.). In accordance with these sections of the *ACA Code of Ethics* (2014), the current study investigated the effects of client variables (i.e., drug of choice, previous treatment experience, understanding of substance use, preferred treatment goal) on addiction professionals’ selection of a theoretical perspective and recommended treatment approach.

**Theories of Substance Use Disorders**

The practice of treating mental health disorders is informed by theory. Likewise, the practice of treating substance use disorders should be informed by theory. Theories offer explanations about the etiology, progression, maintenance, and treatment of disorders. Case conceptualization has been defined as a set of “hypotheses about the
causes, precipitants, and maintaining influences of a person’s psychological, interpersonal, and behavioral problems” (Eells, 2002, p. 815). Case conceptualization, therefore, is linked to theoretical perspectives (Berman, 1997; Kuyken, Padesky, & Dudley, 2008; Sperry, 2005) and it is the theoretical perspective of addiction professionals that was investigated in the current study. What follows is a review of theories, models, and approaches informing the practice of treating substance use disorders.

**Disease or Medical Theories of Substance Use Disorders**

Thombs and Osborn (2013) indicated that there are multiple disease, or medical, theories of SUDs. Differences among these theories primarily relate to how the etiologies of SUDs are understood. Some give credence to physical or psychological influences and others credit a spiritual absence or spiritual immaturity to the development of SUDs. For example, members of Alcoholics Anonymous (AA) commonly refer to addiction as a spiritual disease (Kranitz, Holt, & Cooney, 2009): attributing the etiology to spiritual immaturity and recovery to spiritual maturity. However, those in the medical field ascribe genetic composition or physical and psychological adaptation (e.g., tolerance and withdrawal) to the development and maintenance of SUDs (Ducci & Goldman, 2008). Although AA is not a practice aligned with the medical model, focusing instead on spiritual, social, and psychological changes (Nowinski, 2002), it is the modality most linked to the disease perspectives (Ries, Galanter, Tonigan, & Ziegler, 2011) and is the most widely used treatment approach in the United States (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; NIDA, 2012).
Thombs and Osborn (2013) differentiated between the ideologies of AA and medical professionals by suggesting that the use of the term *disease* is conflicted. Contrary to society’s understanding, many members of AA do not maintain that their condition is a disease, at least not in the same way that cancer or diabetes are viewed as diseases. However, members of AA describe their experiences as *disease-like* (i.e., when considering potential progression, chronicity, or fatality), an important philosophy to consider. Medical personnel, on the other hand, take a literal stance by labeling SUDs as a disease because they believe that genetic composition is profoundly responsible for one’s susceptibility to contracting the disease (Ducci & Goldman, 2008; Talbott, 1989).

Talbott (1989) explained this medical perspective, labeling SUDs as congenital: whoever is born with a genetic predisposition and engages in substance use is at risk for developing the disease. However, those who lack the supposed genetic predisposition at birth may engage in substance use without ever developing the disease. In other words, individuals either have the predisposition or they don’t (i.e., those who are not predisposed cannot “use” into a disorder). Congruent with this contention, treatment from the perspective of disease theories requires complete abstinence to achieve recovering status. This status is ongoing and never fully reaches a status of recovered; therefore, recovery (i.e., ongoing abstinence) is something that is always taking place rather than ever being fully achieved (Leshner, 2003).

Mueser, Drake, Turner, and McGovern (2006) clearly stated that little is known about the etiology of SUDs. For clients who attribute their addiction to their genetic composition, treatment from a traditional medical perspective would be appropriate. For
clients who attribute their addiction to spiritual immaturity, treatment from the 12-step philosophy (i.e., one that includes participation in AA) would be appropriate. This practice encourages counselors to match client preferences with treatment philosophy: catering to client preferences within the realm of treatment.

**Co-occurring Theories of Substance Use Disorders**

Co-occurring disorders, historically termed dual diagnoses and recently labeled as comorbid disorders (i.e., the term used in the medical and public health fields), refer to at least two conditions experienced simultaneously, such as a SUD and mental health disorder. Mueser, Drake, and Wallach (1998) and Mueser et al. (2006) identified four primary models that explain co-occurring disorders: (a) common factors model, (b) secondary substance abuse model, (c) secondary psychopathology model, and (d) bidirectional model.

**Common factors model.** Common factors influencing substance use can be biological, individual, or social (Gregg, Barrowclough, & Haddock, 2007). Risk factors that have been identified as “common” among individuals with substance use disorders make up this model. Mueser et al. (1998) and Mueser et al. (2006) explained that from this perspective, co-occurring disorders develop when individuals possess, or are exposed to, risk factors linked to the development of each disorder. For example, they noted that genetic composition, levels of cognitive functioning, and environmental variables have been identified as factors associated with the development of substance use and mental health disorders. They listed exposure to any type of abuse, impoverished living, or other stressful situations to be additional risk factors in the development of such disorders.
Genetic and environmental risk factors contribute to either internalized or externalized disorders (Kendler, Prescott, Myers, & Neale, 2003; Kessler, 2004). Internalized disorders include mood disorders (Kessler, 2004), phobias (Kendler et al., 2003), and anxiety (Kendler et al., 2003; Kessler, 2004), whereas externalized disorders include oppositional-defiant disorder, attention-deficit/hyperactivity disorder (Kessler, 2004), substance use disorders, antisocial personality disorder (Kendler et al., 2003), and conduct disorder (Kendler et al., 2003; Kessler, 2004). The common factors model attributes the development of co-occurring disorders to these genetic and environmental risk factors.

Treating individuals from a common factors model requires addressing a primary condition(s). Primary conditions in the common factors model refer to the risk factors (e.g., childhood abuse and poverty) influencing the co-occurring disorder (e.g., depression and a SUD). If clients believe growing up in an impoverished community influenced their current substance use and depression, treatment from a common factors perspective would honor their frame of reference. When clients say their anxiety and substance use are responses to childhood abuse, treatment from a common factors model would also support their preferences. This model advocates for the resolution of whatever condition preceded, and simultaneously promoted, the co-occurring disorders.

**Secondary substance abuse model.** From this perspective, co-occurring disorders can be understood from a somewhat linear model of causation: a primary mental health disorder, rather than an external condition (e.g., child abuse or poverty referenced above), influences a secondary substance use disorder (Kessler, 2004; Mueser
et al., 1998; Mueser et al., 2006). In other words, the SUD is secondary to (i.e., in response to or influenced by) the primary mental health disorder. An example would be an individual developing anxiety first, or predominantly, and then developing an alcohol use disorder in response to, or secondarily to, the mental health disorder. Primary mental health disorders strongly predict secondary substance use disorders (Kessler, 2004).

There are four sub-models of the secondary substance abuse model.

**Self-medication hypothesis.** The philosophy of Khantzian’s (1985) self-medication hypothesis (SMH), a philosophy rooted in psychoanalysis (Gottdiener, Murawski, & Kucharski, 2008), suggests that individuals engage in substance use to alleviate or temper unpleasant symptoms associated with preexisting mental health disorders (Gregg et al., 2007; Kessler, 2004; Mueser et al., 1998). Further, the SMH asserts that the substances individuals select is intentional (i.e., individuals select substances because of their unique psychotropic effects; Gregg et al., 2007; Khantzian, 1985; Lembke, 2012; Mueser et al., 1998). For example, individuals who experience hyperactivity may choose to use amphetamines because of their stimulating effect whereas individuals who experience anxiety may choose to use alcohol because of its anxiolytic effect (Lembke, 2012). According to this hypothesis, repeated substance use to manage negative affect influences the development of a co-occurring substance use disorder (Gregg et al., 2007).

Criticisms of the SMH exist. Khantzian (1985) noted that in the short-term, individuals typically do experience relief from seemingly overwhelming and unmanageable affective states; however, in the long-term, the negative consequences
associated with regular and high levels of substance use negate the principle of self-medication (i.e., conditions get worse). Additionally, the rates of co-occurring psychopathology and levels of suicidality increase significantly among those who self-medicate (Leeies, Pagura, Sareen, & Bolton, 2010). Lembke (2012) offered three main criticisms of the SMH. It solely focuses on treating mental health disorders and completely ignores the concept of addiction. It teaches clients that all unpleasant emotions stem from a preexisting mental health disorder and disregards the idea that unpleasant emotions may actually stem from substance use. It provides a false rationale for promoting substance use as “medication” instead of discussing the negative and lasting consequences of use. She blatantly asserted that the SMH is detrimental to the treatment of SUDs and that it needs to be abandoned.

When clients believe their substance use alleviates symptoms associated with a mental health disorder or unpleasant emotions, they may prefer to work within this philosophy and may then benefit from conceptualizing and addressing the co-occurring disorders from the SMH perspective. Treatment focuses on the primary disorder, or the preexisting mental health disorder. Learning how to manage the mental health disorder without substances becomes the goal of treatment. Clients with this understanding of addiction may benefit from working with a counselor who incorporates the principles of this philosophy into their treatment approach.

**General dysphoria theory.** Alleviating dysphoria is the most frequently endorsed reason for substance use among individuals with co-occurring disorders (Gregg et al., 2007). Mueser et al. (1998) and Mueser et al. (2006) explained that individuals whose
lives are fraught with negativity use substances to emulate positive life experiences. They noted that unlike the self-medication hypothesis, which refers specifically to alleviating negative mental health symptoms, the general dysphoria theory refers to alleviating negativity that stems from many causes. Some examples of negativity include boredom, pain, loneliness, or insomnia. Individuals repeatedly use substances to produce sensations that differ from the norm (i.e., they use substances to produce feel-good experiences instead of regular dysphoria). Repeated use is then believed to contribute to the development of a substance use disorder.

Clients who believe their use of substances creates positive experiences in their lives may agree with this perspective. If clients are using substances because they are bored or because they experience chronic pain, then treatment would focus on managing that dysphoria without the use of substances. Treatment would promote the exploration of other activities that provide positive experiences or elicit positive emotional states. Treatment focused on decreasing the regular experience of unhappiness while increasing the regular experience of pleasure would likely make sense to individuals with this understanding of addiction.

**Supersensitivity model.** This model is based on the vulnerability model of schizophrenia (Zubin & Spring, 1977) and is unique to explanations of co-occurring disorders because the SUD is atypical; not requiring a great amount of the substance or regular frequency of use. Preexisting disorders, namely psychotic disorders, increase an individual’s sensitivity to substances (Mueser et al., 1998; Mueser et al., 2006). This increase in sensitivity results in negative consequences of substance use without
individuals engaging in high levels of or frequent use. That is, individuals using substances within normal ranges, or at levels considered to be culturally appropriate, experience the same adverse consequences (e.g., poor health or difficulty in social, occupational, interpersonal functioning) as those using significantly more of the same substance frequently (Gregg et al., 2007). In the United States, normal or moderate (i.e., low-risk) drinking patterns are defined as ≤ 4 standard drinks per day and ≤ 14 standard drinks per week for men and ≤ 3 standard drinks per day and ≤ 7 standard drinks per week for women (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2013).

Clients who believe preexisting conditions make them vulnerable to the effects of substances may benefit from working with a counselor who incorporates the principles of this philosophy into their treatment approach. Understanding their substance use as it relates to their unique mental health condition may help them understand the consequences of their use. Understanding this interplay could promote treatment involvement and symptom improvement; however, this is only possible when counselors identify this theoretical perspective and choose to honor client preferences.

Secondary psychosocial effects model. According to this model, the influence of mental health disorders on an individual’s psychosocial consequences (e.g., cognitive, social, academic, career, housing, and economic consequences) places an individual in situations and environments prone to substance use (Mueser et al., 2006). For example, education may be negatively influenced by cognitive impairments or social ineptness. Negative influences on education could prohibit adequate career conceptualization or training, decreasing individuals’ likelihood to become gainfully employed, for example.
Lacking financial resources could lead to living in low socioeconomic environments, environments where research has suggested substance use is commonplace and substances are readily available (Mueser et al., 2006).

Those who believe the psychosocial consequences of mental health disorders influence substance use may benefit from working with a counselor who incorporates the principles of this model into their treatment approach. It would make sense to clients whose success in the workplace, for example, was prohibited by the consequences or symptoms of a mental health disorder. It also would seem to make sense to clients who live in or grew up in subpar housing in and around areas where substance use is prevalent. Treatment would focus on repairing the psychosocial consequences of the preceding mental health disorder influencing the substance use.

**Secondary psychopathology model.** This model is the polar opposite of the secondary substance abuse models. From the perspective of secondary psychopathology, co-occurring disorders can still be understood using a linear model of causation. In this case, however, the primary substance use disorder gives way to a secondary mental health disorder (Kessler, 2004; Mueser et al., 1998; Mueser et al., 2006). In other words, the mental health disorder is secondary to, or in response to or influenced by, the primary substance use disorder.

Mueser et al. (2006) noted that this model focuses namely on SUDs and their association with schizophrenia, depression, and personality disorders. For example, individuals who use depressants (e.g., alcohol or barbiturates) may begin to experience depressive symptoms influenced by their substance use. Continued use may lead to
increased rates of depression, contributing to a co-occurring mental health disorder. The negative consequences associated with problematic substance use (e.g., interpersonal conflict, loss of employment, legal implications) can perpetuate the development of mental health symptoms (e.g., depression or anxiety) that may also contribute to co-occurring disorders.

Clients who believe their substance use is responsible for the development of another mental health disorder would likely benefit from working with a counselor who incorporates the principles of this theory into their treatment approach. Treatment from this perspective might also be preferred by those who believe their mental health symptoms are a direct result of the negative consequences of their substance use. Treatment first addresses the substance use and related consequences to alleviate the mental health symptoms. The secondary psychopathology model would likely benefit clients who understand addiction from this perspective.

**Bidirectional model.** From the perspective of the bidirectional model, co-occurring disorders can be explained by considering how each disorder influences, perpetuates, and maintains the other disorder (Gregg et al., 2007; Kessler, 2004; Mueser et al., 1998; Mueser et al., 2006). An example would be to combine the principles of the secondary substance abuse model and the secondary psychopathology model. Regardless of which disorder existed prior to the other, there is a cyclical nature contributing to their maintenance (i.e., the principle of circular causality). Each disorder promotes, maintains, and exacerbates the other; therefore, assigning the labels primary or secondary to each disorder is removed under this model (Kavanagh & Connolly, 2009).
Consider depression and alcohol use. Depressive symptoms may be relieved for a short period of time by consuming alcohol. On the other hand, consuming alcohol may perpetuate depressive symptoms. Individuals may drink to alleviate depressive symptoms. In doing so, they actually increase their experience of depression which leads them back to drinking in an effort to experience those brief moments of symptom relief. Plainly stated, consuming alcohol fuels the depression and the depression fuels the consumption of alcohol.

When clients believe they are stuck in a cycle of use worsened by mental health symptoms and their mental health symptoms are made worse by their use, their understanding of addiction is represented by this perspective. Clients who are not sure or possibly not interested in which disorder came first may prefer to work within this model. Clients who cannot identify a linear progression between the disorders but who know the two conditions influence one another may benefit from treatment informed by this theory. Treatment would then focus on managing both disorders simultaneously, rather than one followed by the other.

**Psychoanalytic Theories of Substance Use Disorders**

The conscious versus the unconscious, instant versus delayed gratification, and functional versus dysfunctional defense mechanisms are at the heart of psychoanalysis. Thombs and Osborn (2013) discussed these three distinct contributions of psychoanalysis to understanding SUDs. First, the unconscious (i.e., where painful memories or experiences are repressed) is partly responsible for the development and maintenance of SUDs (see Johnson, 2011). As long as individuals repress negative memories or
unpleasant events, problems with substance use will continue. Second, the id, that which
demands instant gratification, is responsible for the initial and maintained cravings
experienced by individuals with SUDs (see Wurmser, 1974). Although the id may be
highly influential to some individuals, fostering problematic substance use, others are not
as susceptible to its influence. Third, many psychoanalysts view SUDs as nothing more
than defense mechanisms targeting the resolve of unpleasant affect. This defense
mechanism (e.g., “denial”) is linked to the Khantzian’s (1985) self-medication hypothesis
discussed earlier.

Psychoanalytic theories of SUDs are similar to the secondary substance abuse
models because they refer to SUDs as symptoms of mental health disorders (Morgenstern
& Leeds, 1993). There are varying schools of psychoanalytic thought; however, Leeds
and Morgenstern (1996) reported four common assumptions of these schools: (a)
problems with substance use are symptoms of preexisting psychopathology, (b) the cause
of SUDs is linear (i.e., originating from the pre-existing mental health disorder), (c)
SUDs do not vary (i.e., all SUDs are the same), and (d) SUDs cannot exist independent of
a mental health disorder (i.e., other psychopathology will always accompany an existing
SUD). In addition, Morgenstern and Leeds (1993) explained commonly held beliefs
among psychoanalysts about individuals with SUDs. These beliefs suggest that
individuals with substance use disorders: (a) find it difficult to tolerate and regulate
emotions; (b) have trouble attending to the feelings, opinions, or preferences of others;
(c) use substances to replace faulty thinking; and (d) experience interpersonal difficulties.
From a psychoanalytic perspective, substance use reflects a desire for drug-induced relief (Hatterer, 1982; Wurmser, 1974) from disturbances housed within the unconscious (Johnson, 2011). It represents a single symptom of underlying disturbances, pain, or conflict (Johnson, 2011; Morgenstern & Leeds, 1993; Wurmser, 1974), and offers temporary reprieve from, or masking of, unpleasant affect (Hatterer, 1982; Johnson, 2011). Substances are used to replace or avoid emotions, and internal difficulty is dealt with by external behavior (i.e., substance use; Johnson, 2011; Morgenstern & Leeds, 1993). According to Wurmser (1974), the accessibility and appeal of substances, along with cravings for substances, are always present in those with SUDs.

Within the realm of treatment, clinicians decide whether they will treat the symptom or the underlying disturbance. Clients may benefit from services that are consistent with this theory if they believe a preexisting mental health disorder influenced or caused their substance use disorder. This theory would also appeal to those who identify SUDs as uniform, despite severity or drug of choice (i.e., etiology, maintenance, and treatment are the same regardless of preferred substance or severity of substance use). When clients maintain they use substances because of past negative experiences or because of current unpleasant emotional states, psychoanalytic perspectives honor their beliefs. Likewise, those who place emphasis on the experience of cravings and the need for instant gratification may also benefit from treatment that reflects this perspective.

**Behavior Theories of Substance Use Disorders**

Behavioral theories are also referred to as theories of learned or conditioned behavior. Among behavioral theories pertaining to SUDs, urges or compulsions to use
substances represent the cornerstone to understanding why individuals engage in and return to problematic substance use (O’Brien, Childress, Ehrman, & Robbins, 1998). The principle of self-regulation also contributes to this understanding (Webb, Sniehotta, & Michie, 2010).

Behavior theorists posit that all human behavior, both adaptive and maladaptive, is learned (Thombs & Osborn, 2013). Specific to this principle, behaviorists regard operant conditioning as the primary learning process experienced by humans. Operant conditioning requires humans to operate on, or engage in, behavior that elicits some sort of response: positive reinforcement, negative reinforcement, or punishment. The response will either increase or decrease the frequency of the behavior. Humans learn which behaviors elicit positive or negative reinforcement (i.e., responses that increase the frequency of behavior) and which behaviors elicit punishment (i.e., a response that decreases the frequency of behavior). Seeking such reinforcement represents an attempt at self-regulation (Webb et al., 2010) and these reinforcements significantly influence the course of substance use disorders (Higgins, Heil, & Lussier, 2004).

This process sheds light on substance use disorders because anything linked to previous substance use can elicit a conditioned response (O’Brien et al., 1998). These conditioned responses begin the cycle of drug-seeking, a conditioned behavior or habit, which is then reinforced by finding and using a desired substance. The concept of impulsivity is similar.

Dawe and Loxton (2004) suggested that two components of impulsivity contribute to the etiology and maintenance of substance use disorders. The first, reward
sensitivity/drive, describes substance use behavior for sheer pleasure of substances (i.e., impulsivity to achieve the “feel good” response). The second component, rash/spontaneous impulsivity, describes substance use that is “off the cuff” (i.e., use without consideration of future, or past, consequences). This interplay might explain why individuals find it difficult to stop the using process once it has begun. That desire to use “right here, right now” (rash/spontaneous impulsivity) is reinforced by the “feel good” experience of the use (reward sensitivity/drive).

Impulsivity can be directly related to the principle of delayed discounting and is a common notion when discussing substance use disorders (Murphy, Correia, & Barnett, 2007). For example, an individual who prefers the immediate gratification of having a drink over the postponed benefits of sobriety has discounted the value of their long-term goal, sobriety, in exchange for a lesser goal, drinking right now. Self-regulation is exhibited when the greater goal (e.g., obtaining sobriety) outweighs a lesser goal (e.g., having a drink right now; Webb et al., 2010).

Behaviorists define SUDs as a pattern of behavior: a learned, or conditioned, behavioral pattern to use substances regularly and at high levels (Thombs & Osborn, 2013). The idea that a behavioral pattern defines SUDs challenges other theoretical views: views maintaining that individuals enter a distinct moment when they can no longer control their use (i.e., a point of no return). In addition, behaviorists do not consider physical dependence on substances as a symptom of substance use disorders. It is simply part of the behavioral pattern of using substances regularly and at high levels.
Carroll and Rounsaville (2006) presented two other factors integral to behavioral theories of SUDs: cravings and poor behavioral controls. These factors promote an understanding of SUDs as impulse-control disorders. Cravings are conditioned responses to the prolonged use of substances and their associated appeal. Poor behavioral controls are believed to originate from insufficient coping mechanisms and the absence of reinforcement for non-using behaviors. These non-using reinforcements, or prosocial reinforcements (e.g., being able to spend time with your children), are believed to decrease the prevalence of substance use. Thus, the overall objective of behavioral therapies is to reduce cravings and to increase behavioral controls (i.e., coping skills and provision of reinforcements). The two components of impulsivity described by Dawe and Loxton (2004) and the process of self-regulation described by Webb et al. (2010) supplement the understanding of how cravings and poor behavioral controls influence substance use disorders by supporting the basic tenets of behavioral conditioning.

Clients who understand their substance use to be a learned behavior and a behavior maintained either by positive or negative reinforcement may benefit from behavioral treatment. Those who experience greater reinforcement for substance using behaviors than non-using behaviors may prefer to work from this perspective. Clients who describe their substance use as a pattern of behavior with marked symptoms (e.g., cravings or withdrawal) may benefit from working with a counselor who incorporates the principles of this philosophy into his or her treatment approach. Individuals who can identify with the impulse-control components (e.g., cravings, impulsivity, self-regulation) of SUDs may benefit from treatment interventions promoted by behavior theories.
Cognitive Theories of Substance Use Disorders

Cognitive therapy posits that a person’s thought processes influence affective and behavioral responses to situations according to that person’s perceptions or interpretations of those situations (Beck & Weishaar, 2008). When perceptions and interpretations of situations are misguided or dysfunctional, maladaptive behaviors (e.g., problematic substance use) occur. Examining dysfunctional beliefs as well as encouraging adaptive and flexible thinking is at the core of cognitive therapy. Cognitive models explain SUDs by acknowledging the reinforcing potential of substances, identifying the internal and external cues associated with substance use, and understanding the influence of those cues on thoughts and behaviors (McHugh, Hearon, & Otto, 2010).

Cognitive models consider the thought processes of individuals as they negotiate perceptions or beliefs about substance use (Thombs & Osborn, 2013). Negative thought processes, known as cognitive distortions, are believed to influence people in a way that promotes maladaptive behavior (Beck, 1964). Cognitive models also stress the influence of learning on the development and maintenance of substance use disorders (Sorensen et al., 2009). This is the influence of Albert Bandura, who is credited with furthering cognitive theories when he developed Social Learning Theory in the late 1960s. Three components of cognitive models are: (a) self-regulation, (b) self-efficacy, and (c) expectancy.

Thombs and Osborn (2013) defined *self-regulation* as an individual’s ability to behave based on personally held beliefs. For example, individuals with SUDs display
behaviors that are consistent with, or regulated by, their understanding of use (i.e., they use based on how they think they are supposed to use). This is similar to the understanding of self-regulation adopted by behavior theorists (i.e., substance use is maintained because of reinforcements). In addition, their perception of self is more important than others’ perceptions of them such that problematic external factors (e.g., interpersonal difficulties, health concerns, legal implications) do not mitigate substance use. In other words, using substances is more important than improving interpersonal difficulties, managing health concerns, or dealing with legal implications. When clients believe that patterns of substance use are consistent with their personal beliefs about use and when the influence of external factors is minimal, exploring the principles of self-regulation may be advantageous in treatment.

*Self-efficacy* is a core component of cognitive theories and refers to an individual’s belief that he or she has the ability to engage in behaviors that will produce desired outcomes (Bandura, 1977). Two components of self-efficacy related to SUDs are outcome expectation and efficacy expectation. The former refers to an individual’s belief that a desired outcome will come to fruition based on particular behaviors, and the latter refers to an individual’s belief that they themselves can accomplish the particular behavior needed to bring about the desired outcome. The principles of self-efficacy are reflected in treatment when clients believe they have the ability to reach their goals (e.g., abstinence, decreased use) and believe they themselves can engage in the required behaviors.
Lastly, the principle of *expectancy* contends that individuals’ experiences of substance use (e.g., physical, emotional, or behavioral effects) are dependent on perceived expectations of, or anticipated responses to, substance use (Holt, Kranitz, & Cooney, 2009). This principle is reflected in the various reasons given for substance use. Clients who expect to experience relaxation or increased energy from using substances will likely experience those outcomes. This notion rests on the premise that thought processes, or preconceived notions, influence responses to substance use.

Clients may prefer to receive treatment consistent with cognitive models if they believe the initiation of their substance use was influenced by outcome expectancies (i.e., what they hoped to experience or gain from use). Those who believe their patterns of use are self-regulated (i.e., organized and purposeful) may also align with this ideology. In its simplest form, clients who believe their SUDs are influenced by the way they think may experience increased satisfaction in treatment if encouraged to work from this perspective. For this to happen, providers need to be able to identify this belief among their clients and promote counseling flexibility, offering treatment approaches grounded in cognitive theory.

**Sociocultural Theories of Substance Use Disorders**

Moos (2007a, 2007b) presented four sociocultural theories of substance use: (a) social control theory, (b) behavioral choice theory, (c) social learning theory, and (d) stress and coping theory. The shared premise of these theories is that social or cultural factors (i.e., one’s environment) promote or discourage substance use.
Social control theory. Social control theory maintains that substance use is influenced by involvement in prosocial (i.e., discouraging substance use) or antisocial (i.e., promoting substance use) organizations (Moos, 2007a, 2007b), particularly the perceived bond with such organizations or systems. When individuals have strong prosocial bonds (e.g., with family, occupation, religion) they are more likely to exhibit healthy substance use patterns. On the other hand, when individuals have weak connections to prosocial organizations, it leaves them vulnerable to stronger antisocial bonds that may perpetuate problematic substance use.

Moos (2007a, 2007b) explained that increased structure and cohesion increases the likelihood of developing strong relational bonds. The opposite is true in the development of weaker relational bonds. For clients who believe that SUDs are related to their involvement with antisocial organizations, or disengagement from prosocial organizations, this theoretical orientation would likely fit their ideology. Treatment focuses on decreasing antisocial bonds (i.e., bonds promoting substance use) and increasing prosocial bonds (i.e., bonds discouraging substance use) to manage SUDs.

Behavioral choice theory. Whereas social control theory focuses on individuals’ relationships within organizations or systems, this theory focuses on individuals’ specific activities that either promote or discourage substance use (Moos, 2007a, 2007b; Murphy et al., 2007). Individuals select activities because they provide reinforcements. When the reinforcements of non-substance-using behaviors are stronger than the reinforcements of substance-using behaviors, individuals will maintain non-using behaviors. The opposite is also true: when the reinforcements of substance-using behaviors are stronger than the
reinforcements of non-substance-using behaviors, individuals will maintain using behaviors. Behavioral choice theory focuses on freedom to choose one’s activities (i.e., using or non-using) based on elicited reinforcements.

Selecting non-substance-using activities over using activities depends on the availability of such activities (Moos, 2007a, 2007b) and how well those activities align with individual preferences (Murphy et al., 2007). Individuals who have access to occupational opportunities, religious organizations, or wellness centers may choose those activities over substance use. They may find greater reinforcement from being employed, involved in youth ministry, or exercising, for example, than they do from substance use. When clients say their use is influenced by a lack of alternative activities that provide strong reinforcements, this theory honors their belief system. Treatment encourages the adoption of activities that are incongruent with substance use to replace activities that promote substance use.

Social learning theory. Moos (2007a, 2007b) described social learning theory of substance use in a linear fashion. First, individuals see others using substances and they begin to model those behaviors. Next, they experience the reinforcements they hoped to experience through use (e.g., increased socialization), confirming that substance use produces the desired effect (e.g., social acceptance) and leading to regular use. In essence, social learning theory posits that substance use is learned by observing, modeling, and receiving reinforcement; we learn how to use and how to respond to substances from those around us. In the same manner, our attitudes and beliefs about substance use are developed (Tomlinson & Brown, 2012).
For clients who explain their substance use as the norm in their social group or of those they admire (i.e., “It’s just how we are” or “It’s always been this way”), this theory would likely make sense. When they believe their pattern of use is influenced by what they saw growing up, their preference may be to receive treatment from this perspective. Sometimes, clients do not recognize their patterns of use as atypical because they are unaware of general patterns of use (e.g., alcohol use among 18-year-olds nationwide is lower than alcohol use in one 18-year-old’s group of friends). Treatment may begin by educating individuals about true norms and healthy using behaviors that may be in stark contrast to what they originally believed. To some degree, psychoeducation paves the way for insight-oriented discussions. Working from this theory would honor clients’ beliefs that SUDs are established and maintained by what they learned growing up.

**Stress and coping theory.** Moos (2007a, 2007b) explained stress and coping theory as a linear progression of three activities. First, individuals experience stress related to their daily lives. Second, they remove themselves from the distressing situations and become isolated. Third, they use substances to cope with their feelings of stress and isolation. In this example, substance use is the result of experiencing stressful situations or being exposed to stressful environments and being unable to achieve resolution.

Individuals who identify with this description typically have limited coping skills and difficulty resolving stressful situations, often avoiding problems (Moos, 2007a, 2007b). Clients may benefit from treatment aligned with this theory if they believe their substance use is a direct result of stressful life events. Stressful life events may be
influenced by their occupation, academic endeavors, finances, interpersonal relationships, or family responsibilities. Treatment would focus on developing coping skills and improving communication in the context of managing difficult or stressful situations.

**Sociological perspectives on substance use.** Sociological perspectives of substance use are a departure from socially constructed norms (Thombs & Osborn, 2013), a departure intended to: (a) ease social interaction, (b) experience reprieve from daily responsibilities, (c) promote solidarity with others, and (d) simply disregard conventional standards. Each of these purposes is explained by one of the previously mentioned theories of SUDs. Such departures simply go against what is expected or common in one’s culture.

Clients may benefit from treatment that endorses sociological theories of addiction if they maintain a high regard for their own beliefs and values (Thombs & Osborn, 2013) because personal ideology and preferences are honored. They would likely appreciate a counselor who offers treatment from a philosophy that remains objective, respects their value system, and refrains from imposing socially constructed norms (e.g., when to drink alcohol or how many drinks are acceptable). Clients who believe their substance use is explained by one of the four sociological perspectives may prefer to receive treatment from this theoretical perspective. Treatment may focus on identifying alternate activities that fulfill similar purposes with favorable results. Implementing a sociological perspective of treatment requires counselors to respect the values of clients.
Evidence-Based Practice

Evidence-based practice (EBP) is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This style of practice represents providers’ overall mode of operation. It is informed by research, and includes everything from how providers interact with clients, to how they develop treatment plans, to what theoretical perspective they use, to how they assess client progression. It is a style of practice that pays attention to client individuality, as well as client autonomy.

Part of evidence-based practice includes using evidence-based treatment (EBTs), or “treatments that have been scientifically tested and subjected to clinical judgment and determined to be appropriate for the treatment of a given individual, population, or problem area” (Sorensen et al., 2009, p. 17). It could be said that these evidence-based treatments represent the how of evidence-based practice. In order to practice from an evidence-based position, providers need to be using evidence-based treatments. Both definitions influenced the current study. The theoretical perspective used by addiction professionals should be informed by client characteristics, culture, and preferences. Recommended treatment approaches should be scientifically tested and appropriate for the individual or problem area.

The routine application of evidence-based practice in the field of addictions treatment is inadequate. Despite the effectiveness of several known evidence-based treatments, their implementation in clinical practice is rather limited (Tuchman &
The dominant treatment modality in the United States, a model resting on historical principles rather than evidence (Sorensen et al., 2009), reflects expensive, long-term, residential care accompanied by ongoing participation in mutual-help groups (e.g., Alcoholics Anonymous/Narcotics Anonymous) with a standing goal of lifelong abstinence (Mee-Lee et al., 2010). Nationwide, the dominant treatment approach remains abstinence-based group counseling (McLellan et al., 2003; NIDA, 2012). Despite research showing support for various EBTs in addiction treatment, the dominant treatment modality (i.e., the disease or medical models, the Minnesota Model, 12-step support groups), and its poor success rate, remains prevalent in clinical practice (Kaskutas et al., 2009; Ries et al., 2011; Stewart & Conrod, 2005).

**Evidence-Based Treatments in Addiction Treatment**

Research indicates that EBTs for substance use disorders vary considerably in their understanding of the change process; however, each treatment generates favorable results (Sorensen et al., 2009). The following approaches showcase different perspectives, philosophies or beliefs about addiction, and have received consistent empirical support for treatment effectiveness: (a) motivational interviewing, (b) relapse prevention, (c) contingency management, (d) 12-step facilitation, (e) adjunctive pharmacotherapy, and (f) harm reduction. On the other hand, confrontational counseling and required participation in mutual-help groups (practices common within the dominant treatment modality; NIDA, 2012) yield unfavorable or ineffective results (Miller & Wilbourne, 2002; White & Miller, 2007).
**Motivational interviewing.** Motivational interviewing (MI) is a style of counseling designed to help people initiate change (Miller, 2000) and resolve ambivalence about change (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Miller, 1996, 2000; Rollnick & Heather, 1992). It encourages the promotion of intrinsic motivation among clients (Miller, 2000) and facilitates a process whereby clients talk themselves into behavioral change (Hettema, Steele, & Miller, 2005; Moyers & Rollnick, 2002). Miller (1983) and Moyers and Rollnick (2002) identified the main principles of the MI philosophy: (a) express empathy, (b) develop discrepancies, (c) avoid argument, (d) roll with resistance, and (e) support self-efficacy. Counselors offer empathy, help clients identify discrepancies between what they want and what they are doing, respect clients’ decision not to change, and promote clients’ self-efficacy through a collaborative, directive, and person-centered style of interaction (Hettema et al., 2005; Lundahl et al., 2010; Miller, 1983).

Rollnick and Heather (1992) explained that MI originated because people frequently enter treatment without being entirely ready to change. This limited readiness to change results in fairly nonproductive discussions between providers and clients. Practitioners seek to remedy these nonproductive discussions by encouraging clients to verbalize reasons why change may be beneficial, and also why change may be difficult. It provides a level of congruence between individuals’ readiness to change and providers’ method of treatment delivery. This readiness to change spans a three-point continuum (Rollnick & Heather, 1992). On the far left, individuals have not begun to consider change. In the middle, individuals vacillate between changing and staying the same (i.e.,
ambivalence). On the far right, individuals are committed to the change process, some already implementing behavioral changes. Together, clinicians and clients identify where clients lie on this continuum, and then clinicians respond accordingly (i.e., matching treatment strategies to clients’ readiness to change).

The concept of resistance to change (e.g., the idea of “denial” in addictions treatment) is seen as the provider’s problem, not the client’s (Moyers & Rollnick, 2002). Resistance is an interpersonal phenomenon, a reluctance to change because of incongruent provider strategies (i.e., providers pushing for changes that are incongruent with clients’ readiness to change). Clients liken these experiences to a loss of autonomy, and respond by entering into a natural state of resistance. Here, it becomes the provider’s responsibility to comment on both sides of the ambivalence: the side that is considering change, and the side that is considering maintaining the current status (Hettema et al., 2005).

Client autonomy is a central tenet of MI: change occurs at the client’s pace. This principle of MI stands in stark contrast to traditional and current confrontational treatments of chemical addictions (Miller, 1996; White & Miller, 2007). Coercion and intimidation, supported by confrontational treatments, are antithetical to motivational interviewing (Miller, 2000; White & Miller, 2007) and “four decades of research have failed to yield a single clinical trial showing efficacy of confrontational counseling, whereas a number have documented harmful effects, particularly for more vulnerable populations” (White & Miller, 2007, p. 12). Motivational interviewing is collaborative,
represents a partnership between provider and client, and largely promotes clients’ freedom of choice.

Moyers and Rollnick (2002) listed five assumptions of MI. Providers assume that: (a) intrinsic motivation can be promoted, (b) motivation will not develop unless clients discuss their ambivalence, (c) persuasion is ineffective, (d) a collaborative therapeutic relationship is essential, and (e) a quiet, supportive environment promotes behavioral change. Embracing the spirit of MI is also essential. The spirit of MI reflects the following: (a) partnership and active collaboration, (b) acceptance, (c) compassion, and (d) evocation (Miller & Rollnick, 2013).

Miller and Rose (2009) proposed the development of a theory of MI that includes two primary components: relational and technical. The relational component combines the spirit of MI with empathic understanding, and the technical component involves providers eliciting, identifying, and amplifying clients’ change talk. Change talk is present when clients speak in favor of change (Miller & Rose, 2009). Change talk is divided into five categories derived by Amrhein, Miller, Yahne, Palmer, and Fulcher (2003): desire, ability, reasons, need, and commitment. The first four types of change talk are considered preparatory speech and are not predictive of behavioral change; however, commitment talk is predictive of behavioral change (Miller & Rose, 2009).

Some confusion has surfaced about what exactly constitutes motivational interviewing. In response to this confusion, Miller and Rollnick (2009) identified 10 concepts and procedures that are not synonymous with motivational interviewing. First, although the application of MI seemingly parallels Prochaska and DiClemente’s (1984)
transtheoretical model (TTM) and its stages of change (precontemplation, contemplation, preparation, action, maintenance), it is not based on this model. Rather, MI offers a practical example of how clinicians can facilitate movement from precontemplation or contemplation towards preparation or action by enhancing intrinsic motivation among individuals. There is interrelatedness between the two, but MI stands entirely on its own.

Second, MI is not a method of manipulation or persuasion to get people to change. It is a way of identifying and enhancing individuals’ intrinsic motivation and desire to change. Third, MI is not a technique. It is a style of interaction: a complex method of relating that promotes enhanced motivation for change. Fourth, MI is not a method of weighing the pros and cons of change. Instead of giving equal attention to reason for or against change, MI intentionally identifies and amplifies client-stated reasons for change, focusing more on change-talk than sustain-talk.

The fifth distinction Miller and Rollnick (2009) make is that assessment feedback is not required, or even necessary, when practicing motivational interviewing. The pairing of assessment feedback with motivational interviewing constitutes its own therapy: motivational enhancement therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1992). Sixth, MI is not cognitive-behavioral therapy. MI does not correct irrational or dysfunctional thinking, nor does it consider principles of learned behavior. Fundamentally, the philosophy of MI is humanistic. Seventh, MI is more than client-centered therapy. It is directive and goal-oriented. Providers intentionally identify and amplify clients’ change talk, promoting a strengthening of the argument for change.

Eighth, MI is difficult. The practice moves beyond the microskill of reflective listening.
It represents a complex and systematic style of communication that purposes to enhance intrinsic motivation. Ninth, MI is not a practice providers have been employing their entire life. Yes, it is reflective of genuine communication or problem solving, but it is also a highly strategic and purposeful style of communication aimed at resolving ambivalence about behavioral change. Finally, MI is not a “cure all” intervention. Although it can be used across several problem areas, it is not appropriate for individuals who are already committed to change. It has a specific purpose, and that purpose is to encourage movement from not considering change, or being unsure about change, towards a commitment to change. It is “a collaborative, person-centered form of guiding to elicit and strengthen motivation for change” (Miller & Rollnick, 2009, p. 137).

**Relapse prevention.** For the purpose of this discussion, relapse is defined as a return to problematic substance use characterized by a loss of control over use (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Relapse prevention (RP) is a cognitive-behavioral approach designed to help individuals identify circumstances that trigger their desire to use substances (i.e., high-risk situations), followed by identifying alternate, non-drug using responses to those circumstances (Brandon, Vidrine, & Litvin, 2007; McHugh et al., 2010; Witkiewitz & Marlatt, 2004). Its purpose is to decrease individuals’ chances of returning to problematic substance use after experiencing a period of non-problematic use, or abstinence (Brandon et al., 2007; Hendershot, Witkiewitz, George, & Marlatt, 2011). It aims to increase perceived self-efficacy, decrease the appeal of substances, and promote overall lifestyle changes (Brandon et al., 2007). Marlatt (1996) included environmental, social, and cognitive (Hendershot et al., 2011) influences in his conceptualization of the
relapse process. Namely, he identified risk-factors associated with relapse and noted that educating individuals on how to monitor and cope with high-risk situations is tantamount to relapse prevention (Hendershot et al., 2011; Marlatt, 1996).

Witkiewitz and Marlatt (2004) and Brandon et al. (2007) summarized Gordon and Marlatt’s (1985) original model of relapse. First, a high-risk situation is experienced. These situations include both intra- and interpersonal factors. Marlatt (1996) and Hendershot et al. (2011) identified the intrapersonal factors as: (a) coping with negative affective or physical states, (b) enhancing positive affective states, (c) testing personal control, and (d) giving into cravings. Interpersonal factors include the (a) management of relational conflict, (b) influence of social pressures, and (c) enhancement of positive affective states. Next, failure to successfully manage these high-risk situations decreases an individual’s sense of self-efficacy and increases the appeal of substance use (i.e., positive outcome expectancy). This inverse relationship (i.e., lowered sense of self-efficacy and heightened appeal of substances use) promotes initial use. This initial use after a period of deliberate abstinence generates the “abstinence violation effect” (AVE; Marlatt, 1985) which provokes negative, or failed, thinking in the individual. These negative and failure-like thought processes launch the individual into a full relapse.

Witkiewitz and Marlatt (2004) reformulated the aforementioned model. Their model continues to include high-risk situations as a factor contributing to relapse, but also takes into consideration tonic and phasic processes. Tonic processes include (a) family history of problematic substance use, (b) thought processes, and (c) the presence of withdrawal. Phasic processes include (a) behaviors representing effective coping or
substance use, (b) emotional states, and (c) the abstinence violation effect. This model postulates that tonic factors begin the relapse process, phasic factors continue its progression, and both are influenced by the experience of high-risk situations. As does the earlier model of relapse, it considers the interplay between an individual’s disposition, environment, and life experiences. Also like the earlier model, it maintains that intra- and interpersonal factors influence the risk of relapse. Intrapersonal factors are expanded to include self-efficacy, outcome expectancies, craving, motivation, coping, and emotional states. The interpersonal factor considers the level of social support individuals receive. Responding to high-risk situations is influenced by multiple factors and processes occurring simultaneously.

**Contingency management.** Contingency management (CM) is largely based on operant conditioning (Higgins et al., 1991) and is a cognitive behavioral approach (McHugh et al., 2010). Individuals receive rewards contingent upon their ability to achieve specific behavioral goals, or target behaviors (Carroll & Onken, 2005; Higgins, Alessi, & Dantona, 2002; McHugh et al., 2010). The reinforcement focuses on rewarding non-drug using behavior (Petry, Martin, Cooney, & Kranzler, 2000; Silverman, 2004) and withholding rewards when target behaviors are not met (Petry & Martin, 2002; Silverman, 2004). Research suggests that reinforcements significantly influence the etiology and maintenance of substance use disorders (Higgins et al., 2002; Higgins et al., 2004), as well as influence the maintenance of sobriety and deter relapse (Silverman, 2004). The underlying philosophy of CM is that when people receive positive reinforcements (e.g., financial compensation or tangible goods) for achieving previously
established goals, they will continue to act in ways that facilitate goal attainment. For example, an individual is given a gift card (positive reinforcement) because he or she maintained abstinence for one week (previously established goal). The individual receives the gift card contingent upon his or her ability to sustain abstinence for one week. Contingency management principles are also used to encourage goal attainment beyond abstinence (e.g., medication or treatment compliance; Higgins et al., 2002; Higgins et al., 2004), and are readily accepted by clients (Higgins et al., 1991).

Two methods of reinforcement are used in CM: prizes won by chance-drawings and monetary vouchers. Each method is equally effective when compared to the other, and superior to treatment-as-usual (Petry, Alessi, Marx, Austin, & Tardif, 2005). Prizes won by chance-drawings or “fishbowl” prizes (Petry et al., 2000; Petry & Martin, 2002) range from small to large (i.e., valuing $1–$100) and are won by a method similar to a lottery drawing: participants draw slips of paper from a bowl or other container. Chances to draw are acquired by meeting previously established goals and every client has an equal opportunity to acquire chances. Prize-based or fishbowl incentives are less costly than voucher-based incentives and provide quicker reinforcement to participants (Petry & Martin, 2002).

Voucher-based incentives (Higgins et al., 1991) provide participants with monetary vouchers that can be traded for tangible goods or services and are acquired by meeting target behaviors. The values of vouchers increase as subsequent target behaviors are met. When target behaviors are not met, the voucher’s value returns to the original value, and the process repeats itself. Participants never lose vouchers once they have
been acquired. CM improves retention rates and reduces substance use (Higgins et al., 1991; Higgins et al., 2002; Petry et al., 2000; Petry et al., 2005), and has been identified to be effective across various treatment populations (Higgins et al., 2002). There is a positive correlation between the degree and duration of a contingency and its effectiveness and a negative correlation between relapse and how long a contingency is offered (Silverman, 2004).

Twelve-step facilitation. Twelve-step facilitation (TSF) is an evidence-based approach (Ries et al., 2011) used to encourage client involvement in 12-step programs, such as Alcoholics Anonymous/Narcotics Anonymous (Nowinski, 2002; Ries et al., 2011). It is adopted by providers to help clients make the most of 12-step programs. To be clear, 12-step facilitation is not AA or NA. It’s important to note that the vast majority of treatment facilities in the United States maintain a strong orientation to 12-step programs (Kaskutas et al., 2009; Ries et al., 2011), and because 12-step programs dominate the field of addiction treatment, providers’ understanding of TSF is a tool to help clients benefit from these programs.

There are three programs within the TSF structure: a core program, an elective program, and a conjoint program (Nowinski, 2002). These programs are delivered by a professional, whether in recovery or not. Core programs are implemented when clients are experiencing denial, most often during the early phases of treatment. Denial can mean that clients don’t think they have a problem with substance use or that they can easily control their substance use, despite past evidence of negative consequences. The elective program is used with individuals who have reached and maintained their goal of
abstinence. The conjoint program is offered to significant others, and focuses on how they can help to promote recovery.

Ries et al. (2011) provided an overview of TSF goals. The primary goals are for clients to “accept” and “surrender” to their addiction. Acceptance of addiction means that clients are willing to say that they have an illness that is potentially fatal if left untreated, that they cannot reliably control their substance use, and that abstinence is their only hope for recovery. Acceptance has also been explained as clients overcoming denial, admitting that life is unmanageable, and that they cannot regain control on their own (Nowinski, 2002). Surrender includes acknowledging that recovery is possible through faith in a higher power and that 12-step programs are their best chance at recovery. In other words, clients have to accept that they cannot control their use, that abstinence is their only option for recovery, and that they have to give up on their own personal willpower, turning instead to a higher power (Nowinski, 2002).

The objectives of TSF are intended to address cognitive, emotional, behavioral, social, and spiritual aspects of individuals with substance use disorders (Ries et al., 2011). Cognitive objectives are met when clients admit: (a) that substance use influences thinking, (b) that certain thinking encourages denial and resistance, and (c) that there is a connection between substance use and the presence of negative consequences. Nowinski (2002) noted that the first step (i.e., admitting powerlessness) can be thought of as a cognitive shift, where clients begin to think of their substance use as problematic. Emotional objectives are met when clients grasp the influence that emotions have on substance use, and then learn to manage those emotions without using. Behavioral
objectives aim to help clients identify how their behaviors have become conditioned to support substance use, and how those same behaviors have impacted every area of their lives. The goal of social objectives is to help clients identify and become involved with prosocial networks as well as being able to identify and avoid antisocial networks. Lastly, spiritual objectives state that clients need to be able to establish hope: hope that they can overcome their addiction with the help of some power, a power that’s stronger than their own personal willpower. Nowinski (2002) noted that steps two and three are spiritual shifts, putting hope in something greater than self and surrendering to that higher power for help.

**Adjunctive pharmacotherapy.** Different medications target different neurotransmitter systems, influencing or interfering with, substance use disorders (Brady, Johnson, Gray, & Tolliver, 2011; Koob, 2010). Detailing how particular medications influence SUDs is beyond the scope of this section. However, research has shown that, when used in combination with psychotherapy, medications can help individuals achieve and maintain a reduction in substance use, or total abstinence. Studies have investigated pharmacotherapy for alcohol, opioid, and stimulant use disorders. The Food and Drug Administration (FDA) endorses three medications used to treat alcohol use disorders (AUDs): disulfiram, naltrexone, and acamprosate (Lev-Ran, Balchand, Lefebvre, Araki, & Le Foll, 2012). Research has also identified baclofen (Leggio et al., 2012; Lev-Ran et al., 2012), metadoxine (Leggio et al., 2011), and topiramate (Lev-Ran et al., 2012) as hopeful adjunctive pharmacotherapies for treating AUDs.
Medication-assisted treatment for opioid dependence is well known in the forms of methadone and buprenorphine. Methadone maintenance is approved by the FDA and is the most common medication-assisted therapy for opioid dependence, having received the appraisal of being both safe and effective (Kreek, Borg, Ducat, & Ray, 2010). Buprenorphine alone and buprenorphine-naloxone (Suboxone) have also been identified as effective medications for the treatment of opioid dependence (Fishman, Wu, & Woody, 2011; Orman & Keating, 2009). Naltrexone is approved for treating AUDs (Lobmaier, Kunøe, Gossop, & Waal, 2011) and opioid dependence (U.S. Food and Drug Administration, 2010). Mirtazapine, an atypical antidepressant approved by the FDA, is also being investigated for its use with opioid dependence (Graves, Persons, Riddle, & Napier, 2012).

Elkashef et al. (2008) reported that numerous medications have been considered for use in treating methamphetamine dependence; however, FDA-approval has not been received. Many drugs that have been tested for methamphetamine-specific dependence are drugs that have been found to be effective with other stimulants. Examples include Mirtazapine (Graves et al., 2012), as well as dexamphetamine (i.e., D-amphetamine) and methylphenidate (Elkashef et al., 2008). Cocaine dependence has been effectively treated using disulfiram as an adjunctive pharmacotherapy (Kosten et al., 2013).

There is debate about the efficacy of pharmacotherapy treatments for stimulants. Sofuoglu (2010) argued that no medications have been proven effective in the treatment of cocaine or methamphetamine dependence. Rather than considering maintenance medications (i.e., those that decrease, or block, drug reward), Sofuoglu (2010) and Brady
et al. (2011) indicated that studies need to focus on identifying medications that improve cognitive functioning (e.g., decision making, planning, working memory), maintaining that treatment adherence will improve as a result of better thinking. Examples of medications targeting thought processes include galantamine, donepezil, rivastigmine, varenicline, guanfacine, and atomoxetine. Studies investigating the specific relationship between targeting cognitive functioning with pharmacotherapy and improving treatment outcomes among clients are still needed (Brady et al., 2011).

Thomas, Miller, Randall, and Book (2008) and Roman, Abraham, and Knudsen (2011) addressed provider ignorance as a barrier to implementing adjunctive pharmacotherapy in community treatment centers. Providers lack knowledge of, or have poor attitudes about, pharmacotherapies (Abraham, Rieckmann, McNulty, Kovas, & Roman, 2011; Thomas et al., 2008). Providers who endorse the 12-step modality of treatment (Abraham et al., 2011) or those who are in recovery themselves often refute pharmacotherapy (Roman et al., 2011). Pharmacotherapy is viewed as the treatment approach most challenging to traditional approaches (Roman et al., 2011), forestalling its implementation. According to Pettinati, O’Brien, and Dundon (2013), these traditional, disease-oriented (i.e., medical model) approaches often exclude pharmacotherapy. In fact, despite profound research supporting medicinal effectiveness, only 25% of treatment facilities use adjunctive pharmacotherapies for alcohol use disorders (Abraham et al., 2011). This is ironic because traditional approaches identify SUDs as brain disorders, diseases. Intuitively, medication is used to treat diseases, or to alter faulty brain chemistry. On a positive note, with the dissemination of information about supplemental
medications, providers’ knowledge of, and opinions about, pharmacotherapy does improve (Abraham et al., 2011; Roman et al., 2011; Thomas et al., 2008). Such improvement will likely provide greater access to alternative treatments, increase implementation, and ultimately improve client treatment outcomes.

**Harm reduction approaches.** Harm reduction approaches strive to decrease the experience of negative consequences associated with substance use by offering alternatives to abstinence-only approaches (Rotgers, 1996). Without requiring a decrease in substance use, these approaches focus on minimizing or resolving the social, occupational, and inter- or intrapersonal problems caused by use (Heather, Wodak, Nadelmann, & O’Hare, 1993). However, harm reduction approaches can influence a decrease in substance use, as well as the spread of disease, criminal activity, hospitalizations, and incarceration (Alaei & Alaei, 2013). A few examples of the most common harm reduction approaches include (a) needle exchange programs, (b) methadone maintenance programs, and (c) controlled drinking programs.

**Needle exchange programs.** Needle exchange programs do exactly what their name implies: provide sterile needles to injection drug users in exchange for contaminated needles. Their primary purpose is to reduce and prevent the spread of blood-borne illnesses (Vlahov & Junge, 1998). Needle-sharing among injection drug users dramatically increases the prevalence of AIDS and the hepatitis B and C viruses (Hurley, Jolley, & Kaldor, 1997; Vlahov & Junge, 1998). Today, injection drug users represent 14% of individuals living with HIV (Centers for Disease Control and Prevention [CDC], 2016). For individuals who are unwilling, or think they are unable, to
give up injection drug use altogether, harm reduction is warranted (Vlahov & Junge, 1998).

To an overwhelming degree, research on the effectiveness of needle-exchange programs on reducing the consequences of injection drug use has produced positive results (World Health Organization [WHO], 2004). The spread of blood-borne illnesses decreases, and contrary to public fear, participants in needle exchange programs do not increase their levels of use, nor do persons begin using because of the availability of sterile needles (Vlahov & Junge, 1998; WHO, 2004). The exposure to contaminated needles decreases with proper disposal, both for injection drug users and other community members. These programs are cost-effective (WHO, 2004) and they create an environment where at-risk individuals are offered medical care, counseling, education, support groups, or referral to addiction treatment facilities (Alaei & Alaei, 2013; Hurley et al., 1997; Vlahov & Junge, 1998; WHO, 2004). As individuals participate in this harm reduction approach, drug using behaviors become safer (e.g., injection with sterile versus contaminated needles, proper disposal of used needles) and the consequences of use become less harmful, and sometimes even beneficial (e.g., exposure to otherwise avoided treatment options; Vlahov & Junge, 1998).

**Methadone maintenance programs.** Methadone maintenance is increasingly acknowledged as an evidence-based approach for treating opiate addiction and repeatedly shows greater efficacy than abstinence-only approaches (Jerry & Collins, 2013). It is not, however, a stand-alone treatment. Dole (1988) was quick to clarify that methadone maintenance is a corrective treatment used to arrest or reverse neurological damage
resulting from prolonged narcotic use. It is a way to facilitate the provision of treatment to individuals with opiate dependence. Methadone maintenance promotes the normalization of brain functioning so that individuals can effectively participate in supplemental treatment (Dole, 1988).

When compared to abstinence-only approaches, methadone maintenance has greater appeal, better retention rates, and is more effective in reducing substance use among heroin-dependent persons (Mattick, Breen, Kimber, & Davoli, 2009). Among long-term participants, this approach decreases exposure to risks associated with opiate use (e.g., HIV transmission, criminal activity) and increases overall functioning (Alaei & Alaei, 2013; Dole, 1988).

Controversies about methadone maintenance as a harm reduction approach primarily center on the belief that participants are simply replacing one drug for another; however, maintenance substances (e.g., methadone) (a) do not produce a “high,” (b) eliminate withdrawal symptoms, (c) drastically reduce cravings, and (d) block opiate receptors so that, in the event of relapse, individuals do not get “high” (Jerry & Collins, 2013). By managing the negative experiences and harmful consequences of opiate use, individuals can begin to actively participate in other rehabilitative services (Dole, 1988; Mattick et al., 2009).

**Controlled drinking programs.** Thinking that “controlled drinking” is synonymous with “harm reduction” is an American ideology (Heather, 2006). Harm reduction approaches to problematic drinking in Europe, for example, focus solely on reducing the negative consequences associated with drinking, not on reducing, or
controlling, the amount of alcohol consumed. The practice of controlled drinking requires that individuals adjust their levels of alcohol consumption. Controlled drinking programs help individuals acquire the skills needed to reduce, or eliminate, problematic drinking without requiring persons to completely abstain from alcohol use.

These programs have been successful when: (a) they include a period of abstinence, (b) there is continued contact with the treatment facility, (c) persons drink less than the maximum recommended amount, (d) there are periods of abstinence in between drinking days, and (e) drinking only occurs around others (Booth, 2005). The level of dependence on alcohol has influenced the perceived appropriateness of controlled drinking as a goal for some individuals (Rosenberg & Melville, 2005). Those with lower levels of alcohol dependence, or lesser severity of problem drinking, tend to fare better when practicing controlled drinking than their counterparts (Cox, Rosenberg, Hodgins, Macartney, & Maurer, 2004).

The philosophy behind controlled drinking stands in direct contrast to abstinence-only approaches. For individuals endorsing to the philosophy of Alcoholics Anonymous, believing that they cannot drink is tantamount to recovery (Cloud, McKiernan, & Cooper, 2003; el-Guebaly, 2005). Controlled drinking programs, on the other hand, seek to restore the belief that individuals can choose their behaviors, including the amount and frequency of drinking (Nelle, 2005). A recovery group founded in 1994 by Audrey Kishline, Moderation Management (MM), favors the latter belief system and remains the only non-abstinence based treatment program in the United States (Klaw & Humphreys, 2000; Lembke & Humphreys, 2012). Members of MM
reject the dominant perspective of problem-drinking as a disease where submission to a higher power and abstinence are required for recovery. Rather, they seek to achieve a working knowledge about controlled alcohol use and personal responsibility to arrest problem-drinking behaviors and learn to use alcohol without concern. They do this through health education and cognitive-behavioral techniques. A strong focus on self-control, personal responsibility, rational thinking patterns, and individual freedom engender the practice of MM.

Harm reduction approaches can be viewed as intermediate treatment. They serve as the middle ground on a continuum spanning from problematic substance use to abstinence. Just as a dietitian may suggest one small and manageable lifestyle change to promote better health (e.g., being sure to eat at least one serving of fruit per day) harm reduction practices can be understood as a stepping stone towards better health. They offer a gradual path to increased wellness for individuals who may not be ready or able to make dramatic lifestyle changes. Approaches that do not require total abstinence may appeal to and reach more people who need some level of treatment assistance, influencing change above and beyond the limited number of persons currently receiving care for substance use disorders (Arria & McClellan, 2012; Heather, 2006; Saladin & Santa Ana, 2004).

Treating SUDs using the principles outlined in these evidence-based treatments looks very different from the dominant treatment approach. Individualization and autonomy are honored. Clients are given increased authority over the treatment process; they’re listened to. Compassion, respect, and empathy are provided. Collaboration is at
work. These EBTs mirror current approaches used to treat other mental health disorders. They provide a menu of options. Ethical standards are met. Client perspectives are taken into account and collaborative treatment planning takes place.

**Addiction Professionals’ Decision Making**

It goes without saying that the decision to practice from a particular theoretical perspective and to recommend a particular treatment approach is largely dictated by providers. A relatively small number of studies has investigated how client variables influence addiction professionals’ decision making. Although few have investigated how client variables influence recommended treatment approaches, none has explored the influence of client variables on theoretical perspectives, or the recommendation of evidence-based treatments, specifically. A review of studies considering the effects of client variables on decision making is presented here. Although provider variables certainly influence these decisions, the primary focus of the current study is on the influence of client variables.

Samuelsson and Wallander (2013) studied the characteristics that influence providers’ assessment of substance use severity. Characteristics of clients, provider, and work environments were investigated. Specific attention was given to the characteristics of age, sex, ethnicity, and social status, of both clients and providers. This study used the factorial survey approach (Rossi & Nock, 1982) to assess providers’ judgments. Each respondent (i.e., provider) assessed a random sample of 10 fictitious vignettes ($N = 4,724$) that described people who used alcohol, cannabis, or cocaine. Nine client factors were studied: age, sex, ethnicity, social status, civil status, children, substance, frequency
of use, and type of negative consequence (e.g., health concerns, interpersonal turmoil).

Each factor had between two to five levels. *Levels* in the factorial survey approach refer to the breakdown of factors, different options that represent each factor (e.g., *substance* had three levels: alcohol, cannabis, cocaine). Respondents were asked to read each vignette and then rate the severity of substance use. Ratings occurred on a Likert scale ranging from 0 to 10 (i.e., *not severe at all* to *very severe*). Data about respondent characteristics were also collected: age, sex, education, occupational title, years in the field. Respondents were addiction care providers. Characteristics of the work environment included size, treatment philosophy, and target group. Although not explained, it is assumed that “target group” represents the treated clientele (e.g., adolescents, men, women). In the current study, similar client, provider, and workplace variables were investigated: (a) client’s drug of choice; (b) providers’ age, sex, education, and occupational title; and (c) providers’ workplace variables, including treatment philosophy.

Results of Samuelsson and Wallander’s (2013) study suggest that cannabis or cocaine use was seen as more problematic than alcohol use. Providers with social work degrees generally rated the substance use as less severe than providers with medical, or other, degrees. Social status influenced the assessment of severity, with less severe ratings given to individuals who were employed, regardless of substance used. Users in their 40s were assessed with greater severity than users in their 20s, and older providers assessed the use as more severe than younger providers. However, older providers
assessed users in their own age group as less severe, perhaps influenced by the providers’ own personal patterns of use.

The main effects (i.e., the effect of an independent variable on a dependent variable) of Samuelsson and Wallander’s (2013) study suggest that neither the users’ sex nor ethnicity influenced the providers’ assessments; however, interaction effects pointed to particular biases according to the users’ sex. For example, when children were involved, women were assessed more severely than their male counterparts. The presence of negative consequences also led to a more severe assessment when the user was a woman, as opposed to a man. Women were also rated more severely than men by providers with medical degrees, when compared to those with social work degrees. Clients’ drug of choice, social status, age, sex, children, and negative consequences, as well as providers’ educational concentration influenced decision making. Overlapping variables investigated in the current study include the clients’ drug of choice and providers’ educational concentration (e.g., counseling, social work).

Wallander and Blomqvist (2009) investigated the factors that influence social workers’ decisions to recommend inpatient or outpatient treatment. They also used Rossi and Nock’s (1982) factorial survey approach. Each respondent assessed 15 fictitious vignettes. Vignettes included a variation of 11 client characteristics, or variables (e.g., primary drug, treatment experience, treatment preference), and there were two, three, or five levels for each variable. Respondents offered decisions about each vignette, suggesting either inpatient or outpatient treatment as most suitable for the client described. Respondents also answered a demographic questionnaire about themselves.
Part of the demographic questionnaire asked respondents to identify their personal belief about the necessity of treatment for substance use disorders. Variables about the providers’ work settings were also explored. The current study investigated similar client and provider variables. For example, drug of choice, treatment experience, treatment preference, and work setting were explored in the current study, as well.

The respondent sample for Wallander and Blomqvist’s (2009) study included 205 frontline social workers and managers, representing 36 treatment facilities in Stockholm, Sweden. The recommended treatment approach was most influenced by clients’ previous treatment experiences and treatment preferences. Treatment preference was represented by three levels: none, outpatient, or inpatient. Each level was represented by different textual phrases: (a) does not express a preference regarding treatment form, (b) would like the opportunity to stay at home during treatment, or (c) wishes to get away from home during treatment, respectively. Other influencing variables included clients’ method of drug use (e.g., oral, injection) and drug of choice (e.g., alcohol, amphetamines, heroin). Social support network, living arrangement, mental health status, and age were also taken into account. Clients’ sex was the only variable that did not influence providers’ decision making. Regarding the demographics of respondents (i.e., social workers and managers), their beliefs about the necessity of treatment for substance use disorders largely influenced their decision to recommend inpatient or outpatient treatment. These results further justify the investigation of clients’ drug of choice, previous treatment experiences, and treatment preferences on decision making.
Wryobeck and Rosenberg (2005) studied how client characteristics influence psychologists’ decisions to recommend one of two harm reduction approaches: needle exchange or short-term methadone treatment. Research indicates that providers differ on their beliefs about the appropriateness of such approaches, but little is known about the process by which these providers make their decisions (Wryobeck & Rosenberg, 2005). Client characteristics considered in Wryobeck and Rosenberg’s study included sex, race, legal status, years of substance use, previous treatment history, employment history, and HIV status. The clients’ ambivalence to change was held constant in each case.

Wryobeck and Rosenberg (2005) used a “policy-capturing” methodology to study respondents’ judgments. Just like Rossi and Nock’s (1982) factorial survey approach, the policy-capturing design presents respondents with fictitious client cases. Different client characteristics (e.g., HIV status, treatment history) represent the independent variables and respondents’ judgments, or decisions (e.g., treatment recommendations), represent the dependent variables. Multiple regression analysis was then used to identify which client characteristics influenced respondents’ decision making.

Respondents in Wryobeck and Rosenberg’s (2005) study were 120 psychologists who were randomly assigned to each condition (i.e., needle exchange or short-term methadone treatment), with an equal number in both groups. Thirty-three psychologists returned the survey, yielding a 27.5% response rate and representing the study’s respondent sample. A total of 1,536 fictitious client cases were created, representing the different levels of client characteristics (a 2 x 3 x 2 x 4 x 4 x 2 x 2 x 2 design). Fictitious client cases that were unrealistic or unbelievable (e.g., someone with a 1–2 year history
of drug use and six or more previous treatment episodes) were eliminated from the total possible cases. From that pool, 64 cases were randomly selected and sent to participants for review.

Each of the 120 psychologists reviewed the same 64 cases, and was asked to rate how acceptable either needle exchange or short-term methadone treatment was for each respective case. In addition, respondents were asked to rate how important each client characteristic was in their decision making, and to provide demographic information about themselves. Wryobeck and Rosenberg’s (2005) study suggests that the acceptance of, or attitude about, needle exchange by respondents was most influenced by clients’ HIV status (i.e., when clients were positive for HIV) and previous treatment experience. Some respondents endorsed the use of needle exchange regardless of client characteristics (i.e., client characteristics did not matter). The acceptance of short-term methadone use was most influenced by clients’ previous treatment experience, years of substance use, and legal/employment statuses. These results give reason to further investigate the influence of clients’ previous treatment experiences on providers’ decision making.

Breslin, Gladwin, Borsoi, and Cunningham (2000) used an ethnographic methodology (i.e., decision tree modeling) to describe and predict providers’ decisions to recommend long- or short-term treatment for persons with substance use disorders. The purpose of their study was to identify the factors that influenced providers’ decisions to select one of two treatment options (i.e., long- or short-term outpatient treatment) for clients who had completed an intake. Semi-structured interviews were conducted with 11
providers, and real-life recommendations were collected (i.e., actual recommendations made by providers). Providers worked at an addictions treatment facility in Toronto, and routinely completed intake assessments and made referrals.

Data analysis for Breslin et al.’s (2000) study included identifying the reasons behind the referrals, transcribing those reasons onto index cards, and then sorting the index cards into categories. Categories were then labeled and summarized, leading to the construction of a decision tree for making referrals. Results suggest that providers commonly defaulted to long-term treatment recommendations (Breslin et al., 2000). Client factors influencing providers’ decisions to refer to long- or short-term outpatient treatment included: severity of substance use, use of one or multiple substances, legal status, perception of substance use severity, consequences of use, coping skills, social support, previous treatment history, previous relapse experience, willingness to fulfill outside requirements (i.e., homework), verbal and cognitive abilities, goodness-of-fit (i.e., how likely clients were to fit in with their group members), need for specialized groups (e.g., women, gay men), and flexibility of scheduling. This was the only study that investigated clients’ goodness-of-fit within the realm of treatment. The current study considered a similar principle by exploring the “goodness-of-fit” between (a) a client’s understanding of substance use and preferred treatment goals and (b) providers’ theoretical perspectives and recommended treatment approaches. Other similarities considered in the current study included the influence of a client’s previous treatment history and willingness to fulfill outside requirements (e.g., preferred treatment goals).
Lordan, Kelley, Peters, and Siegfried (1997) studied how substance abuse professionals make treatment decisions. Specifically, they were interested in identifying what criteria these professionals use when making their decisions. Twenty-five professionals participated in a five-part, in-depth interview to identify what criteria are used when determining treatment recommendations. During the first part of the interview, participants were asked to recall their five most recent clients, and then discuss the reasons behind each client’s treatment recommendation. In the second phase, participants received a form describing the eight most common treatment placements used in Pennsylvania, where the study took place. They were then given five fictitious client cases, and asked to recommend one of the eight treatment placements for each respective case. Participants could also recommend no treatment. A discussion about the decision making process followed. Next, participants were asked to argue against the placement of each client into a treatment setting other than the one they recommended. Finally, participants were asked to identify what treatment setting they would identify as the next most restrictive (i.e., in comparison to the already selected treatment setting) for each client, and then to identify what would need to be different in the fictitious case scenario to warrant recommending that setting.

Lordan et al. (1997) noted that previous research had identified 10 factors that influence providers’ decision-making: substance abuse history; emotional/behavioral/psychiatric status; medical/physical history; treatment history; treatment acceptance/resistance; family/social network; employment/vocational/educational support status; legal status; demographic data; and, spiritual beliefs/values. The third phase of the
interview process asked participants to rank order these 10 factors from most to least important, in terms of how they influenced their decision making. The fourth phase asked participants to identify the top 10 questions they would ask new clients when conducting an assessment. Then, participants were given the opportunity to identify 10 more questions they would ask. These questions were not predetermined; participants wrote them out as the study progressed. The fifth and final part of the interview involved participants describing real-life situations where their decisions were uncertain, and discussing variables they believed would have helped them determine the appropriateness of long- or short-term treatment recommendations.

Lordan et al. (1997) found the following five client variables had the most influence on providers’ decision making: (a) substance abuse history, (b) past treatment experiences, (c) motivation for treatment, (d) support systems, and (e) mental health status. In addition to these five client variables, providers also considered the ability of the treatment facility to accommodate the treatment preferences of clients, and the clients’ ability to pay for services. Directly or indirectly, all five of these client variables were investigated in the current study, as well as the ability of providers to accommodate clients’ treatment preferences within their work setting.

Previous studies have identified variables that influence addiction professionals’ decision making. Client variables include age, sex, drug of choice, substance abuse history, severity of substance use, previous treatment experiences, previous relapse experience, consequences of use, treatment preferences, motivation for treatment, need for specialized groups, goodness-of-fit (i.e., how likely clients are to fit in with their
group members), mental health status, coping skills, verbal and cognitive abilities, social support, living arrangements, and legal, employment, and health statuses. Provider variables include educational concentration and personal beliefs about the necessity of treatment. Work place variables include the ability of the treatment facility to accommodate clients’ treatment preferences and clients’ ability to pay for services.

Two of the four client variables considered in the current study have been shown to influence providers’ decision making: drug of choice and previous treatment experience. Although “treatment preference” has also been shown to influence decision making in the aforementioned studies, the specific variable of clients’ preferred treatment goal has not been considered. “Goodness-of-fit” could be thought of as a link between (a) clients’ understanding of substance use and providers’ selection of a theoretical perspective or (b) clients’ preferred treatment goal and providers’ recommended treatment approach, but these connections have not been investigated, explicitly. The current study endeavored to fill this research gap.

**Catering to Client Preferences**

Treatment philosophies (i.e., theoretical perspectives) may or may not be appealing to clients and, consequently, responses to or acceptance of treatment by clients may vary depending on their beliefs (Cheney, Galanter, Dermatis, & Ross, 2009; Jorm, 2000; Klingemann & Bergmark, 2006; Mankowski, Humphreys, & Moos, 2001). The importance of a treatment process developed by both client and counselor to promote agreement between process and goals has been stressed (Friedrichs et al., 2016; Godolphin, 2009; Joosten, De Weert-Van Oene, Sensky, Van Der Staak, & De Jong,
Jorm maintained that promoting treatment philosophies at odds with client perspectives, philosophies, or belief systems can lead to treatment avoidance or premature disengagement from treatment.

There is a difference between how clients and counselors understand substance use disorders; therefore, a difference also exists between understanding effective treatments (Klingemann & Bergmark, 2006) or identifying treatment goals (Joosten et al., 2009). When clients feel confident working within a particular therapeutic modality and when they believe they and their counselors are working toward the same goal, their perceptions of treatment are increasingly positive and resistance to treatment decreases (Cournoyer, Brochu, Landry, & Bergeron, 2007). Using treatment philosophies consistent with client preferences increases compliance, satisfaction, and positive outcomes (Dumchev, Schumacher, Slobodyenyuk, Zhu, & Richman, 2007; Klingemann & Bergmark, 2006; Smiley-McDonald & Leukefeld, 2005).

Klingemann and Bergmark (2006) encouraged individualized treatment planning that aligns with client perceptions. They noted that individualized treatment plans need to be comprehensive (i.e., involving familial, spiritual, or innovative elements) and challenging to interventions that lack empirical support for effectiveness. They also encouraged departure from the current hierarchy of treatment: the traditional assumption that clients who receive treatment for SUDs are in denial, passive, and ignorant about what services might best ameliorate their discomfort. They challenged helping professionals to consider clients’ world-views and to combine these world-views with congruent theoretical perspectives and treatment approaches.
There is a general consensus among helping professionals that tailoring treatment to individual client needs contributes to greater success rates (Cheney et al., 2009; Finney & Moos, 1984; Friedrichs et al., 2016; Klingemann & Bergmark, 2006; Thornton, Gottheil, Weinstein, & Kerachsky, 1997). Consideration of client experiences as they relate to the treatment setting, philosophy, staff, or treatment as usual leads to micro- and macro-level adjustment aimed at meeting client needs. Clients should be afforded the opportunity to select treatment approaches from a range of options (Arria & McLellan, 2012; Klingemann & Bergmark, 2006) and clinicians should identify and magnify client selections during treatment implementation (Cheney et al., 2009). Treatment options should reflect the various theories of addiction so that treatment approaches parallel and complement clients’ understanding of, or beliefs about, the etiology, maintenance, and treatment of their condition.

Studies show that clients differ in their understanding of addiction (see Aten, Mangis, & Campbell, 2010; Connors & Franklin, 2000; Klaw & Humphreys, 2000; Lovejoy et al., 1995; McCorkel, Harrison, & Inciardi, 1998; Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996; Smith & Marsh, 2002; Ward, 2011). Previous research shows that several of the theories covered in this chapter have been described by client explanations of addiction. For example, client explanations have represented the disease or medical model (Aten et al., 2010; Connors & Franklin, 2000; McCorkel et al., 1998), secondary substance abuse model (Smith & Marsh, 2002; Ward, 2011), self-medication hypothesis (Ward, 2011), general dysphoria theory (Ward, 2011), secondary psychopathology model (Ward, 2011), bidirectional model (Ward, 2011), psychoanalytic
theory (McCorkel et al., 1998; Ward, 2011), behavioral theory (Klaw & Humphreys, 2000; Lovejoy et al., 1995), cognitive theory (Klaw & Humphreys, 2000; Lovejoy et al., 1995), sociocultural theory (McCorkel et al., 1998; Nelson-Zlupko et al., 1996), behavioral choice theory (Lovejoy et al., 1995), and stress and coping theory (Nelson-Zlupko et al., 1996).

Likewise, several of the evidence-based treatment approaches covered in this chapter can be linked to clients’ preferred treatment goals. Motivational interviewing (Laudet, Stanick, & Sands, 2009), relapse prevention (Lovejoy et al., 1995), contingency management (Lovejoy et al., 1995), 12-step facilitation (Aten et al., 2010; Laudet et al., 2009), adjunctive pharmacotherapy (Nelson-Zlupko et al., 1996), and harm reduction (Klaw & Humphreys, 2000; Laudet et al., 2009; Sell & Zador, 2004; Smith & Marsh, 2002) have all been identified as treatment approaches that match clients’ preferred treatment goals. In addition to linking preferred treatment goals to these treatment approaches, clients have also described their experiences with treatment approaches that they regard to be incompatible with their treatment preferences: adjunctive pharmacotherapy (Aten et al., 2010; Nordfjærn, Rundmo, & Hole, 2010) and 12-step facilitation (Klaw & Humphreys, 2000).

Clients prefer individualized and collaborative treatment planning (Friedrichs et al., 2016; McCorkel et al., 1998; Nelson-Zlupko et al., 1996; Nordfjærn et al., 2010; Ward, 2011). Satisfaction with treatment increases when there is congruence between providers’ treatment philosophies (i.e., theoretical perspectives) and clients’ belief systems (Aten et al., 2010; Hogan, Hershey, & Ritchey, 2007; Klaw & Humphreys, 2000;
Larios, Wright, Jernstrom, Lebron, & Sorensen, 2011; Nordfjærn et al., 2010; Ritter et al., 2002; Sell & Zador, 2004; Smith & Marsh, 2002). Without individualized and collaborative treatment planning, and without working from a treatment philosophy that honors client preferences, treatment receives increasingly negative client appraisals (Al-Tayyib & Koester, 2011; Laudet et al., 2009; McCorkel et al., 1998; Nordfjærn et al., 2010). These negative appraisals stem from clients feeling a loss of autonomy (McCorkel et al., 1998), feeling unheard or misunderstood (even stigmatized; Ward, 2011), and believing that treatment is punitive (Melnick, Hawke, & Wexler, 2004), conflictual and unhelpful (McCorkel et al., 1998). Not offering individualized treatment also leads to premature termination and discouragement (McCorkel et al., 1998), as well as clients electing no treatment over mandated treatment approaches (Klaw & Humphreys, 2000).

Research about individualized treatment planning is not new. Recommendations for clients to be offered a wide array of treatment options or services, options and services that reflect client preferences, have been made known (Arria & McLellan, 2012; Klingemann & Bergmark, 2006). Several researchers have advocated for active participation and collaboration between client and provider (i.e., shared-decision making; Friedrichs et al., 2016; Godolphin, 2009; Klingemann & Bergmark, 2006), promoting negotiation between the two when identifying a working philosophy and establishing treatment goals. Klingemann and Bergmark (2006) have also noted the importance of treating more than a symptom (i.e., the substance use) and incorporating other social, occupational, and interpersonal elements into treatment and recovery (e.g., affect or
spirituality). It is essential for providers to work within the parameters of client preferences if they expect to retain clients and to offer the most efficacious treatment. For some clients, having a provider who is able to work within their belief system and respect their understanding of addiction is tantamount to successful treatment (Aten et al., 2010).

**Purpose of the Current Study and Research Questions**

The current study was prompted by the ethical concern that, despite the vast array of treatments with empirical support, what is commonly practiced in addiction treatment is not supported by research (Arria & McLellan, 2012; Scott, 2000). This directly violates sections C.7.a. and C.7.c. of the *ACA Code of Ethics* (2014). Scott (2000) noted that this practice is maintained mostly because providers base their treatment decisions on personal and anecdotal experiences, a violation of section A.4.b. of the *ACA Code of Ethics* (2014). Scott (2000) also noted that providers tend to subscribe to one theoretical orientation and disregard other orientations that have equal or greater empirical support, violating sections A.4.b., C.7.a., C.2.f., and C.7.c. of the *ACA Code of Ethics* (2014).

There is a tendency towards uniform treatment planning that neglects individualization based on client preferences (Arria & McLellan, 2012; Scott, 2000), a violation of sections A.1.c. and E.5.b. of the *ACA Code of Ethics* (2014). There is a need, and a clear ethical obligation, for addiction professionals to adopt theoretical perspectives and implement treatment approaches supported by research (Arria & McLellan, 2012).

This can be accomplished by honoring client autonomy, an ethical principle, and collaborating with clients to establish treatment goals, an ethical requirement (ACA Code
of Ethics, 2014, Section A.1.c). The decision-making process varies among helping professionals (i.e., different people take different variables into consideration when making decisions; Hays, McLeod, & Prosek, 2009). However, far too often addiction professionals do not take into consideration the needs or preferences of clients (Arria & McClellan, 2012). The purpose of the current study was to investigate addiction professionals’ consideration of client variables during the decision-making process. Four client variables were studied: drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal. How these variables affected two aspects of providers’ decision making, selection of a theoretical perspective and recommended treatment approach, was explored. Research questions were as follows:

1. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understandings of substance use?

2. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal?

**Chapter Summary**

This chapter presented an overview of the prevalence of substance use in the United States. Ethical codes outlining the expectation for individualized client care were
also identified. Six prominent theories of addiction were detailed, as well as 13 sub-theories, or models, of addictive behavior. Definitions of evidence-based practice and evidence-based treatment were given, and six examples of current evidence-based treatments were described. A discussion about addiction professionals’ decision making related to the consideration of client preferences followed. Lastly, the purpose of the current study and research questions were stated.

The purpose of the current study was to investigate the effects of client variables on addiction professionals’ decision making. Two research questions guided the investigation:

1. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understandings of substance use?

2. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal?

Chapter 2 identifies the current study’s participants and explains the study’s procedures. Descriptions of the research methodology, instrumentation, and data collection are presented. The data analysis processes are identified and the research questions are reviewed, once again.
CHAPTER II

METHODOLOGY

The current study used a factorial survey approach to examine the effects of client variables on addiction professionals’ decision making. Four client variables were explored: drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal. Decision making was measured by addiction professionals’ selection of a theoretical perspective and a recommended treatment approach. This chapter details the current study’s respondents (i.e., participants), research methodology, instrumentation, and data collection and data analysis procedures. Participants are referred to as respondents in the factorial survey approach; therefore, the term respondent is used to reflect the current study’s participants from this point forward.

The current study considered the effects of four client variables on two measures of addiction professionals’ decision making. Two research questions were explored:

1. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understandings of substance use?

2. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal?
Respondents

Respondents were active members of the Association for Addiction Professionals (NAADAC). Table 1 displays respondent demographics. Respondent ages ranged from 26–82 years, with a mean of 52.6 years. Respondents were 39% male and 61% female; this statistic is representative of NAADAC’s membership at the time of the study (i.e., 40% male and 60% female). The majority of respondents were Caucasian (87%) and identified as Christian (60%). Most respondents held a master’s degree (62%), and most had addiction-specific training: ranging from 60–95% depending on the area of training. The vast majority (88%) were credentialed as an Alcohol/Other Drug Counselor, and the most frequently held professional license was that of Professional Counselor (50%). Roughly 45% of respondents identified as being in recovery and approximately 84% indicated having a friend or family member who identified as being in recovery.

Respondents were employed in the following U.S. regions: (a) Northeast (17%), (b) South (36%), (c) Midwest (25%), and (d) West (22%).

Table 2 presents respondents’ level of familiarity with the theoretical perspectives and treatment approaches explored in the current study. Respondents were most familiar with disease and cognitive behavioral perspectives of substance use. They were most familiar with the treatment approaches of relapse prevention, 12-step facilitation, and motivational interviewing.
Table 1

**Respondent Demographics**

<table>
<thead>
<tr>
<th></th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36 (38.7)</td>
</tr>
<tr>
<td>Female</td>
<td>57 (61.3)</td>
</tr>
<tr>
<td><strong>Age (in years)</strong></td>
<td></td>
</tr>
<tr>
<td>Range 26-82</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>52.6</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>81 (87.1)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Asian</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>More than one</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td><strong>Religious/Spiritual affiliation</strong></td>
<td></td>
</tr>
<tr>
<td>Christianity</td>
<td>56 (60.2)</td>
</tr>
<tr>
<td>Judaism</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Islam</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Hinduism</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Buddhism</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td>Non-Religious</td>
<td>20 (21.5)</td>
</tr>
<tr>
<td>Other</td>
<td>9 (9.7)</td>
</tr>
<tr>
<td><strong>Highest level of education</strong></td>
<td></td>
</tr>
<tr>
<td>Associate’s Degree</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>17 (18.3)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>58 (62.4)</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>11 (11.8)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td><strong>Received training in</strong></td>
<td></td>
</tr>
<tr>
<td>Theories of Addiction</td>
<td>85 (91.4)</td>
</tr>
<tr>
<td>Counseling Procedures and Strategies with Addicted Populations</td>
<td>87 (93.5)</td>
</tr>
<tr>
<td>Group Process and Techniques Working with Addicted Populations</td>
<td>87 (93.5)</td>
</tr>
<tr>
<td>Assessment and Diagnosis of Addiction</td>
<td>86 (92.5)</td>
</tr>
<tr>
<td>Relationship Counseling with Addicted Populations</td>
<td>56 (60.2)</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>76 (81.7)</td>
</tr>
<tr>
<td>Prevention Strategies</td>
<td>75 (80.6)</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>87 (93.5)</td>
</tr>
<tr>
<td>Legal and Ethical Issues Pertaining to Chemical Dependency</td>
<td>84 (90.3)</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (continued)

Respondent Demographics*

<table>
<thead>
<tr>
<th></th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crede</strong>ntialed as an Alcohol/Other Drug Counselor**</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81 (88.0)</td>
</tr>
<tr>
<td>No</td>
<td>11 (12.0)</td>
</tr>
<tr>
<td><strong>Professional licenses held</strong></td>
<td></td>
</tr>
<tr>
<td>Professional Counselor</td>
<td>46 (50.0)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>15 (16.3)</td>
</tr>
<tr>
<td>Marriage and Family Therapist</td>
<td>8 (8.7)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Other</td>
<td>36 (39.1)</td>
</tr>
<tr>
<td>Addiction-specific License or Certification</td>
<td>24 (26.1)</td>
</tr>
<tr>
<td>Pending licenses</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>No license or certificate</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td><strong>Primary work setting</strong></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>College/University</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Detoxification</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Residential/Inpatient Facility</td>
<td>15 (16.3)</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>33 (35.9)</td>
</tr>
<tr>
<td>Halfway or ¾ House</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Community Mental Health Center</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>College/University Health Center</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Other</td>
<td>36 (39.1)</td>
</tr>
<tr>
<td>Private Practice</td>
<td>13 (14.1)</td>
</tr>
<tr>
<td>Specific Organization</td>
<td>8 (8.7)</td>
</tr>
<tr>
<td>Hospital/Emergency Department</td>
<td>5 (5.4)</td>
</tr>
<tr>
<td>Prison/Probation</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Government/Military</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td><strong>Treatment philosophy of clinical work setting</strong></td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>36 (39.6)</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>24 (26.4)</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (8.8)</td>
</tr>
<tr>
<td>Not Applicable (Employed in a non-clinical work setting)</td>
<td>21 (23.1)</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (continued)

**Respondent Demographics***

<table>
<thead>
<tr>
<th>Permitted to work from a different treatment philosophy than that endorsed by clinical work setting</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>43 (60.6)</td>
</tr>
<tr>
<td>No</td>
<td>2 (2.8)</td>
</tr>
<tr>
<td>Somewhat</td>
<td>26 (36.6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permitted to offer treatment approaches that differ from those endorsed by clinical work setting</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>51 (71.8)</td>
</tr>
<tr>
<td>No</td>
<td>3 (4.2)</td>
</tr>
<tr>
<td>Somewhat</td>
<td>17 (23.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred theoretical orientation (instructed to select only one)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlerian</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Behavior</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Cognitive-behavioral</td>
<td>32 (34.8)</td>
</tr>
<tr>
<td>Existential</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Family and Couples</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Feminist</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Gestalt</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Narrative</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Person/Client-centered</td>
<td>25 (27.2)</td>
</tr>
<tr>
<td>Psychoanalytic/Psychodynamic</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Reality/Choice</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>Solution-focused</td>
<td>4 (4.3)</td>
</tr>
<tr>
<td>Spiritual/Religious</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>Other</td>
<td>10 (10.9)</td>
</tr>
<tr>
<td>Eclectic</td>
<td>7 (7.6)</td>
</tr>
<tr>
<td>Rational Emotive Therapy</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Positive Psychology</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>Biopsychosocial</td>
<td>1 (1.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routinely receive supervision</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56 (61.5)</td>
</tr>
<tr>
<td>No</td>
<td>35 (38.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routinely provide supervision</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35 (38.5)</td>
</tr>
<tr>
<td>No</td>
<td>56 (61.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identifies as someone in recovery</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41 (44.6)</td>
</tr>
<tr>
<td>No</td>
<td>51 (55.4)</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (continued)

**Respondent Demographics***

<table>
<thead>
<tr>
<th></th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a friend(s) or family member(s) who identifies as someone in recovery</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>77 (83.7)</td>
</tr>
<tr>
<td>No</td>
<td>15 (16.3)</td>
</tr>
<tr>
<td>Region of employment in the United States</td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>15 (17.0)</td>
</tr>
<tr>
<td>South</td>
<td>32 (36.3)</td>
</tr>
<tr>
<td>Midwest</td>
<td>22 (25.0)</td>
</tr>
<tr>
<td>West</td>
<td>19 (21.6)</td>
</tr>
</tbody>
</table>

*Not all respondents completed the demographic portion of the instrument, though they may have provided responses to vignettes. The frequencies presented in Table 1 are based on those who completed each respective section of the demographic questionnaire. Therefore, percentages may not reflect the total sample of respondents.

Table 2

**Respondents’ Level of Familiarity With Theoretical Perspectives and Treatment Approaches**

<table>
<thead>
<tr>
<th>Theoretical Perspectives</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>2.9</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>2.3</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>2.8</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>2.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Approaches</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivational Interviewing</td>
<td>2.8</td>
</tr>
<tr>
<td>Relapse Prevention</td>
<td>2.9</td>
</tr>
<tr>
<td>Contingency Management</td>
<td>2.0</td>
</tr>
<tr>
<td>Twelve-Step Facilitation</td>
<td>2.8</td>
</tr>
<tr>
<td>Adjunctive Pharmacotherapy</td>
<td>2.3</td>
</tr>
<tr>
<td>Harm Reduction</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Note. Range 1-3 (1 = not at all familiar, 2 = somewhat familiar, 3 = very familiar). N = 92.*
Procedures

The following section explains how respondents were recruited for the current study. It also offers a detailed description of the research methodology, the instrumentation process, and components of the pilot study. Data collection procedures are also outlined.

Respondent Recruitment

The current study was approved by the Kent State University Institutional Review Board (IRB approval #15-321; see Appendix A). At the time of the study, NAADAC had approximately 8,600 members (40% male and 60% female) and approximately 8,140 available email addresses (Candy Brecht, personal communication, January 29, 2015). No other demographic data about NAADAC members were available.

Respondents were surveyed using an online format. Invitations to participate in the current study were sent to a random sample of 1,274 potential respondents, a number determined by NAADAC. An email was used to recruit respondents (see Appendix B), and invited NAADAC members were sent three reminder emails (see Appendix C). The emails were sent by NAADAC’s Senior List Operations Manager. The researcher did not obtain or have access to respondent names or email addresses. One-hundred twenty-four people participated in the current study, yielding a response rate of 9.7%.

Research Methodology

The current study used the factorial survey approach (Rossi & Nock, 1982) to investigate addiction professionals’ decision making. The factorial survey approach uses randomly constructed vignettes for data collection. These vignettes are intended to
represent hypothetical and lifelike scenarios. Respondents address a series, or collection, of vignettes, and this collection of vignettes is called the *respondent subsample* (Rossi & Anderson, 1982). The respondent subsample is a random sample of all possible vignettes derived from a factorial design.

Rossi and Nock (1982) designed the factorial survey approach to identify variables that influence such complex processes as decision making, or judgments. This approach is inherently hierarchical, or multilevel (Hox, Kreft, & Hermkens, 1991). This means that data are gathered at both the vignette and respondent levels. In addition, vignettes are hierarchically nested within respondents (Hox et al., 1991). This means that each respondent is asked to provide multiple responses across time (i.e., a repeated measures design); they are asked to address multiple vignettes. Two regression equations result: (a) one that considers the effects of the vignette characteristics on the decision making, and (b) one that consider the effects of respondent characteristics on the decision making (Hox et al., 1991). Rossi and Nock (1982) explained that unlike full factorial designs where only a few independent variables can be studied at once, the factorial survey approach allows researchers to manipulate an unlimited number of independent variables—and levels of those independent variables—in their vignettes.

The factorial survey approach stems from three basic assumptions about decision making (Rossi & Anderson, 1982). First, it is assumed that people only pay attention to a limited number of variables (i.e., contextual factors or characteristics) when making decisions. Second, decisions have some social context; that is, there are social norms dictating that one variable is more important than another, or that the presence of a
particular combination of variables should have more bearing on how decisions are made than the presence of other combinations of variables. Lastly, individuals differ in their decision making processes, but these differences will consistently depart from established social norms. For example, an addictions care provider may consistently encourage harm reduction approaches during the beginning of treatment even though the social norm (e.g., in the context of that provider’s work environment or treatment setting) is to encourage abstinence only.

Rossi and Anderson (1982) also asserted that decisions are rarely made from scratch (i.e., without any preconceived notions). Rather, decision making is influenced by personal preferences: individuals will make choices based on what they believe is most appealing or appropriate. The questions that guided Rossi and Nock’s (1982, p. 19) development of this approach were intended to expose the underlying principles of the decision making process: “what information is used in making judgments . . . And how do individuals differ in the ways in which information of different sorts is combined?” They posited that even though different people will generally make different decisions, the norm is that decisions will reflect the most common and uniform practices (e.g., referral to 12-step meetings).

In the factorial survey approach, several fictitious vignettes are read by respondents, and respondents are then asked to make decisions about each of the vignettes. This vignette technique uses randomly constructed vignettes intended to represent real life scenarios and are used to investigate how certain variables (e.g., client characteristics), standing alone or in combinations, influence decision making. The
factorial survey approach is one of the more sophisticated methods of studying decision making because it randomly assigns levels of independent variables to the vignettes, and it also randomly assigns a respondent subsample to respondents for review (Taylor, 2006).

Most survey research faces the issue of multicollinearity (i.e., high correlation) among the variables studied (Rossi & Anderson, 1982). This can make it difficult for researchers to identify which variable, or combination of variables, is actually influencing the results. The experimental design used in the factorial survey approach eliminates the problems associated with multicollinearity (Jasso, 2006) by randomly assigning different levels of different variables to each of the vignettes, promoting orthogonality (i.e., independence) among the variables studied. This orthogonality makes it possible for researchers to identify which variable, or combination of variables, is influencing results.

The factorial survey design can accommodate several variables with many levels, or categories, producing increasingly lifelike vignettes (Rossi & Anderson, 1982; Taylor, 2006). The idea that many variables produce increasingly lifelike vignettes comes from an understanding that situations found in real life are complicated and complex, influenced by socioeconomic status, level of education, interpersonal relationships, and mental health or other medical history, to name a few. Rossi and Anderson (1982) explained the factorial survey approach in this way: “from the experimental tradition, the factorial survey borrows and adapts the concept of factor orthogonality and from the survey tradition it borrows the greater richness of detail and complexity that characterizes real-life circumstances” (p. 16). Ganong and Coleman (2006) explained that the
approach combines “elements of experimental designs and probability sampling, with the inductive, exploratory approach of qualitative research” (p. 455). In other words, the factorial survey approach allows researchers to see how a broad domain of variables, both individually and combined with one another, influences decision making.

Identifying independent variables and incorporating them into the vignette is important (Stokes & Schmidt, 2012). Independent variables are selected based on clinical knowledge and practice, previous research, and a review and understanding of the scholarly literature on the topic investigated (Jasso, 2006; Ludwick et al., 2004; Taylor, 2006); they also can be categorical, ordinal, or interval (Taylor, 2006). The current study used independent variables that were categorical. Levels of each independent variable are randomly assigned to the vignette format until a complete vignette is constructed. As previously noted, constructed vignettes should resemble real life scenarios; therefore, the selected variables and levels need to represent characteristics that are common in everyday practice (Rossi & Anderson, 1982). If there are variables that people consider to be important, even when contradicted by research findings, it is recommended to include those variables because they likely influence the decision making (Jasso, 2006).

When all possible vignettes have been developed, the study’s vignette pool (i.e., the vignette universe; Rossi & Nock, 1982) has been created. A review of the vignette pool is then done, and vignettes that are unbelievable or unrealistic are removed (Jasso, 2006). The current study controlled for unrealistic scenarios by only including levels of independent variables that are realistic when combined. Therefore, vignettes were not removed from the vignette pool. For example, it is realistic for a client to attend
inpatient/residential treatment when using any of the drugs of choice presented in the current study (alcohol, pain relievers, tranquilizers, cocaine, heroin), but it is unrealistic for a client to attend inpatient/residential treatment when using marijuana, alone. Because of this, marijuana was omitted as a possible drug of choice. Had marijuana been included in the current study, any vignette with a pairing of marijuana and inpatient/residential treatment would have been removed from the vignette pool.

Studies using the factorial survey approach have generated high internal and external validity (Ludwick & Zeller, 2001; Stokes & Schmidt, 2012; Taylor, 2006) as well as robustness (Stokes & Schmidt, 2012; Taylor, 2006). The random combination of variables within each vignette contributes to the high internal validity (Ganong & Coleman, 2006; Landsman & Hartley, 2007; Taylor, 2006). External validity is high because respondent decisions mirror those made in real life (Stokes & Schmidt, 2012; Taylor, 2006). In other words, respondents are assessing multiple scenarios that reflect what they likely see in real life. In addition, the uniform wording of the variables reduces interpretation bias (Landsman & Hartley, 2007). Robustness is increased because the vignettes, being independent of one another, serve as the primary unit of analysis (Stokes & Schmidt, 2012). The sample size is thus determined by the number of vignettes responded to, maximizing statistical power (Landsman & Hartley, 2007). Given the hierarchical nature of the design, the influence of respondent variables (e.g., recovery status) on decision making is sometimes analyzed as well (Taylor, 2006).

In the current study, 320 fictitious client vignettes were created (i.e., the vignette pool), derived from a 5x4x4x4 factorial design (see Table 3). All vignettes depicted a
Table 3

Description of Vignette Variables, Levels, Wording, and Intended Theoretical and Treatment Matches

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Variable Levels and Wording</th>
</tr>
</thead>
</table>
| Client’s Drug of Choice (5 Levels) | 1—Alcohol  
  2—Pain Relievers  
  3—Cocaine  
  4—Tranquilizers  
  5—Heroin |
| Client’s Previous Treatment Experience (4 Levels) | 1—Never received any kind of addiction treatment  
  2—Attended self-help groups in the past year  
  3—Attended outpatient rehabilitation in the past year  
  4—Attended inpatient/residential rehabilitation in the past year |
| Client’s Understanding of Substance Use (4 Levels) | 1—Predisposition, “something genetic.” He says that he “just can’t stop using.” He tried to control his use but he “fails every time.” He’s also heard that there’s “no cure for addiction” and that all he can do is manage it by not using at all. (Disease)  
  2—Depression. He says that his life “sucks” and that it always has. He mentioned growing up with a “jerk of a father” and that his home life was “flat out miserable.” He reported that “nothing has really changed” and that the present is “just as miserable as the past.” He says that using is “just how I cope” with his depression. (Psychoanalytic)  
  3—Habit. Substances “give me what I want—the best kind of relief.” Anytime he’s “looking to relax” or when he’s “craving a pick-me-up,” using is a “guaranteed fix.” He says its “great for managing withdrawal, too!” (Cognitive Behavioral)  
  4—Environmental. He says “it’s just how I am, it’s what I do.” In fact, he noted that “it’s how all of my friends are . . . and my family, too.” It’s what he saw growing up—“perfectly normal!” (Sociocultural) |
| Client’s Preferred Treatment Goal (4 Levels) | 1—Doesn’t really have to change anything. (Motivational Interviewing)  
  2—Can keep using at the same levels, but decrease the negative consequences of use. (Harm Reduction)  
  3—Can keep using, but in a controlled way. (Harm Reduction; Contingency Management; Adjunctive Pharmacotherapy)  
  4—Can stop using altogether. (Twelve-step facilitation; Relapse Prevention; Adjunctive Pharmacotherapy) |

*Note. Theoretical and treatment matches are displayed in italics beside the corresponding textual fragment.  
*Parameters were set in Qualtrics so that each level would appear with approximately the same frequency.*
Caucasian male in his late 20s. Respondents addressed (i.e., they read and answered questions about) a random sample of all possible vignettes (i.e., the respondent subsample). Respondents typically received anywhere between 3 and 30 vignettes (Ludwick & Zeller, 2001) as their respondent subsample.

In addition to the levels of each independent variable, Table 3 also displays the intended theoretical and treatment matches based on a fictitious client’s (a) understanding of substance use and (b) preferred treatment goal. These matches were predetermined by the researcher and were supported by an expert panel of three reviewers who agreed that the respective textual fragments represented the intended theoretical perspectives and the most appropriate treatment approaches. These theoretical and treatment matches are displayed in italics in Table 3 beside the corresponding textual fragment. For example, the textual fragment included for level 1 of the client’s understanding of substance use was intended to represent the theoretical perspective of the disease model as the best explanation for the client’s description of his use. Furthermore, the textual fragment included for level 1 of the client’s preferred treatment goal in Table 3 was intended to illustrate motivational interviewing as the most appropriate treatment option for the client’s preferred treatment goal.

The predetermined matches resulted in correct/incorrect responses to the survey questions. A client’s drug of choice, previous treatment experience, and respondent demographics were not linked to correct/incorrect responses. The predetermined matches resulted in two different versions of coding the dependent variables: (a) a collapsed version and (b) an uncollapsed version. These different versions of the dependent
variable refer only to how the dependent variables were coded. Analyzing the data set with the collapsed version of the dependent variables (i.e., the correct/incorrect responses) is unique to the current study and does not represent the traditional analytic method of the factorial survey approach.

One example of analyzing the data set with the collapsed version of the dependent variables was determining whether respondents identified a predetermined (or correct) match between (a) a client’s understanding of substance use and (b) addiction professionals’ selection of a theoretical perspective. Analyzing the data set with the uncollapsed version of the dependent variables is representative of traditional factorial survey analysis. In the current study, analysis conducted with the collapsed version of the dependent variables served as an analytical subset of the analysis conducted with the uncollapsed version and explored the correct/incorrect matching of specific independent and dependent variables.

In the current study, fictitious client vignettes were randomly constructed by a computer program and followed a standard format. Although vignettes can be simple or complex (Hox et al., 1991; Ludwick et al., 2004), there is a preference for short vignettes to minimize respondent fatigue during survey completion (Hox et al., 1991). It is recommended that a larger number of vignettes reflecting, or representing, a smaller number of independent variables be presented to respondents (Hox et al., 1991). This is the case in the current study. The vignette technique used in the factorial survey approach requires that vignettes be standardized: statements appear in a fixed order and
variables thought to influence decision making were randomly assigned to the vignettes (Jasso, 2006; Rossi & Nock, 1982).

Computer-generated programs use the principles of simple random sampling to assign levels of independent variables to the vignettes (Landsman & Hartley, 2007). In the current study, the random assignment of independent variables was done in Qualtrics (2005). For example, one of five levels for the client variable drug of choice was selected: alcohol, pain relievers, cocaine, tranquilizers, or heroin. The program also assigned each vignette a level of the client’s previous treatment experience, understanding of substance use, and preferred treatment goal. The compilation of these randomly assigned levels of independent variables created the fictitious client vignettes. This process ensured that each level of all variables appeared with equal frequency in the vignette pool, an important criterion in factorial survey research (Ludwick et al., 2004).

Four independent client variables were selected for the current study because of their salience in clinical practice: (a) drug of choice, (b) previous treatment experience, (c) understanding of substance use, and (d) preferred treatment goal. As mentioned, drug of choice had five levels, and the other three variables had four levels (see Table 3). To maintain a focus on the four variables of interest, client demographics were held constant; all vignettes represented a Caucasian male in his late 20s.

Fictitious client vignettes were developed by randomly assigning levels of these variables to the following vignette format:

The client is seeking treatment for [drug of choice].

He has [treatment experience].
He believes that the cause of his substance use is [understanding of substance use].

His preferred treatment goal is one in which he [treatment preference].

Taylor (2006) noted that the factorial survey approach allows an unlimited number of variables to be studied; however, most studies using this approach limit the number of variables to five to 10. In the current study, two vignettes out of the 320 possible vignettes read as follows:

The client is seeking treatment for [cocaine].

He has [never received any kind of addiction treatment].

He believes that the cause of his substance use is [depression. He says that his life “sucks” and that it always has. He mentioned growing up with a “jerk of a father” and that his home life was “flat out miserable.” He reported that “nothing has really changed” and that the present is “just as miserable as the past.” He says that using is “just how I cope” with his depression].

His preferred treatment goal is one in which he [can keep using, but in a controlled way].

The client is seeking treatment for [alcohol].

He has [attended self-help groups in the past year].

He believes that the cause of his substance use is [habit. Substances “give me what I want—the best kind of relief.” Anytime he’s “looking to relax” or when he’s “craving a pick-me-up,” using is a “guaranteed fix.” He says it’s “great for managing withdrawal, too”]!
His preferred treatment goal is one in which he [can stop using altogether].

See Appendix D for a complete list of all 320 vignettes (i.e., the vignette pool).

Respondents were given the following directions:

The following 10 fictitious client vignettes describe a Caucasian male in his late 20s seeking treatment for substance use. Client information is purposely limited.

Using only the information provided, please answer the corresponding questions about each vignette. Lastly, please complete the demographic questionnaire.

Respondents were asked the following two questions after each vignette was read:

Question 1. Based on the client’s belief about his substance use, please select the theoretical perspective that you think best represents his description.

Question 2. Although several treatment approaches may be applicable, please select the treatment approach you would recommend as the most appropriate treatment option for this client’s goal.

These questions represented the dependent variables (DV), or the focus of the statistical analysis. Theoretical perspective (DV₁) had five levels, or options: disease, cognitive behavioral, psychoanalytic, sociocultural, and I’m not sure. The psychoanalytic perspective was selected to account for and represent the secondary substance abuse model, one of the eight co-occurring theories of substance use disorders presented in Chapter 1. Recommended treatment approach (DV₂) had seven levels, or options: motivational interviewing, relapse prevention, contingency management, 12-step facilitation (TSF), adjunctive pharmacotherapy, harm reduction, and I’m not sure. It was expected that all client variables would have an effect on respondents’ decisions. The
dependent variables, or questions about the decision making, are often kept few in number; typically, one or two, and the questions reflecting these variables are frequently related.

**Instrumentation**

Instrumentation for the current study involved four steps. First, independent and dependent variables—and levels of those variables—were identified. Table 3 was then created to contextualize the levels of each independent variable. Table 3 also was created to identify intended (or correct) theoretical and treatment matches (presented in *italics*). Table 3 and a draft of the response page intended for respondents were then sent to an expert review panel for feedback. This feedback elicited changes now reflected in the textual fragments presented in Table 3; changes also were made to directions and wording of questions on the online survey’s response page. Next, a pilot study was conducted to solicit feedback about the data collection process. This feedback was used to further refine the methodological procedures.

**Expert review panel.** To assess the credibility of vignettes, an expert panel of three reviewers was consulted. A recent study using an expert panel also consulted three persons (Stokes & Schmidt, 2012). Addiction counselors and/or those teaching addiction counseling courses in graduate counseling programs served as reviewers in the current study. They assessed the readability of the vignettes, as well as the appropriateness of the variables and their respective levels. They also were asked to comment on whether or not the information presented in the vignettes was sufficient for decision making. Suggested changes were incorporated to improve the vignettes prior to data collection. Each
reviewer was sent Table 3 and Appendix E (Factorial Survey) via email. See Appendix F (Expert Review Panel) for instructions given to the reviewers.

**Intended theoretical perspectives.** Generally, the panel believed that the textual fragments found in Table 3 represented the intended theoretical perspectives; however, some suggestions were made. It was pointed out that

Responses . . . will [likely] be dictated by the respondents’ theoretical orientation.

For example, if I’m a CBT person, I’m going to read everything through a CBT lens. If I use the disease model, I will see everything thought that lens, etc. And really, we should be looking for each of these components given the biopsychosocial/cultural/spiritual model.

A suggestion was made to improve the question that read: *Please select the theoretical perspective that you believe best explains the client’s condition.* Suggested wording included, “Select the theoretical perspective described by the client above . . . or . . . Only taking into account the information provided above, select the theoretical perspective described.” To ameliorate this, suggested phrasing was included in the directions/questions on the response page.

It was also noted that the textual fragment intended to represent the psychoanalytic perspective seemed to represent a “psychological model (i.e., addiction is secondary to psychological turmoil).” This expert reviewer was correct. For the current study, the psychoanalytic model was selected to represent a model of co-occurring disorders; specifically, the secondary substance abuse model. Nothing was changed with regard to this because it represented the intended theoretical perspective; however, the
reviewer identified it by a different name. It was also suggested to add “segments about his [the client’s] thinking” to better represent the cognitive behavioral perspective, and to better represent the sociocultural perspective, it was suggested to mention “social learning or modeling . . . it is not just that others do it, but that he [the client] has learned how to use by watching others do it.” Both of these recommendations elicited changes to the cognitive behavioral and sociocultural texts.

**Intended treatment approaches.** Again, the expert review panel generally believed that the intended treatment approaches were appropriately matched with the textual fragments in Table 3; however, some comments were made. More information (e.g., “method of use, frequency, for how long”) was desired before recommending a treatment approach. Certainly, addiction professionals’ decisions are influenced by multiple variables and several variables that are commonly considered when making treatment decisions were not included in the current study. This was intentional. To remedy any confusion among respondents, specific phrasing was included in the directions and questions: phrasing that recognized the presence of limited information, but that also asked respondents to consider only the information provided.

It was also noted that motivational interviewing (MI) could be used for any of the client’s preferred treatment goals. The decision to specify MI as the intended treatment recommendation for the treatment goal of “doesn’t really have to change anything” was made because MI is a style of counseling designed to help people initiate change (Miller, 2000). The three other treatment goals represent a client who had already decided to change at some level. There was also a suggestion to allow respondents to be able to
select multiple treatment options. To facilitate data analysis, the final survey did not permit multiple treatment selections. But more importantly, asking respondents to select only one treatment approach forced them to select the approach they believed was most appropriate, thereby helping to identify the dominant treatment approach for the respective independent variable.

**Levels of independent variables.** Generally, the three-person panel agreed that the levels of independent variables were representative of what is commonly seen in practice. Only tranquilizers were commented on as a drug of choice. One reviewer said, “If by tranquilizers you mean Benzos, then yes” and another reviewer commented, “I’m not sure how common tranquilizers are. I’ve never seen someone who had this as their drug of choice. We see more meth here.” The third reviewer was simply curious about how the drugs of choice were selected.

According to the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2013), the top six substances for which treatment was provided in 2012 were alcohol, pain relievers, marijuana, cocaine, tranquilizers, and heroin. Marijuana was left out of the current study because it would have created unrealistic vignettes (e.g., persons do not attend inpatient/residential treatment for marijuana use only). Respondents in the current study were members of a nationwide organization; therefore, the five substances identified by the NSDUH comprised the five levels for drug of choice. No comments were made regarding a client’s previous treatment experience; however, those, too, were
taken from the NSDUH and represented the top four locations where treatment was received in 2012.

**Content of vignettes.** The final component reviewed by the panel was the content and believability of the vignettes. Responses were varied regarding whether or not the vignettes provided enough information to answer the questions. Generally, the panel thought the questions could be answered, but there were some concerns about the link between theoretical perspective and recommended treatment approaches. For example, one reviewer noted that “the vignettes read fine” and they were able to easily answer the question about theoretical perspective; however, they wondered about an inconsistency between theoretical perspectives and available treatment approaches.

In the opinion of the aforementioned reviewer, treatment approaches were categorized as either cognitive behavioral or disease. This meant that there was a perception that none of the treatment approaches could be linked to psychoanalytic or sociocultural understandings of substance use. Although the basis of this is interpretation is understandable (i.e., many of the treatment approaches stem from CBT or disease perspectives), each of the treatment approaches can realistically be used with each of the theoretical perspectives. Furthermore, the purpose of the current study was not to link theoretical perspective with recommended treatment approach, but rather to investigate the links between (a) a client’s understanding of substance use and addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understanding of substance use, and (b) a client’s preferred treatment goal and
addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal.

Panel members also expressed curiosity about the presence of “contradictory vignettes,” given the randomization of independent variables. For example, one reviewer stated:

Client describes the disease model of conceptualization which notes “all he can do is manage it by not using at all” but then says his goals is to continue use. This would seem odd to me, if I were taking the survey. Perhaps this speaks to a disconnect between the theoretical perspective and the treatment—as it’s set up, you’re asking them [respondents] to only take into account the client’s goal and not the theory when recommending treatment. Indeed, this is what respondents were asked to do. In practice, clients might very well understand addiction from a disease model, but want to continue using. Therefore, one might identify the disease perspective of understanding substance use, but also recognize that harm reduction approaches could benefit this particular client.

Similarly, it was noted by another panel member that “respondents might answer with their (italics added) preferred treatment.” Ironically, this notion—that addiction professionals may consider their preferences over their clients’ preferences when recommending treatment approaches—served as an impetus for the current study and was identified as a component of decision making by Rossi and Anderson (1982). Another suggestion was to reword this question as: “Based on the information provided in the vignette, which treatment seems most appropriate for this client’s goal?” To be clear
about what respondents were being asked, this suggestion did result in a change to the wording of the question. The final question specifically asked about treatment approaches that were believed to be most appropriate for this client’s goal.

Lastly, there was a “want to know” about “method of use, frequency, for how long, previous attempts to quit, withdrawal symptoms” before making a treatment recommendation. There also was a comment on the simplicity of the vignettes, noting that the limited information “detracts a little from them seeming real.” These were all valid points, but were beyond the scope of the current study. Again, the wording of the questions/directions was changed to reinforce the idea of considering only what is presented. Additionally, the vignettes used in the current study were consistent with the factorial survey approach: short vignettes that included a reasonable number of variables.

**Pilot study.** As mentioned, a pilot study was conducted to solicit feedback about the data collection process, as well as to receive further information about the survey itself. The pilot study was approved by Kent State University’s Institutional Review Board (IRB approval #14-558; See Appendix G) and was conducted from November 2014 through January 2015. Respondents were recruited from three chemical dependency treatment facilities in Northeast Ohio. Table 4 presents the directions and questions asked of pilot study respondents after completing the online survey.
Table 4

*Directions and Questions Asked of Pilot Study Respondents*

Directions: Please take a few additional minutes to provide feedback about this survey. As you do this, be careful to consider all elements—recruitment email, informed consent document, survey, and demographic questionnaire.

<table>
<thead>
<tr>
<th>Question 1</th>
<th>How long did it take you to complete the survey?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 2</td>
<td>Please comment on the length of the survey. Too many vignettes? Too few? About right?</td>
</tr>
<tr>
<td>Question 3</td>
<td>Please comment on the vignettes. For example, did they provide enough information for you to answer the questions? Did they represent what you might see in real life? etc.</td>
</tr>
<tr>
<td>Question 4</td>
<td>Was anything confusing?</td>
</tr>
<tr>
<td>Question 5</td>
<td>Please provide any suggestions that you think would improve the survey.</td>
</tr>
</tbody>
</table>

Ten respondents provided feedback. The average length of time to complete the survey was 25 minutes. Respondents thought that being asked to complete 10 vignettes was a reasonable number; however, some commented that the vignettes became repetitive. This was a concern of the researcher but given the limited number of variables used in factorial survey research, it was seemingly unavoidable. One respondent also “figured out” that the vignettes were randomized.

Conflicting feedback was received about whether or not the vignettes provided sufficient information to answer the questions. Some respondents noted outright that there was enough information, others said that they would have liked to have had more information but that the information provided was sufficient, and still others said that there simply was not enough. Again, to help remedy this, the questions used in the final
survey were worded to convey that there was limited information, and for respondents to consider the information presented. Questions were also asked in a more specific way. A few respondents noted that they would have liked to be able to select multiple treatment options, and one respondent requested that more treatment options be added. Again, limiting the selection of treatment approach to one was not changed because forcing a choice helped the researcher identify the dominant treatment approach for the respective independent variable. No additional treatment options were included because the current options represented those that are most known in the field. However, the wording of this question was changed to express that there could be multiple treatment approaches that were appropriate, but respondents were still asked to identify what they believe to be the most appropriate from the list provided.

Overall, feedback from the expert review panel and pilot study influenced how the current study’s directions and questions read, tailoring them to account for limited information, inability to select multiple treatment options, and providing greater specificity within each question. This feedback also exposed potential limitations of the current study.

Data Collection

As previously mentioned, once Institutional Review Board (IRB) approval was secured (see Appendix A), a request was made of NAADAC’s Senior List Operations Manager to distribute an email to 1,274 (a number determined by NAADAC) randomly selected NAADAC members that introduced the study and requested participation (see Appendix B). The email contained a statement about the amount of time required to
participate in the study (approximately 25 minutes). NAADAC’s data services team was responsible for the random selection of respondents.

Individuals who were interested in participating were directed to a secure (https) website monitored by Qualtrics (2005), an online survey site used by Kent State University. The website contained an informed consent document (see Appendix H) where individuals could electronically agree to or decline participation. There were no exclusion criteria. The website also contained an anonymous link to the survey for those who agreed to participate. The survey consisted of 10 randomly assigned vignettes for each respondent (i.e., the respondent subsample), two questions about each vignette, and a 20-item demographic questionnaire. A computer-generated program within Qualtrics permitted the random assignment of respondent subsamples; each time the anonymous link was “clicked,” a unique subsample (i.e., 10 vignettes) was selected for that respondent. All data collection occurred online within the Qualtrics platform.

Directions for completing the survey (see Appendix E) and the demographic questionnaire (see Appendix I) were presented on the website. Respondents were asked to read each vignette and then answer the corresponding questions. The first question asked respondents to select which of the four theories listed best represented the client’s description of his substance use. Respondents could select only one theory or “I’m not sure.” The second question asked respondents to select which of the six treatment approaches listed they would recommend as the most appropriate treatment option for the client’s preferred treatment goal. Respondents could select only one treatment approach
or “I’m not sure.” Lastly, respondents completed the demographic questionnaire (see Appendix I).

Data remained anonymous and were reported in aggregate form so that neither individual nor institution (i.e., work setting) could be identified. Respondents were given the opportunity to be entered into a drawing that awarded 10 $50 gift cards. Respondents who wanted to enter the drawing did so by entering their email address upon survey completion. At that point, the following disclosure statement alerted respondents that by entering the drawing, they were also agreeing to disclose their name and mailing address to the researcher so that gift cards could be processed and distributed:

**Please note:** Your responses are anonymous and in no case will your individual responses be linked to you; however, to process the gift cards, winners will be asked to disclose their name and mailing address to the researcher. This information will be treated as confidential and will be used only to distribute the award.

The email addresses of respondents who entered the drawing were sent to and stored in Qualtrics, with no names attached. Ten email addresses were then randomly selected through Qualtrics to identify the winners. The winners were notified by the Qualtrics operator, a staff member of the Research and Evaluation Bureau at Kent State University, and were asked to complete and return a Research Participant Receipt 1 (RPR-1) form (Appendix J). Once the RPR-1 was returned, the Qualtrics operator gave the researcher the name and mailing addresses of the winners. The researcher then mailed the gift cards to the winners. For the duration of the current study, the researcher
never had access to personal information stored in the Qualtrics database (e.g., respondent email addresses).

**Data Analysis**

Data from the current study were analyzed using the data set with uncollapsed and collapsed versions of the dependent variables, as mentioned earlier. The collapsed and uncollapsed versions refer only to how the dependent variables were coded. Tables 5 and 6 display how the collapsed versions of the dependent variables were coded for the current study. This coding applies to analyses conducted at both the vignette and respondent levels. Figures 1 and 2 offer visuals of how each research question (RQ) was then analyzed.
Table 5

*Coding of the Collapsed Version of the First Dependent Variable, Addiction Professionals’ Selection of a Theoretical Perspective (DV₁)*

<table>
<thead>
<tr>
<th>Client’s Understanding of Substance Use (IV3)</th>
<th>1 = Correct, 0 = Incorrect (DV₁)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease (Predisposition)</td>
<td>Disease (1)</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic (0)</td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioral (0)</td>
</tr>
<tr>
<td></td>
<td>Sociocultural (0)</td>
</tr>
<tr>
<td></td>
<td>I’m not sure (0)</td>
</tr>
<tr>
<td>Psychoanalytic (Depression)</td>
<td>Disease (0)</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic (1)</td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioral (0)</td>
</tr>
<tr>
<td></td>
<td>Sociocultural (0)</td>
</tr>
<tr>
<td></td>
<td>I’m not sure (0)</td>
</tr>
<tr>
<td>Cognitive Behavioral (Habit)</td>
<td>Disease (0)</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic (0)</td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioral (1)</td>
</tr>
<tr>
<td></td>
<td>Sociocultural (0)</td>
</tr>
<tr>
<td></td>
<td>I’m not sure (0)</td>
</tr>
<tr>
<td>Sociocultural (Environmental)</td>
<td>Disease (0)</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic (0)</td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioral (0)</td>
</tr>
<tr>
<td></td>
<td>Sociocultural (1)</td>
</tr>
<tr>
<td></td>
<td>I’m not sure (0)</td>
</tr>
</tbody>
</table>

*Note.* The left-hand column displays the four levels of the third independent variable, a client’s understanding of substance use (IV3). Parenthetical words are the actual words respondents were presented in their vignettes (see Table 3). The right-hand column displays the five options respondents were given to select from when asked to identify which theoretical perspective best explained the client’s description of use. The right-hand column also identifies how each option was coded for data analysis. This coding represents the collapsed version of the first dependent variable, addiction professionals’ selection of a theoretical perspective (DV₁).
Table 6

**Coding of the Collapsed Version of the Second Dependent Variable, Addiction Professionals’ Recommended Treatment Approach (DV2)**

<table>
<thead>
<tr>
<th>Client’s Preferred Treatment Goal (IV4)</th>
<th>1 = Correct, 0 = Incorrect (DV2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doesn’t really have to change anything</td>
<td>Motivational Interviewing (1) Relapse Prevention (0) Contingency Management (0) 12-step Facilitation (0) Adjunctive Pharmacotherapy (0) Harm Reduction (0) I’m not sure (0)</td>
</tr>
<tr>
<td>Can keep using at the same levels, but decrease the negative consequences of use</td>
<td>Motivational Interviewing (0) Relapse Prevention (0) Contingency Management (0) 12-step Facilitation (0) Adjunctive Pharmacotherapy (0) Harm Reduction (1) I’m not sure (0)</td>
</tr>
<tr>
<td>Can keep using, but in a controlled way</td>
<td>Motivational Interviewing (0) Relapse Prevention (0) Contingency Management (1) 12-step Facilitation (0) Adjunctive Pharmacotherapy (1) Harm Reduction (1) I’m not sure (0)</td>
</tr>
<tr>
<td>Can stop using altogether</td>
<td>Motivational Interviewing (0) Relapse Prevention (1) Contingency Management (0) 12-step Facilitation (1) Adjunctive Pharmacotherapy (1) Harm Reduction (0) I’m not sure (0)</td>
</tr>
</tbody>
</table>

*Note.* The left-hand column displays the four levels of the fourth independent variable, a client’s preferred treatment goal (IV4). The right-hand column displays the seven options respondents were given to select from when asked to identify which treatment approach they would recommend as most appropriate for the client’s preferred treatment goal. The right-hand column also identifies how each option was coded for data analysis. This coding represents the collapsed version of the second dependent variable, addiction professionals’ recommended treatment approach (DV2).
Figure 1. Flow of research question one. Selection of a theoretical perspective (RQ1) is analyzed with chi-square analysis using the collapsed version of the dependent variable to test for the association between each of the four independent variables (IV1, IV2, IV3, and IV4) and selected theoretical perspective (DV1). Selection of a theoretical perspective (RQ1) is analyzed with regression analysis using the collapsed version of the dependent variable to test for the effect of the client’s understanding of substance use (IV3) on the selection of the predetermined theoretical perspective (DV1). Regression analysis is also used with the collapsed version of the dependent variable to test for the effects of respondent variables on the selection of the predetermined theoretical perspective (DV1). Correct and incorrect responses were coded as 1 and 0, respectively.
Figure 2. Flow of research question two. Recommended treatment approach (RQ2) is analyzed with chi-square analysis using the uncollapsed version of the dependent variable to test for the association between each of the four independent variables (IV1, IV2, IV3, and IV4) and the recommended treatment approach (DV2). Recommended treatment approach (RQ2) is analyzed with regression analysis using the collapsed version of the dependent variable to test for the effect of the client’s preferred treatment goal (IV4) on the recommendation of a predetermined treatment approach (DV2). Regression analysis is also used with the collapsed version of the dependent variable to test for the effects of respondent variables on the recommendation of a predetermined treatment approach (DV2). Correct and incorrect responses were coded as 1 and 0, respectively.
The data set for the uncollapsed version of the dependent variable was analyzed using the chi-square test of association and focused on exploring the effects of each independent variable on the two dependent variables, regardless of correct/incorrect responses. The data set for the collapsed version of the dependent variables was analyzed using hierarchical regression analysis and focused on exploring how likely respondents were to correctly match (a) the client’s understanding of substance use with the correct theoretical perspective determined by the researcher and (b) the client’s preferred treatment goals with a correct treatment approach determined by the researcher. Hierarchical regression analysis was also used to explore the effects of respondent demographics on their likelihood to select the predetermined responses.

Raw data were collected in the Qualtrics platform and then converted to Excel spreadsheets. The Excel spreadsheets were then “copy/pasted” into the data analysis and statistical software program, Stata (2013). The data were then coded in Stata. Chi-square analyses were conducted on the data set with the uncollapsed version of the dependent variables first, and then hierarchical regression analyses were conducted on the data set with the collapsed version of the dependent variables (i.e., correct/incorrect responses at the vignette and respondent levels). Independent and dependent variables were converted to dummy variables and then coded as either “1” or “0” to represent “correct” or “incorrect” responses, respectively (i.e., intended theoretical and treatment matches). Demographic variables were coded in a similar manner.
Chi-Square Analysis

Chi-square analysis was the primary method of analysis for each research question. This analytic procedure was used to explore the data set with the uncollapsed version of the dependent variables at the vignette level and resulted in eight independent chi-square tests (see Figures 1 & 2). For example, chi-square analysis considered the association between a client’s drug of choice depicted in vignettes and addiction professionals’ selection of a theoretical perspective. It also considered the association between a client’s drug of choice depicted in vignettes and addiction professionals’ recommended treatment approach. Again, analysis of the data set with the uncollapsed version of the dependent variables considered the effects of each independent variable on the dependent variables regardless of researcher determined correct/incorrect responses.

Hierarchical Regression Analysis

Hox et al. (1991) explained that the factorial survey design produces hierarchical or multilevel data. As previously mentioned, this means that data are collected at the vignette and respondent levels. This also means that data are collected over time, with each respondent providing multiple responses. The vignette serves as the primary unit of analysis and the respondent serves as a secondary unit of analysis. When dependent variables are unordered and categorical, as is the case in the current study, chi-square analysis is appropriate. Furthermore, the experimental design of the current study suggests that a simple bivariate comparison (i.e., chi-square analysis) is sufficient. However, because chi-square analysis does not account for repeated observations (i.e.,
multiple responses provided by the same respondent), hierarchical regression analysis also was conducted.

Hierarchical regression analysis takes into consideration differences among respondents (i.e., unobserved heterogeneity). It controls for respondent demographics. Wallander (2009) pointed out that few researchers who use the factorial survey approach actually use analytic methods that are consistent with hierarchical data. She strongly suggested using such multilevel analysis to account for intra-respondent correlation (i.e., the repeated observations noted above).

In the current study, four regression analyses were conducted using the data set with the uncollapsed version of the dependent variables (i.e., the data set that disregarded correct/incorrect responses) and produced results that were mathematically similar to the chi-square analyses. Therefore, it was decided that the hierarchical regression analyses would be used only to explain analysis of the data set with the collapsed version of the dependent variables. Analysis of the data set with the collapsed version of the dependent variables focused on exploring how likely respondents were to correctly match a (a) client’s presumed understanding of substance use with the predetermined theoretical perspective determined by the researcher, and a (b) client’s presumed preferred treatment goal with a predetermined treatment approach determined by the researcher (see Figures 1 & 2).

It is important to note that results of the analysis of the data set with the collapsed version of the dependent variables were all relative to a baseline vignette (i.e., the vignette that was omitted from the regression model). Respondents’ likelihood to select a
predetermined (or correct) response remained the same regardless of the vignette used as the baseline (i.e., order was preserved). Therefore, the vignette that presented the first level of each independent variable (see Table 3), served as the baseline vignette and depicted the following scenario:

The client is seeking treatment for alcohol.
He has never received any kind of addiction treatment.
He believes the cause of his substance use is predisposition, “something genetic.”
He says that he “just can’t stop using.” He’s tried to control his use but he “fails every time.” He’s also heard that there’s “no cure for addiction” and that all he can do is manage it by not using at all.
His preferred treatment goal is one in which he doesn’t really have to change anything.

A tertiary analysis of the data set with the collapsed version of the dependent variables considered how respondent demographics influenced decision making.
Hierarchical regression analysis was used to explore the effects of respondent variables on their likelihood to select the predetermined responses. The effects of 10 demographic variables on the dependent variables were considered. Demographic variables considered at the respondent level are displayed in Figure 3.
**Figure 3.** Independent and dependent variables at the respondent level. Respondent variables serve as the independent variables (IVs) during the regression analyses at the respondent level.

**Research Questions**

The current study considered the effects of client variables on addiction professionals’ decision making. Two research questions were explored:

1. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understanding of substance use?
2. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal?

Additional considerations (i.e., the analytical subset) explored (a) the likelihood of respondents to select the predetermined theoretical perspective based on their interpretation of a client’s understanding of substance use, and (b) the likelihood of respondents to recommend a predetermined treatment approach based on their interpretation of a client’s preferred treatment goal. In a like manner, the effects of respondent variables on predetermined responses were also investigated.

Research Hypotheses

Although each independent variable likely influenced respondents’ decision making, the questions of interest considered (a) the effect of a client’s understanding of substance use on addiction professionals’ selection of the predetermined theoretical perspective according to their interpretation of a client’s understanding of substance use, and (b) the effect of a client’s preferred treatment goal on addiction professionals’ recommendation of a predetermined treatment approach according to their interpretation of a client’s preferred treatment goal (i.e., the collapsed version of the dependent variables). The research hypotheses for the data set comprising the collapsed version of the dependent variables and for the current study are as follows:

Research hypothesis 1: There is a relationship between a client’s understanding of substance use and addiction professionals’ selection of the predetermined (or
correct) theoretical perspective according to their interpretation of a client’s understanding of substance use.

Sub-hypotheses:

1. When a client’s understanding of substance use represents the disease perspective, addiction professionals will select the disease perspective as the theoretical perspective that best represents the client’s description of use.

2. When a client’s understanding of substance use represents the psychoanalytic perspective, addiction professionals will select the psychoanalytic perspective as the theoretical perspective that best represents the client’s description of use.

3. When a client’s understanding of substance use represents the cognitive behavioral perspective, addiction professionals will select the cognitive behavioral perspective as the theoretical perspective that best represents the client’s description of use.

4. When a client’s understanding of substance use represents the sociocultural perspective, addiction professionals will select the sociocultural perspective as the theoretical perspective that best represents the client’s description of use.

Research hypothesis 2: There is be a relationship between a client’s preferred treatment goal and addiction professionals’ recommendation of a predetermined
(or correct) treatment approach according to their interpretation of a client’s preferred treatment goal.

*Sub-hypotheses:*

1. When the client’s preferred treatment goal is *doesn’t really have to change anything*, addiction professionals will select *motivational interviewing* as the most appropriate treatment recommendation for that client’s goal.

2. When the client’s preferred treatment goal is *can keep using at the same levels, but decrease the negative consequences of use*, addiction professionals will select *harm reduction* as the most appropriate treatment recommendation for that client’s goal.

3. When the client’s preferred treatment goal is *can keep using, but in a controlled way*, addiction professionals will select either *harm reduction, contingency management, or adjunctive pharmacotherapy* as the most appropriate treatment recommendation for that client’s goal.

4. When the client’s preferred treatment goal is *can stop using altogether*, addiction professionals will select *12-step facilitation, relapse prevention, or adjunctive pharmacotherapy* as the most appropriate treatment recommendation for that client’s goal.

**Chapter Summary**

This chapter provided an extensive description of the research methodology used in the current study. A detailed account of the study’s respondents, instrumentation, data
collection and data analysis, and research questions were presented. Chapter 3 presents the results of data analysis.
CHAPTER III

RESULTS

The current study used a factorial survey approach to examine the effects of client variables on addiction professionals’ decision making. The effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective and recommended treatment approach were explored. This chapter begins with a review of the current study’s research questions and hypotheses. Next, an overview of the current study’s research methodology, methods of data analysis, and research findings are presented.

Research Questions

The current study considered the effects of client variables on addiction professionals’ decision making. Two research questions were explored:

1. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understanding of substance use?

2. What are the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal?
Additional considerations (i.e., the analytical subset) explored (a) the likelihood of respondents to select the predetermined (or correct) theoretical perspective according to their interpretation of a client’s understanding of substance use, and (b) the likelihood of respondents to recommend a predetermined (or correct) treatment approach according to a client’s preferred treatment goal. In a like manner, the effects of respondent variables on researcher-predetermined (or correct) responses were also investigated.

**Research Hypotheses**

Although each of the independent variables likely influenced respondents’ decision making, the questions of interest considered (a) the effect of a client’s understanding of substance use on addiction professionals’ selection of the predetermined theoretical perspective according to their interpretation of a client’s understanding of substance use, and (b) the effect of a client’s preferred treatment goal on addiction professionals’ recommendation of a predetermined treatment according to their interpretation of a client’s preferred treatment goal approach (i.e., the collapsed version of the dependent variables). The research hypotheses for the data set comprising the collapsed version of the dependent variables and for the current study are as follows:

*Research hypothesis 1:* There is a relationship between a client’s understanding of substance use and addiction professionals’ selection of the predetermined (or correct) theoretical perspective according to their interpretation of a client’s understanding of substance use.
Sub-hypotheses:

1. When a client’s understanding of substance use represents the disease perspective, addiction professionals will select the disease perspective as the theoretical perspective that best represents the client’s description of use.

2. When a client’s understanding of substance use represents the psychoanalytic perspective, addiction professionals will select the psychoanalytic perspective as the theoretical perspective that best represents the client’s description of use.

3. When a client’s understanding of substance use represents the cognitive behavioral perspective, addiction professionals will select the cognitive behavioral perspective as the theoretical perspective that best represents the client’s description of use.

4. When a client’s understanding of substance use represents the sociocultural perspective, addiction professionals will select the sociocultural perspective as the theoretical perspective that best represents the client’s description of use.

Research hypothesis 2: There is be a relationship between a client’s preferred treatment goal and addiction professionals’ recommendation of a predetermined (or correct) treatment approach according to their interpretation of a client’s preferred treatment goal.
Sub-hypotheses:

1. When the client’s preferred treatment goal is *doesn’t really have to change anything*, addiction professionals will select *motivational interviewing* as the most appropriate treatment recommendation for that client’s goal.

2. When the client’s preferred treatment goal is *can keep using at the same levels, but decrease the negative consequences of use*, addiction professionals will select *harm reduction* as the most appropriate treatment recommendation for that client’s goal.

3. When the client’s preferred treatment goal is *can keep using, but in a controlled way*, addiction professionals will select either *harm reduction, contingency management, or adjunctive pharmacotherapy* as the most appropriate treatment recommendation for that client’s goal.

4. When the client’s preferred treatment goal is *can stop using altogether*, addiction professionals will select *12-step facilitation, relapse prevention, or adjunctive pharmacotherapy* as the most appropriate treatment recommendation for that client’s goal.

**Factorial Survey Approach**

The current study used the factorial survey approach developed by Rossi and Nock (1982) to investigate addiction professionals’ decision making. Rossi and Nock developed this approach to expose the underlying principles of the decision-making process. In the factorial survey approach, fictitious vignettes are read by respondents
who are then asked to make decisions about the vignettes. This vignette technique uses randomly constructed vignettes intended to represent real-life scenarios and are used to investigate how certain variables (e.g., a client’s drug of choice or previous treatment experience), alone or in combination, influence decision making.

In the current study, a 5x4x4x4 factorial design yielded 320 fictitious client case vignettes; these vignettes made up the vignette pool. Respondents addressed (i.e., they read and answered questions about) a random sample of all possible vignettes (i.e., the respondent subsample). Each respondent was randomly assigned 10 vignettes from the total vignette pool. Respondents answered the same two questions about each vignette and then completed a 20-item demographic questionnaire (see Appendix I).

**Findings**

Data from the current study were analyzed with uncollapsed and collapsed versions of the dependent variable. Analysis of the data set with the uncollapsed version of the dependent variables was conducted using the chi-square test of association and focused on exploring the effects of each independent variable on the two dependent variables, regardless of predetermined responses. Analysis of the data set with the collapsed version of the dependent variables was conducted using hierarchical regression and focused on exploring how likely respondents were to correctly match (a) a client’s understanding of substance use with the predetermined (or correct) theoretical perspective, and (b) a client’s preferred treatment goal with a predetermined (or correct) treatment approach. Hierarchical regression analysis was also used to explore the effects of respondent variables on their likelihood to correctly select these predetermined
responses. Therefore, hierarchical regression analysis was conducted at both the vignette and respondent levels, whereas the chi-square analysis was conducted only at the vignette level.

As previously noted, independent variables were a fictitious client’s (a) drug of choice, (b) previous treatment experience, (c) understanding of substance use, and (d) preferred treatment goal. A client’s drug of choice had five levels and the other three independent variables had four levels, which resulted in a 5x4x4x4 factorial design. The two dependent variables had multiple levels of response options as well. The first dependent variable (DV₁), addiction professionals’ selection of a theoretical perspective had five levels, or options: (a) disease, (b) psychoanalytic, (c) cognitive behavioral, (d) sociocultural, and (e) I’m not sure. The second dependent variable (DV₂), addiction professionals’ recommended treatment approach, had seven levels, or options: (a) motivational interviewing, (b) relapse prevention, (c) contingency management, (d) 12-step facilitation, (e) adjunctive pharmacotherapy, (f) harm reduction, and (g) I’m not sure. The effects of select respondent variables (e.g., level of education, supervision status) on the dependent variables were also considered (see Figure 3). Results from each analytical procedure are presented in the following sections.

Chi-square Test of Association

A chi-square test of association was the primary method of analysis for each research question. There were eight separate chi-square analyses conducted. Refer to Figures 1 and 2 in Chapter 2. The independent variables tested were a fictitious client’s (a) drug of choice, (b) previous treatment experience, (c) understanding of substance use,
and (e) preferred treatment goal. The dependent variables tested were (a) addiction professionals’ selection of a theoretical perspective (DV\textsubscript{1}), and (b) addiction professionals’ recommended treatment approach (DV\textsubscript{2}).

Again, the chi-square analyses occurred only at the vignette level (i.e., client variables only); therefore, responses, not respondents, were analyzed. Table 7 displays the raw data of the association between a client’s drug of choice and addiction professionals’ selected theoretical perspectives. The expected count refers to the selection that was expected of respondents, whereas the observed count represents the actual selections made by respondents. For example, when considering the association between alcohol and the disease perspective, the observed count (17.0) was greater than the expected count (7.4), indicating that the disease perspective was selected more often than expected when respondents were presented with a vignette depicting alcohol as the client’s drug of choice.

The observed counts in Table 7 were then converted to percentages to create the corresponding figures presented in Table 8. The conversion from observed counts to percentages is common when reporting chi-square results because it facilitates the interpretation and discussion of the findings. The percentages in Table 8, then, refer to the frequency of responses, or selections, provided by respondents. All subsequent chi-square results are presented only in the form of percentages.
Table 7

Raw Data of the Crosstab of a Client’s Drug of Choice by Addiction Professionals’ (N = 92) Selected Theoretical Perspective

<table>
<thead>
<tr>
<th>Drug of choice</th>
<th>Disease</th>
<th>PsychoA</th>
<th>CogBeh</th>
<th>SocioC</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observed</td>
<td>17.0</td>
<td>53.0</td>
<td>27.0</td>
<td>76.0</td>
<td>52.0</td>
<td>225</td>
</tr>
<tr>
<td>Expected</td>
<td>7.4</td>
<td>72.5</td>
<td>18.5</td>
<td>75.0</td>
<td>51.7</td>
<td>225</td>
</tr>
<tr>
<td>Pain Relievers</td>
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<td></td>
</tr>
<tr>
<td>Observed</td>
<td>2.0</td>
<td>68.0</td>
<td>16.0</td>
<td>69.0</td>
<td>47.0</td>
<td>202</td>
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<td>Expected</td>
<td>6.6</td>
<td>65.1</td>
<td>16.6</td>
<td>67.3</td>
<td>46.4</td>
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<tr>
<td>Cocaine</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Observed</td>
<td>5.0</td>
<td>86.0</td>
<td>18.0</td>
<td>69.0</td>
<td>49.0</td>
<td>227</td>
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<tr>
<td>Expected</td>
<td>7.4</td>
<td>73.1</td>
<td>18.7</td>
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<td>Tranquilizers</td>
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<tr>
<td>Observed</td>
<td>6.0</td>
<td>63.0</td>
<td>19.0</td>
<td>68.0</td>
<td>50.0</td>
<td>206</td>
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<tr>
<td>Expected</td>
<td>6.7</td>
<td>66.4</td>
<td>16.9</td>
<td>68.7</td>
<td>47.3</td>
<td>206</td>
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<tr>
<td>Heroin</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Observed</td>
<td>5.0</td>
<td>75.0</td>
<td>8.0</td>
<td>75.0</td>
<td>48.0</td>
<td>211</td>
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<tr>
<td>Expected</td>
<td>6.9</td>
<td>68.0</td>
<td>17.3</td>
<td>70.3</td>
<td>48.5</td>
<td>211</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observed</td>
<td>35.0</td>
<td>345.0</td>
<td>88.0</td>
<td>357.0</td>
<td>246.0</td>
<td>1071</td>
</tr>
<tr>
<td>Expected</td>
<td>35.0</td>
<td>345.0</td>
<td>88.0</td>
<td>357.0</td>
<td>246.0</td>
<td>1071</td>
</tr>
</tbody>
</table>

Note. The top row represents theories of substance use: PsychoA = Psychoanalytic; CogBeh = Cognitive behavioral; SocioC = Sociocultural. The column displays the observed and expected counts for each drug of choice.

0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.60 ($\chi^2 = 36.345$, df = 16, $p < .01$).

*p < .01 ($p = .003$).
### Table 8

*Crosstab of a Client’s Drug of Choice by Addiction Professionals’ (N = 92) Selected Theoretical Perspective as Percentages*

<table>
<thead>
<tr>
<th>Drug of choice</th>
<th>Disease</th>
<th>PsychoA</th>
<th>CogBeh</th>
<th>SocioC</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>8</td>
<td>24</td>
<td>12</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>1</td>
<td>34</td>
<td>8</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>38</td>
<td>8</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>3</td>
<td>31</td>
<td>9</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td>Heroin</td>
<td>2</td>
<td>36</td>
<td>4</td>
<td>35</td>
<td>23</td>
</tr>
<tr>
<td>Total % of Sample</td>
<td>3</td>
<td>32</td>
<td>8</td>
<td>34</td>
<td>23</td>
</tr>
</tbody>
</table>

*Note.* The top row represents theories of substance use: PsychoA = Psychoanalytic; CogBeh = Cognitive behavioral; SocioC = Sociocultural.

*Percentages in this table are based on chi-square analysis: 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.60 ($\chi^2 = 36.345$, $df = 16$, $p < .01$).

*p < .01 (p = .003).

**Addiction professionals’ selection of a theoretical perspective.** The chi-square tests revealed a statistically significant relationship between the first dependent variable (DV1), addiction professionals’ selection of a theoretical perspective, and three of the independent variables: client’s drug of choice, previous treatment experience, and understanding of substance use. Respondents were instructed to select a theoretical perspective from a list of five options they believed best represented the fictitious client’s description of use.

Overall, respondents identified the sociocultural (34%) or psychoanalytic (32%) perspectives as the theoretical perspectives that best represented the client’s understanding of substance use. Twenty-three percent of selections represented the option of being unsure about which theoretical perspective best represented the client’s...
substance use. The cognitive behavioral (8%) and disease (3%) perspectives were identified as the theoretical perspectives that best represented the client’s understanding of use least often.

**Drug of choice.** There was a statistically significant relationship between addiction professionals’ selection of a theoretical perspective and a fictitious client’s drug of choice ($\chi^2 = 36.345, df = 16, p < .01$). Table 8 displays the results of a cross tabulation (see Table 7) converted to percentages.

When alcohol was the drug of choice presented in the vignette, respondents selected the sociocultural (34%) perspective most often, followed by the psychoanalytic perspective (24%). Twenty-three percent of selections represented the option of being unsure, and the cognitive behavioral (12%) and disease (8%) perspectives were selected least often. They were more likely to select cognitive behavioral and disease perspectives, but less likely to select the psychoanalytic perspective.

When pain relievers were the drug of choice presented in the vignette, respondents selected the psychoanalytic or sociocultural (each 34%) perspectives most often. Twenty-three percent of selections represented the option of being unsure, and the cognitive behavioral (8%) and disease (1%) perspectives were selected least often.

When cocaine was the drug of choice presented in the vignette, respondents selected the psychoanalytic (38%) perspective most often, followed by the sociocultural (30%) perspective. Twenty-two percent of selections represented the option of being unsure, and the cognitive behavioral (8%) and disease (2%) perspectives were selected
least often. They were more likely to select the psychoanalytic perspective and less likely to select the sociocultural perspective.

When tranquilizers were the drug of choice presented in the vignette, respondents selected the sociocultural (33%) perspective most often, followed by the psychoanalytic (31%) perspective. Twenty-four percent of selections represented the option of being unsure, and the cognitive behavioral (9%) and disease (3%) perspectives were selected least often.

When heroin was the drug of choice presented in the vignette, respondents selected the psychoanalytic (36%) perspective most often, followed by the sociocultural (35%) perspective. Twenty-three percent of selections represented the option of being unsure, and the cognitive behavioral (4%) and disease (2%) perspectives were selected least often. They were more likely to select the psychoanalytic perspective and less likely to select the cognitive behavioral perspective.

**Previous treatment experience.** There was a statistically significant relationship between addiction professionals’ selection of a theoretical perspective and a fictitious client’s previous treatment experience \( \chi^2 = 30.096, df = 12, p < .01 \). Table 9 displays the results of a cross tabulation converted into percentages.

When a client had no previous treatment experience, respondents most often selected the sociocultural (32%) or psychoanalytic (30%) perspectives. Twenty percent of selections represented the option of being unsure, and the cognitive behavioral (11%) and disease (7%) perspectives were selected least often. They were more likely to select disease and cognitive behavioral perspectives.
Table 9

Crosstab of a Client’s Previous Treatment Experience by Addiction Professionals’ \((N = 92)\) Selected Theoretical Perspective as Percentages

<table>
<thead>
<tr>
<th>Tx Experience</th>
<th>Disease</th>
<th>PsychoA</th>
<th>CogBeh</th>
<th>SocioC</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>7</td>
<td>30</td>
<td>11</td>
<td>32</td>
<td>20</td>
</tr>
<tr>
<td>Self-Help</td>
<td>2</td>
<td>30</td>
<td>6</td>
<td>36</td>
<td>26</td>
</tr>
<tr>
<td>Outpatient</td>
<td>2</td>
<td>34</td>
<td>8</td>
<td>34</td>
<td>22</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2</td>
<td>34</td>
<td>8</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>Total % of Sample</td>
<td>3</td>
<td>32</td>
<td>8</td>
<td>34</td>
<td>23</td>
</tr>
</tbody>
</table>

Note. The top row represents theories of substance use: PsychoA = Psychoanalytic; CogBeh = Cognitive behavioral; SocioC = Sociocultural.

aPercentages in this table are based on chi-square analysis: 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.24 (χ² = 30.096, df = 12, \(p < .01\)).

*\(p < .01\) (\(p = .003\)).

When self-help groups depicted a client’s previous treatment experience, respondents most often selected the sociocultural (36%) or psychoanalytic (30%) perspectives. Twenty-six percent of selections represented the option of being unsure, and the cognitive behavioral (6%) and disease (2%) perspectives were selected least often.

When a client’s previous treatment experience was represented by outpatient therapy, respondents were equally likely to select the sociocultural or psychoanalytic perspectives (each 34%). Twenty-two percent of selections represented the option of being unsure, and the cognitive behavioral (8%) and disease (2%) perspectives were selected least often.

When a client’s previous treatment experience was represented by inpatient therapy, respondents most often selected the psychoanalytic (34%) or sociocultural (31%)
perspectives. Twenty-five percent of selections represented the option of being unsure, and the cognitive behavioral (8%) and disease (2%) perspectives were selected least often.

**Understanding of substance use.** There was a statistically significant relationship between addiction professionals’ selection of a theoretical perspective and their interpretation of the client’s understanding of substance use ($\chi^2=567.909$, $df=12$, $p < .001$). Table 10 displays the results of a cross tabulation converted into percentages.

Table 10

*Crosstab of a Client's Understanding of Substance Use by Addiction Professionals’ (N = 92) Selected Theoretical Perspective as Percentages*

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Disease</th>
<th>PsychoA</th>
<th>CogBeh</th>
<th>SocioC</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>6</td>
<td>67</td>
<td>6</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>PsychoA</td>
<td>3</td>
<td>22</td>
<td>22</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>CogBeh</td>
<td>2</td>
<td>24</td>
<td>4</td>
<td>62</td>
<td>8</td>
</tr>
<tr>
<td>SocioC</td>
<td>2</td>
<td>18</td>
<td>1</td>
<td>19</td>
<td>60</td>
</tr>
<tr>
<td>Total % of Sample</td>
<td>3</td>
<td>32</td>
<td>8</td>
<td>34</td>
<td>23</td>
</tr>
</tbody>
</table>

*Note.* Row and column abbreviations represent theories of substance use: PsychoA = Psychoanalytic; CogBeh = Cognitive behavioral; SocioC = Sociocultural.

*aPercentages in this table are based on chi-square analysis: 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.2 ($\chi^2=567.909$, $df=12$, $p < .001$).*

*When a vignette portrayed the client’s understanding of substance use from the disease perspective, respondents most often selected the psychoanalytic (67%) perspective, followed by the sociocultural (17%) perspective. Respondents were equally likely to select the disease and cognitive behavioral (each 6%) perspectives and 4% of*
selections represented the option of being unsure. They were much more likely to select the psychoanalytic perspective, and less likely to select the sociocultural perspective or the option of being unsure.

When a vignette portrayed the client’s understanding of substance use from the psychoanalytic perspective, respondents most often selected the sociocultural (37%) perspective. Respondents were equally likely to select the psychoanalytic and cognitive behavioral (each 22%) perspectives. Sixteen percent of selections represented the option of being unsure, and the disease perspective (3%) was selected least often. They were less likely to select the psychoanalytic perspective or the option of being unsure, and more likely to select the cognitive behavioral perspective.

When a vignette portrayed the client’s understanding of substance use from the cognitive behavioral perspective, respondents most often selected the sociocultural (62%) perspective, followed by the psychoanalytic (24%) perspective. Eight percent of selections represented the option of being unsure, and respondents selected the cognitive behavioral (4%) and disease (2%) perspectives least often. They were less likely to select the psychoanalytic perspective or the option that represented being unsure, and more likely to select the sociocultural perspective.

When a vignette portrayed the client’s understanding of substance use from the sociocultural perspective, 60% of responses represented the option of being unsure, followed by a selection of either the sociocultural (19%) or psychoanalytic (18%) perspectives. Respondents least often selected the disease (2%) and cognitive behavioral (1%) perspectives. They were much less likely to select psychoanalytic, cognitive
behavioral, or sociocultural perspectives, and much more likely to select the option of being unsure.

Again, from an overall perspective (i.e., regardless of the client’s drug of choice), respondent selections represented the sociocultural (34%) or psychoanalytic (32%) perspectives. Twenty-three percent of selections represented the option of being unsure. The cognitive behavioral (8%) and disease (3%) perspectives were least often selected as the theoretical perspectives that best explained the client’s substance use.

**Addiction professionals’ recommended treatment approach.** The chi-square tests involving the second dependent variable (DV₂), addiction professionals’ recommended treatment approach, revealed a statistically significant relationship between two of the independent variables: client’s understanding of substance use and client’s preferred treatment goal. Respondents were instructed to select a treatment approach from a list of seven options they believed was most appropriate for the fictitious client’s preferred treatment goal.

Overall, respondents most often recommended the option of motivational interviewing (34%) as the most appropriate treatment approach for the fictitious client’s preferred treatment goal. Next, they recommended harm reduction (17%), 12-step facilitation (15%), adjunctive pharmacotherapy (13%), or relapse prevention (12%). They recommended contingency management (7%) as the most appropriate treatment approach for the client least often, and 2% of selections represented the option of being unsure.
Understanding of substance use. There was a statistically significant relationship between addiction professionals’ recommended treatment approach and their interpretation of the client’s understanding of substance use ($\chi^2 = 61.490$, $df = 18$, $p < .001$). Table 11 displays the results of a cross tabulation converted into percentages.

Table 11

Crosstab of a Client’s Understanding of Substance Use by Addiction Professionals’ (N = 92) Recommended Treatment Approach as Percentages

<table>
<thead>
<tr>
<th>Understanding</th>
<th>MI</th>
<th>RP</th>
<th>CM</th>
<th>TSF</th>
<th>APharm</th>
<th>HR</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>28</td>
<td>18</td>
<td>7</td>
<td>24</td>
<td>10</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>PsychoA</td>
<td>33</td>
<td>9</td>
<td>6</td>
<td>13</td>
<td>20</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>CogBeh</td>
<td>38</td>
<td>11</td>
<td>8</td>
<td>11</td>
<td>10</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>SocioC</td>
<td>40</td>
<td>10</td>
<td>6</td>
<td>13</td>
<td>10</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Total % of Sample</td>
<td>34</td>
<td>12</td>
<td>7</td>
<td>15</td>
<td>13</td>
<td>17</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. The top row represents treatment approaches: MI = Motivational Interviewing; RP = Relapse Prevention; CM = Contingency Management; TSF = Twelve-Step Facilitation; APharm = Adjunctive Pharmacotherapy; HR = Harm Reduction. Column abbreviations represent theories of substance use: PsychoA = Psychoanalytic; CogBeh = Cognitive behavioral; SocioC = Sociocultural. aPercentages in this table are based on chi-square analysis: 4 cells (14.3%) have expected count less than 5. The minimum expected count is 4.22 ($\chi^2 = 61.490$, $df = 18$, $p < .001$).

When a vignette portrayed the client’s understanding of substance use from the disease perspective, respondents most often recommended motivational interviewing (29%) or 12-step facilitation (24%). Next, respondents recommended relapse prevention (18%), harm reduction (11%), adjunctive pharmacotherapy (10%), and contingency management (7%). Two percent of selections represented the option of being unsure.
They were less likely to select motivational interviewing or the option of being unsure, and they were more likely to recommend relapse prevention and 12-step facilitation.

When a vignette portrayed the client’s understanding of substance use from the psychoanalytic perspective, respondents most often recommended motivational interviewing (33%) or adjunctive pharmacotherapy (20%). Next, respondents recommended harm reduction (16%), 12-step facilitation (13%), relapse prevention (9%), and contingency management (6%). Three percent of selections represented the option of being unsure. They were more likely to recommend adjunctive pharmacotherapy.

When a vignette portrayed the client’s understanding of substance use from the cognitive behavioral perspective, respondents most often recommended motivational interviewing (38%) or harm reduction (20%). Respondents were equally likely to recommend relapse prevention and 12-step facilitation (each 11%), followed by adjunctive pharmacotherapy (10%) and contingency management (8%). Two percent of selections represented the option of being unsure.

When a vignette portrayed the client’s understanding of substance use from the sociocultural perspective, respondents most often recommended motivational interviewing (40%). Next, respondents recommended harm reduction (21%) and 12-step facilitation (13%). Respondents were equally likely to recommend relapse prevention and adjunctive pharmacotherapy (each 10%). Respondents were least likely to recommend contingency management (6%). They were more likely to recommend motivational interviewing or harm reduction.
**Preferred treatment goal.** There was a statistically significant relationship between addiction professionals’ recommended treatment approach and their interpretation of a client’s preferred treatment goal ($\chi^2 = 256.852, df = 18, p < .001$).

Table 12 displays the results of a cross tabulation converted into percentages.

Table 12

*Crosstab of a Client’s Preferred Treatment Goal by Addiction Professionals’ (N = 92) Recommended Treatment Approach as Percentages*

<table>
<thead>
<tr>
<th>Preferred Goal</th>
<th>MI</th>
<th>RP</th>
<th>CM</th>
<th>TSF</th>
<th>APharm</th>
<th>HR</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>50</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>12</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Use/Dec (-)</td>
<td>37</td>
<td>3</td>
<td>8</td>
<td>12</td>
<td>10</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>Use/Controlled</td>
<td>33</td>
<td>4</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>Stop Using</td>
<td>21</td>
<td>31</td>
<td>4</td>
<td>25</td>
<td>15</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total % of Sample</td>
<td>34</td>
<td>12</td>
<td>7</td>
<td>15</td>
<td>13</td>
<td>17</td>
<td>2</td>
</tr>
</tbody>
</table>

*Note.* The top row represents treatment approaches: MI = Motivational Interviewing; RP = Relapse Prevention; CM = Contingency Management; TSF = Twelve-Step Facilitation; APharm = Adjunctive Pharmacotherapy; HR = Harm Reduction. The left column represents clients’ preferred treatment goal: No Change = Doesn’t really have to change anything; Use/Dec (-) = Can keep using at the same levels, but decrease the negative consequences of use; Use/Controlled = Can keep using, but in a controlled way; Stop Using = Can stop using altogether.

*Percentages in this table are based on chi-square analysis: 4 cells (14.3%) have expected count less than 5. The minimum expected count is 4.17 ($\chi^2 = 256.852, df = 18, p < .001$).*

When a vignette indicated a client goal of not having to change anything, respondents most often recommended motivational interviewing (50%). Next, respondents recommended harm reduction (14%), adjunctive pharmacotherapy (12%), 12-step facilitation (8%), relapse prevention (7%), and contingency management (6%). Three percent of selections represented the option of being unsure. They were more
likely to recommend motivational interviewing, and less likely to recommend relapse prevention, 12-step facilitation, or harm reduction.

When a vignette indicated a client goal of continued use at the same levels but decreased negative consequences of use, respondents most often recommended motivational interviewing (37%) or harm reduction (28%). Next, respondents recommended 12-step facilitation (12%) and adjunctive pharmacotherapy (10%). Respondents least often recommended contingency management (8%) and relapse prevention (3%). Two percent of selections represented the option of being unsure. They were less likely to recommend relapse prevention and more likely to recommend harm reduction.

When a vignette indicated a client goal of continued use but in a controlled way, respondents most often recommended motivational interviewing (33%) and harm reduction (27%). Next, respondents recommended 12-step facilitation (14%) and adjunctive pharmacotherapy (12%). Respondents least often recommended contingency management (9%) and relapse prevention (4%). One percent of selections represented the option of being unsure. They were also less likely to recommend relapse prevention and more likely to recommend harm reduction.

When a vignette indicated a client goal of stopping use altogether, respondents most often recommended relapse prevention (31%) and 12-step facilitation (25%). Next, respondents recommended motivational interviewing (21%) and adjunctive pharmacotherapy (15%). Respondents least often recommended contingency management (4%) and harm reduction (3%). One percent of selections represented the
option of being unsure. They also were much less likely to recommend motivational interviewing and harm reduction, and more likely to recommend relapse prevention and 12-step facilitation.

Again, from an overall perspective (i.e., regardless of the client’s preferred treatment goal), respondents most often recommended motivational interviewing (34%), followed by harm reduction (17%), 12-step facilitation (15%), adjunctive pharmacotherapy (13%) or relapse prevention (12%). They recommended contingency management (7%) least often, and two percent of selections represented the option of being unsure.

Hierarchical Regression Analysis

Hierarchical regression analysis was used to supplement the chi-square analyses, serving as the secondary analytic method. Given the random assignment of vignettes to respondents, hierarchical regression analysis may not have been necessary. However, because this was a repeated measures design in which the same respondent addressed multiple vignettes, hierarchical regression was used to control for the differences across individuals while testing for the relationship between the vignette variables and the two dependent variables. Two hierarchical regression analyses were conducted at the vignette level to estimate the probability that respondents correctly identified the predetermined (or correct) theoretical perspective and treatment approach. Two additional regression analyses were conducted incorporating respondent-level characteristics to examine whether these characteristics affected the likelihood that respondents correctly matched the predetermined theoretical perspective and treatment approach.
As explained in Chapter 2, a 3-person expert review panel was consulted to verify the correct responses determined by the researcher for the dependent variables. These predetermined responses represented the correct/incorrect matches of theoretical perspectives and treatment approaches to textual fragments in each vignette. Members of the panel were asked to read the textual fragments in Table 3. Table 3 identified the vignette variables, levels, wording, and intended theoretical and treatment approach matches. Members of the panel were then asked to assess (a) whether or not the intended theoretical perspective was represented by the client’s understanding of substance use and (b) whether or not the appropriate treatment approaches were identified for each client’s treatment goal.

These correct/incorrect responses specifically identified the association between (a) a client’s understanding of substance use and addiction professionals’ selection of the predetermined theoretical perspective based on their interpretation of a client’s understanding of substance use, and (b) a client’s preferred treatment goal and addiction professionals’ recommendation of a predetermined treatment approach based on their interpretation of a client’s preferred treatment goal. These were analyzed using the data set with the collapsed version of the dependent variables. Responses were coded as “1” or “0” and represented correct/incorrect responses, respectively (see Tables 5 and 6).

Given that the dependent variables were binary (i.e., correct/incorrect), a generalized hierarchical linear model with a binomial distribution and a logit link function was estimated. The p value, and test of statistical significance, reported in the current study tested whether or not a coefficient was different than zero. If there is not a
statistically significant difference between the coefficient and zero, the independent variable does not have a statistically significant relationship with the dependent variable. This method of interpretation is the same as with ordinary least squares regression. However, dependent variables in the current study are binary, indicating either a correct or incorrect response, necessitating the use of a generalized hierarchical linear model. So while the interpretation of the statistical significance of the coefficients is done in the same was as ordinary least squares regression, the interpretation of the substantive results is different. Given the nonlinear relationship between the independent variables and the binary dependent variables, predicted probabilities are calculated using the coefficients. That is, coefficients are passed through the logit link function and used to calculate the probability of being correct/incorrect.

In the regression analysis, a dummy variable was included for each level of each independent variable. There were five levels for a client’s drug of choice: alcohol, pain relievers, cocaine, tranquilizers, and heroin. There were four levels for each of the remaining three independent variables: a client’s previous treatment experience, understanding of substance use, and preferred treatment goal. A binary indicator for each level of each independent variable was included, while excluding one level for each independent variable to represent the baseline, or constant.

As mentioned in Chapter 2, the baseline vignette was the vignette to which all vignettes in the analysis were compared. The baseline vignette in the current study presented the first level of each independent variable (see Table 3). The baseline vignette
is vignette #1 in the vignette pool and depicted the following scenario (see Appendix D for a complete list of all 320 vignettes):

The client is seeking treatment for alcohol.
He has never received any kind of addiction treatment.
He believes the cause of his substance use is predisposition, “something genetic.”
He says that he “just can’t stop using.” He’s tried to control his use but he “fails every time.” He’s also heard that there’s “no cure for addiction” and that all he can do is manage it by not using at all.
His preferred treatment goal is one in which he doesn’t really have to change anything.

Mathematically, results of the hierarchical regression analyses remained the same regardless of the levels of independent variables selected to represent the baseline. Although small changes in percentages were found, the order was preserved when using the vignette depicting the first level of each independent variable (vignette #1) versus the vignette depicting the third level of each independent variable (vignette #171), which read as follows:

The client is seeking treatment for cocaine.
He has attended outpatient rehabilitation in the past year.
He believes the cause of his substance use is habit. Substances “give me what I want - the best kind of relief.” Anytime he’s “looking to relax” or when he’s “craving a pick-me-up,” using is a “guaranteed fix.” He says it’s “great for managing withdrawal, too!”
His preferred treatment goal is one in which he can keep using, but in a controlled way.

It was determined, then, that the vignette presenting the first level of each independent variable (vignette #1) would represent the baseline. Therefore, any variable of statistical significance is significant only compared to the baseline vignette.

**Selection of the predetermined theoretical perspective at the vignette level.**

Table 13 presents the results of the hierarchical regression of addiction professionals’ selection of the predetermined theoretical perspective on a client’s understanding of substance use. Again, because this analysis was conducted at the vignette level, respondent selections, rather than respondents themselves, were analyzed. Figure 4 displays the predicted probability of selecting the predetermined (or correct) theoretical perspective for the different levels of a client’s understanding of substance use. The labels (a) disease, (b) psychoanalytic, (c) cognitive behavioral, and (d) sociocultural represent the four levels of a client’s understanding of substance use. The predicted probabilities in Figure 4 are based on the regression results in Table 13 and are estimated relative to the baseline vignette. The regression results in Table 13 were converted to predicted probabilities by passing the regression coefficients through the logit link function. This process uses the coefficients to calculate the predicted probability of selecting the correct, or predetermined, response.
Table 13

Hierarchical Regression of Addiction Professionals’ Selection of the Predetermined Theoretical Perspective on A Client’s Drug of Choice, Previous Treatment Experience, Understanding of Substance Use, and Preferred Treatment Goal

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug of Choice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>-0.13</td>
<td>0.36</td>
<td>0.69</td>
</tr>
<tr>
<td>Cocaine</td>
<td>-0.50</td>
<td>0.36</td>
<td>0.14</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>-0.86</td>
<td>0.37</td>
<td>0.02*</td>
</tr>
<tr>
<td>Heroin</td>
<td>-0.44</td>
<td>0.32</td>
<td>0.17</td>
</tr>
<tr>
<td>Previous Treatment Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Help</td>
<td>-0.64</td>
<td>0.31</td>
<td>0.04*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>-0.23</td>
<td>0.29</td>
<td>0.43</td>
</tr>
<tr>
<td>Inpatient</td>
<td>-0.64</td>
<td>0.32</td>
<td>0.05*</td>
</tr>
<tr>
<td>Understanding of Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>1.63</td>
<td>0.44</td>
<td>0.00*</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>-0.47</td>
<td>0.50</td>
<td>0.35</td>
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<tr>
<td>Sociocultural</td>
<td>1.45</td>
<td>0.46</td>
<td>0.00*</td>
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<tr>
<td>Preferred Treatment Goal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use/Decrease (-) Consequences</td>
<td>0.37</td>
<td>0.31</td>
<td>0.24</td>
</tr>
<tr>
<td>Use/Controlled</td>
<td>0.27</td>
<td>0.31</td>
<td>0.47</td>
</tr>
<tr>
<td>Stop Using</td>
<td>0.49</td>
<td>0.30</td>
<td>0.10</td>
</tr>
<tr>
<td>Order</td>
<td>0.11</td>
<td>0.04</td>
<td>0.01*</td>
</tr>
<tr>
<td>Constant</td>
<td>-3.26</td>
<td>0.64</td>
<td>0.00*</td>
</tr>
</tbody>
</table>

Note. Values in this table have been rounded to two decimal places.
*aOrder accounts for the sequencing of vignettes presented to each respondent (i.e., vignette 1-10) and measures changes to the probability of selecting the predetermined response based on how many vignettes were seen. A positive coefficient suggests that the more vignettes a respondent saw, the more likely they were to select the predetermined response.
*bConstant variables include alcohol as the client’s drug of choice, no previous treatment experience, an understanding of substance use explained by the disease perspective, and a preferred treatment goal of no change.
*p < .05
Information presented in Figure 4 and Table 13 suggests that when respondents were presented with a vignette that represented the psychoanalytic perspective as the client’s understanding of substance use, they selected the psychoanalytic perspective 18% of the time. Furthermore, respondents correctly matched the sociocultural perspective 15% of the time, the disease perspective 4% of the time, and the cognitive behavioral perspective 3% of the time.

In addition, respondents were less likely to select the predetermined theoretical perspective when a client’s drug of choice was tranquilizers than when a client’s drug of choice was alcohol. They were less likely to select the predetermined theoretical perspective when a client had attended self-help groups within the past year or when a client had attended inpatient/residential rehabilitation in the past year than when a client...
had never received any kind of addiction treatment. Respondents were more likely to select the predetermined theoretical perspective when a client’s understanding of substance use was represented by the psychoanalytic or sociocultural perspectives than when a client’s understanding of substance use was represented by the disease perspective. Lastly, the more vignettes a respondent saw, the more likely they were to be correct in their responses.

**Recommendation of a predetermined treatment approach at the vignette level.** Table 14 presents the results of the hierarchical regression of addiction professionals’ recommendation of a predetermined treatment approach on the client’s preferred treatment goal. As with the previous regression analysis, this analysis was conducted at the vignette level; therefore, respondent *selections*, rather than respondents themselves, were analyzed. Figure 5 displays the predicted probabilities of recommending a predetermined treatment approach for different levels of a client’s preferred treatment goal. Independent variables depicting a client’s preferred treatment goal are represented in Figure 5. From left to right, the labels in Figure 5 represent the following preferred treatment goals: (a) doesn’t really have to change anything; (b) can keep using at the same levels, but decrease the negative consequences of use; (c) can keep using, but in a controlled way; and (d) can stop using altogether. The predicted probabilities in Figure 5 are based on the regression results in Table 14 and are estimated relative to the baseline vignette. Again, the regression results in Table 14 were converted to predicted probabilities by passing the regression coefficients through the logit link
function. This process uses the coefficients to calculate the predicted probability of selecting the correct, or predetermined, response.

Table 14

Hierarchical Regression of Addiction Professionals’ Recommendation of a Predetermined Treatment Approach on A Client’s Drug of Choice, Previous Treatment Experience, Understanding of Substance Use, and Preferred Treatment Goal

<table>
<thead>
<tr>
<th>Drug of Choice</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Relievers</td>
<td>0.25</td>
<td>0.23</td>
<td>0.28</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.30</td>
<td>0.21</td>
<td>0.16</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>0.25</td>
<td>0.24</td>
<td>0.29</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.14</td>
<td>0.25</td>
<td>0.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Treatment Experience</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Help</td>
<td>0.19</td>
<td>0.22</td>
<td>0.38</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.15</td>
<td>0.21</td>
<td>0.47</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.31</td>
<td>0.22</td>
<td>0.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Understanding of Use</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoanalytic</td>
<td>-0.10</td>
<td>0.24</td>
<td>0.66</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>-0.04</td>
<td>0.24</td>
<td>0.85</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>0.32</td>
<td>0.22</td>
<td>0.14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Treatment Goal</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use/Decrease (-) Consequences</td>
<td>-1.17</td>
<td>0.27</td>
<td>0.00*</td>
</tr>
<tr>
<td>Use/Controlled</td>
<td>-0.03</td>
<td>0.25</td>
<td>0.89</td>
</tr>
<tr>
<td>Stop Using</td>
<td>1.00</td>
<td>0.28</td>
<td>0.00*</td>
</tr>
</tbody>
</table>

| Ordera                        | 0.03 | 0.03 | 0.41 |
| Constantb                     | 0.54 | 0.35 | 0.13 |

Note. Values in this table have been rounded to two decimal places.

*a* Order accounts for the sequencing of vignettes presented to each respondent (i.e., vignette 1-10) and measures changes to the probability of selecting a predetermined response based on how many vignettes were seen. A positive coefficient suggests that the more vignettes a respondent saw, the more likely they were to select a predetermined response.

*b* Constant variables include alcohol as the client’s drug of choice, no previous treatment experience, an understanding of substance use explained by the disease perspective, and a preferred treatment goal of no change.

*p < .05
Figure 5. The predicted probability of recommending a correct treatment approach

Information presented in Figure 5 and Table 14 suggests that when respondents were presented with a vignette depicting a client whose preferred treatment goal was to stop using altogether, they selected a predetermined (or correct) treatment approach (i.e., Twelve-step facilitation, relapse prevention, or adjunctive pharmacotherapy) 62% of the time. Respondents correctly matched motivational interviewing with a client goal of no change 38% of the time. They correctly matched harm reduction, contingency management, or adjunctive pharmacotherapy with a client goal of controlled use 37% of the time. Correct matches were made between harm reduction and a client goal of decreasing the negative consequences of use 16% of the time.

Further inspection of the data shows that respondents were less likely to select a predetermined treatment approach when a client’s preferred treatment goal was to keep
using at the same levels, but decrease the negative consequences of use than when a client’s preferred treatment goal was that he didn’t really have to change anything.

**Selection of the predetermined theoretical perspective at the respondent level.** Table 15 presents the results of the hierarchical regression of addiction professionals’ selection of the predetermined theoretical perspective on the client’s understanding of substance use at the respondent level.

Table 15

*Hierarchical Regression of Addiction Professionals’ Selection of the Predetermined Theoretical Perspective on the Respondent and Vignette Variables*

<table>
<thead>
<tr>
<th>Respondent Variables</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s</td>
<td>-1.01</td>
<td>0.37</td>
<td>0.01*</td>
</tr>
<tr>
<td>Doctoral</td>
<td>-0.99</td>
<td>0.58</td>
<td>0.09</td>
</tr>
<tr>
<td><strong>Areas of Addiction Training</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theories of Addiction</td>
<td>-0.85</td>
<td>0.59</td>
<td>0.15</td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>1.56</td>
<td>0.79</td>
<td>0.05*</td>
</tr>
<tr>
<td><strong>Primary Work Setting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonclinical</td>
<td>0.52</td>
<td>0.57</td>
<td>0.36</td>
</tr>
<tr>
<td>Residential/Inpatient</td>
<td>-0.22</td>
<td>0.34</td>
<td>0.53</td>
</tr>
<tr>
<td><strong>Tx Philosophy of Work Setting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>0.20</td>
<td>0.44</td>
<td>0.65</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>-0.48</td>
<td>0.48</td>
<td>0.32</td>
</tr>
<tr>
<td>Different Tx Philosophy</td>
<td>0.98</td>
<td>0.57</td>
<td>0.08</td>
</tr>
<tr>
<td>Different Tx Approach</td>
<td>-0.12</td>
<td>0.60</td>
<td>0.84</td>
</tr>
<tr>
<td><strong>Preferred Theoretical Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>0.31</td>
<td>0.32</td>
<td>0.34</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>0.39</td>
<td>0.35</td>
<td>0.26</td>
</tr>
<tr>
<td>Receive Supervision</td>
<td>-0.23</td>
<td>0.29</td>
<td>0.44</td>
</tr>
<tr>
<td>Personally in Recovery</td>
<td>-0.16</td>
<td>0.29</td>
<td>0.57</td>
</tr>
<tr>
<td>Friend/Family in Recovery</td>
<td>0.16</td>
<td>0.39</td>
<td>0.69</td>
</tr>
</tbody>
</table>

*(table continues)*
### Table 15 (continued)

**Hierarchical Regression of Addiction Professionals’ Selection of the Predetermined Theoretical Perspective on the Respondent and Vignette Variables**

<table>
<thead>
<tr>
<th>Vignette Variables</th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug of Choice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>0.16</td>
<td>0.35</td>
<td>0.66</td>
</tr>
<tr>
<td>Cocaine</td>
<td>-0.45</td>
<td>0.37</td>
<td>0.22</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>-0.61</td>
<td>0.39</td>
<td>0.12</td>
</tr>
<tr>
<td>Heroin</td>
<td>-0.42</td>
<td>0.36</td>
<td>0.25</td>
</tr>
<tr>
<td>Previous Treatment Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended Self-Help Groups</td>
<td>-0.64</td>
<td>0.35</td>
<td>0.07</td>
</tr>
<tr>
<td>Attended Outpatient Treatment</td>
<td>-0.03</td>
<td>0.30</td>
<td>0.92</td>
</tr>
<tr>
<td>Attended Inpatient Treatment</td>
<td>-0.47</td>
<td>0.33</td>
<td>0.16</td>
</tr>
<tr>
<td>Understanding of Substance Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>2.63</td>
<td>0.50</td>
<td>0.00*</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>0.53</td>
<td>0.59</td>
<td>0.36</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>2.60</td>
<td>0.51</td>
<td>0.00*</td>
</tr>
<tr>
<td>Preferred Treatment Goal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use/Decrease (-) Consequences</td>
<td>-0.01</td>
<td>0.33</td>
<td>0.98</td>
</tr>
<tr>
<td>Use/Controlled</td>
<td>-0.09</td>
<td>0.34</td>
<td>0.79</td>
</tr>
<tr>
<td>Stop Using</td>
<td>0.38</td>
<td>0.31</td>
<td>0.21</td>
</tr>
<tr>
<td>Order</td>
<td>0.06</td>
<td>0.04</td>
<td>0.11</td>
</tr>
<tr>
<td>Constant</td>
<td>-4.41</td>
<td>1.28</td>
<td>0.00*</td>
</tr>
</tbody>
</table>

**Note.** Different Tx Philosophy and Different Tx Approach indicate that respondents were able to work from a treatment philosophy or treatment approach other than those endorsed by their work setting. Statistics for the rows Receive Supervision, Personally in Recovery, and Friend/Family in Recovery represent respondents who do receive supervision, who are personally in recovery, and who have friend/family members in recovery. Percentages in this table have been rounded to two decimal places.

*a*Order accounts for the sequencing of vignettes presented to each respondent saw (i.e., vignette 1-10) and measures changes to the probability of selecting the predetermined response based on how many vignettes were seen. A positive coefficient suggests that the more vignettes a respondent saw, the more likely they were to select the predetermined response.

*b*Constant variables at the respondent level include a bachelor’s degree/associate’s degree/other degree, an outpatient work setting, being able to ‘somewhat’ work from a different treatment philosophy and treatment approach other than those endorsed by their work setting (responses of ‘somewhat’ and ‘no’ are included in this baseline), a preferred theoretical orientation of Adlerian, Behavior, Cognitive, Existential, Family and Couples, Gestalt, Psychoanalytic/Psychodynamic, Reality/Choice, Solution-focused, Spiritual/Religious, and Other, not receiving supervision, not in recovery, and not having friends or family members in recovery. Constant variables at the vignette level include alcohol as the client’s drug of choice, no previous treatment experience, an understanding of substance use explained by the disease perspective, and a preferred treatment goal of no change.

*p < .05*
Two respondent variables had a statistically significant influence on respondents’ selection of the predetermined (or correct) theoretical perspective: (a) a master’s level of education ($\beta = -1.01$, SE = 0.37, $p = 0.01$), and (b) having received addiction-specific training in treatment planning ($\beta = 1.56$, SE = 0.79, $p = 0.05$). Relative to the baseline, respondents with a master’s degree were less likely to be correct in their selection of the predetermined theoretical perspective, and those who had received addiction-specific training in treatment planning were more likely to be correct in their selection of the predetermined theoretical perspective. Also, respondents were more likely to select the correct theoretical perspective when the fictitious client’s understanding of substance use portrayed the psychoanalytic or sociocultural perspectives than when the fictitious client’s understanding of substance use portrayed the disease perspective.

**Recommendation of a predetermined treatment approach at the respondent level.** Table 16 presents the results of the hierarchical regression of addiction professionals’ recommendation of a predetermined treatment approach on the client’s preferred treatment goal at the respondent level.

Relative to the baseline, no respondent variables yielded statistically significant results. Respondent variables did not have a statistically significant influence on addiction professionals’ recommendation of a predetermined treatment approach. However, further inspection of the data shows that respondents were less likely to be correct in their recommendation of a predetermined treatment approach when a client’s preferred treatment goal was to continue using at the same levels (but decrease the negative consequences of use) than when the client’s goal was that he didn’t really have
Table 16

*Hierarchical Regression of Addiction Professionals’ Selection of a Predetermined Treatment Approach on the Respondent and Vignette Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
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<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respondent Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Education</td>
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<td></td>
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</tr>
<tr>
<td>Master’s</td>
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<td>0.35</td>
<td>0.14</td>
</tr>
<tr>
<td>Doctoral</td>
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<td>0.62</td>
</tr>
<tr>
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<tr>
<td>Theories of Addiction</td>
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<td>0.91</td>
</tr>
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<td>Treatment Planning</td>
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<td>0.77</td>
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<td>Primary Work Setting</td>
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<tr>
<td>Nonclinical</td>
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<td>0.54</td>
<td>0.51</td>
</tr>
<tr>
<td>Residential/Inpatient</td>
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<td>0.32</td>
<td>0.41</td>
</tr>
<tr>
<td>Tx Philosophy of Work Setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease</td>
<td>0.51</td>
<td>0.44</td>
<td>0.25</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>0.48</td>
<td>0.45</td>
<td>0.29</td>
</tr>
<tr>
<td>Different Tx Philosophy</td>
<td>-0.24</td>
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<td>0.62</td>
</tr>
<tr>
<td>Different Tx Approach</td>
<td>0.17</td>
<td>0.51</td>
<td>0.74</td>
</tr>
<tr>
<td>Preferred Theoretical Orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>-0.14</td>
<td>0.30</td>
<td>0.65</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>-0.39</td>
<td>0.33</td>
<td>0.24</td>
</tr>
<tr>
<td>Receive Supervision</td>
<td>-0.19</td>
<td>0.28</td>
<td>0.50</td>
</tr>
<tr>
<td>Personally in Recovery</td>
<td>-0.05</td>
<td>0.27</td>
<td>0.84</td>
</tr>
<tr>
<td>Friend/Family in Recovery</td>
<td>0.50</td>
<td>0.36</td>
<td>0.16</td>
</tr>
<tr>
<td><strong>Vignette Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug of Choice</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>0.02</td>
<td>0.26</td>
<td>0.94</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.33</td>
<td>0.26</td>
<td>0.20</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>0.26</td>
<td>0.26</td>
<td>0.32</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.17</td>
<td>0.26</td>
<td>0.50</td>
</tr>
<tr>
<td>Previous Treatment Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended Self-Help Groups</td>
<td>0.12</td>
<td>0.23</td>
<td>0.60</td>
</tr>
<tr>
<td>Attended Outpatient Treatment</td>
<td>0.10</td>
<td>0.22</td>
<td>0.65</td>
</tr>
<tr>
<td>Attended Inpatient Treatment</td>
<td>0.33</td>
<td>0.23</td>
<td>0.15</td>
</tr>
<tr>
<td>Understanding of Substance Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoanalytic</td>
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<td>0.23</td>
<td>0.71</td>
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<tr>
<td>Cognitive Behavioral</td>
<td>0.13</td>
<td>0.24</td>
<td>0.57</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>0.35</td>
<td>0.23</td>
<td>0.13</td>
</tr>
<tr>
<td>Preferred Treatment Goal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use/Decrease (-) Consequences</td>
<td>-0.97</td>
<td>0.23</td>
<td>0.00</td>
</tr>
<tr>
<td>Use/Controlled</td>
<td>0.09</td>
<td>0.23</td>
<td>0.69</td>
</tr>
<tr>
<td>Stop Using</td>
<td>0.99</td>
<td>0.22</td>
<td>0.00*</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 16 (continued)

Hierarchical Regression of Addiction Professionals’ Selection of a Predetermined Treatment Approach on the Respondent and Vignette Variables

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order(^a)</td>
<td>0.03</td>
<td>0.03</td>
<td>0.21</td>
</tr>
<tr>
<td>Constant(^b)</td>
<td>-1.40</td>
<td>1.02</td>
<td>0.17</td>
</tr>
</tbody>
</table>

Note. Different Tx Philosophy and Different Tx Approach indicate that respondents were able to work from a treatment philosophy or treatment approach other than those endorsed by their work setting. Statistics for the rows Receive Supervision, Personally in Recovery, and Friend/Family in Recovery represent respondents who do receive supervision, who are personally in recovery, and who have friend/family members in recovery. Percentages in this table have been rounded to two decimal places.

\(^a\)Order accounts for the sequencing of vignettes presented to each respondent saw (i.e., vignette 1-10) and measures changes to the probability of selecting the predetermined response based on how many vignettes were seen. A positive coefficient suggests that the more vignettes a respondent saw, the more likely they were to select the predetermined response.

\(^b\)Constant variables at the respondent level include a bachelor’s degree/associate’s degree/other degree, an outpatient work setting, being able to ‘somewhat’ work from a different treatment philosophy and treatment approach other than those endorsed by their work setting (responses of ‘somewhat’ and ‘no’ are included in this baseline), a preferred theoretical orientation of Adlerian, Behavior, Cognitive, Existential, Family and Couples, Gestalt, Psychoanalytic/Psychodynamic, Reality/Choice, Solution-focused, Spiritual/Religious, and Other, not receiving supervision, not in recovery, and not having friends or family members in recovery. Constant variables at the vignette level include alcohol as the client’s drug of choice, no previous treatment experience, an understanding of substance use explained by the disease perspective, and a preferred treatment goal of no change.

\(^p<.05\)

to change anything. By contrast, respondents were more likely to be correct in their selection of a predetermined treatment approach when the fictitious client wanted to stop using altogether than when he didn’t really have to change anything. Likelihood was determined based on the results presented in Table 16.

Chapter Summary

This chapter presented the research questions, hypotheses, and sub-hypotheses of the current study, as well as a review of its methodology: the factorial survey approach
(Rossi & Nock, 1982). The effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective and recommended treatment approach were explored. Two versions of coding the dependent variables were used during data analysis: (a) an uncollapsed version and (b) a collapsed version. Chi-square analysis was used with the uncollapsed version of the dependent variables and hierarchical regression analysis was used with the collapsed versions of the dependent variables. The data set for the collapsed versions of the dependent variables was analyzed at two levels: (a) the vignette level and (b) the respondent level.

Results of the chi-square analysis suggested that a client’s drug of choice, previous treatment experience, and understanding of substance use were all associated with addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understanding of substance use. A client’s understanding of substance use and preferred treatment goal were each associated with addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal. Hierarchical regression analysis at the vignette level revealed that respondent selections were incorrect most of the time when identifying the predetermined theoretical perspectives and recommended treatment approaches. However, statistically significant relationships were found between addiction professionals’ selection of the predetermined theoretical perspective and select drugs of choice, previous treatment experiences, and understandings of substance use.
Statistically significant relationships were also found between addiction professionals’ recommendation of a predetermined treatment approach and specific client goals.

Hierarchical regression analysis at the respondent level showed that level of education and particular addiction-specific training had an effect on addiction professionals’ selection of a predetermined theoretical perspective, as well as select client understandings of substance use. No respondent variables yielded statistically significant effects on the recommendation of a predetermined treatment approach relative to the baseline. However, relationships were found between select client understandings of substance use and addiction professionals’ recommendation of a predetermined treatment approach. Chapter 4 provides a discussion of these results, as well as implications for counseling in the field of substance use treatment and recommendations for future research. Limitations to the current study also are presented.
CHAPTER IV
DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of the current study was to investigate the effects of client variables on addiction professionals’ decision making. The effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective and recommended treatment approach were explored. This chapter provides a discussion of the current study’s findings related to the existing literature and also identifies implications for the treatment of substance use disorders. Limitations of the current study are presented, as well as recommendations for future research.

Research Question One

The first research question explored the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ selection of a theoretical perspective according to their interpretation of a client’s understanding of substance use. Chi-square analysis was used for this research question and explored the data set using an uncollapsed version of the dependent variable, addiction professionals’ selection of a theoretical perspective (see Figure 1). That is, the effect of each independent variable on the dependent variable, regardless of a correct or incorrect response, was explored.

Additional considerations explored the likelihood of respondents to select the predetermined (or correct) theoretical perspective based on their interpretation of a client’s understanding of substance use. This question was explored at the vignette level
and the data set was analyzed with a collapsed version of the dependent variable (see Figure 1 and Table 5). That is, the effect of one specific independent variable, a client’s understanding of substance use, on the dependent variable was explored and responses were either correct or incorrect (i.e., predetermined).

In a like manner, the effects of respondent variables on predetermined responses were also investigated. The effects of respondent variables were explored at the respondent level and, again, the data set was analyzed with a collapsed version of the dependent variable (see Figure 1). That is, the effects of respondent variables on their selection of the correct/incorrect (i.e., predetermined) theoretical perspective were explored. Hierarchical regression analysis was used to analyze the data set with the collapsed version of the dependent variable. A discussion of the findings as they relate to the existing literature is presented next.

**Chi-Square Analysis**

Chi-square analysis of data from the current study found statistically significant relationships between (a) a client’s drug of choice, (b) a client’s previous treatment experience, and (c) a client’s understanding of substance use, and addiction professionals’ selection of a theoretical perspective. No statistically significant relationship was found between a client’s preferred treatment goal and addiction professionals’ selection of a theoretical perspective.

**Drug of choice.** Existing literature has identified a client’s drug of choice as a client variable that influences addiction professionals’ decision making (Breslin et al., 2000; Lordan et al., 1997; Samuelsson & Wallander, 2013; Wallander & Blomqvist,
The decision to refer a client to various levels of treatment has been influenced by a client’s drug of choice (Breslin et al., 2000; Lordan et al., 1997; Wallander & Blomqvist, 2009). Breslin et al. (2000) found that most addiction professionals defaulted to long-term treatment referrals; although, when the client’s drug of choice was crack/cocaine and the client had experienced a significant amount of time substance-free, addiction professionals were open to short-term referrals. By contrast, Breslin et al. also found that if the client’s drug of choice was cocaine and that client identified needing specialized addiction treatment (e.g., a group designed only for cocaine use), then long-term treatment became an option. Additionally, Breslin et al. reported that clients whose drugs of choice were marijuana or alcohol were more likely to be considered for short-term treatment options than those using other drugs of choice.

Wallander and Blomqvist (2009) found that clients who used heroin rather than amphetamines or alcohol were more often referred to inpatient versus outpatient treatment. Lordan et al. (1997) noted that clients who sought treatment for heroin, and had multiple failed treatment attempts, were seen as better candidates for outpatient methadone maintenance than inpatient treatment. Lordan et al. also found that drugs of choice influenced referrals to both non-hospital-based and hospital-based inpatient detoxifications. A client’s drug of choice is also known to influence addiction professionals’ assessment of substance use severity (Samuelson & Wallander, 2013). Samuelson and Wallander found that cannabis or cocaine use was viewed to be more problematic than alcohol use.
In the current study, a statistically significant relationship was found between a client’s drug of choice and addiction professionals’ selection of a theoretical perspective. Alcohol and tranquilizer use were most often associated with the sociocultural perspective of substance use. Cocaine use was most often associated with the psychoanalytic perspective of substance use. Pain reliever and heroin use were equally likely to be associated with the sociocultural or psychoanalytic perspectives of substance use. Least likely to be associated with any of the drugs of choice (i.e., alcohol, pain relievers, cocaine, tranquilizers, heroin) was the disease perspective of substance use. This finding is surprising given that the dominant understanding of and treatment for substance use disorders in the United States is the disease perspective (NIDA, 2012).

It might be worth noting that similar drugs of choice were linked to similar theoretical perspectives. Alcohol and tranquilizers, for example, are both depressants and each drug was linked to the psychoanalytic perspective. Heroin and pain relievers, both opioids, were linked to either sociocultural or psychoanalytic perspectives. Cocaine, a stimulant drug, was linked to the psychoanalytic perspective. Inspection of these links also revealed that the psychoanalytic perspective spanned all drugs of choice. A possible explanation for these links could be that there are underlying beliefs attached to particular types of substances. It was hypothesized that a client’s drug of choice would influence addiction professionals’ selection of a theoretical perspective, and this hypothesis was supported by the current study’s findings.

**Previous treatment experience.** Existing literature indicates that a client’s previous treatment experiences influence addiction professionals’ decision making
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(Breslin et al., 2000; Lordan et al., 1997; Wallander & Blomqvist, 2009; Wryobeck & Rosenberg, 2005). Wryobeck and Rosenberg (2005) found that a client’s previous treatment experience influenced providers’ decisions about the acceptability of two harm reduction approaches: short-term methadone use and needle exchange. They noted that the number of previous treatment experiences was directly related to providers’ acceptance of needle exchange; however, beliefs about the number of previous treatment experiences differed among providers in their study. Some providers thought that needle exchange was an acceptable treatment approach when clients had fewer previous treatment experiences, whereas others thought that needle exchange was an acceptable treatment approach when clients had a greater number of previous treatment experiences. Wryobeck and Rosenberg’s study also found that previous treatment experience was the only client variable that influenced providers’ acceptance of short-term methadone use. Overall, they found that needle exchange was viewed as a more acceptable treatment option than short-term methadone use for clients in their study.

Wallander and Blomqvist (2009) found that clients who had attended outpatient treatment in the past were two times as likely to be referred to inpatient treatment than those who had no previous treatment experience, suggesting that unsuccessful outpatient experiences indicate a need for inpatient treatment. On the other hand, those with no previous treatment experience were more likely to be referred to outpatient treatment than those with previous treatment experience. Breslin et al. (2000) also found a link between previous treatment experiences and referral to long-term versus short-term treatment options. Individuals in their study who had not responded well to prior treatment were
referred to the long-term treatment approach; however, those who had responded well to prior treatment were considered for the short-term treatment approach. Similarly, Lordan et al. (1997) noted that individuals who had experienced several failed treatment attempts, and who were seeking treatment for heroin, were referred to outpatient methadone maintenance programs over inpatient programs. They found failed treatment experiences to be the one client variable most associated with the perceived need for long-term treatment.

In the current study, a statistically significant relationship was found between a client’s previous treatment experience and addiction professionals’ selection of a theoretical perspective. Addiction professionals most often identified the sociocultural perspective of substance use when a client’s previous treatment experience represented one of the following: (a) never received any kind of addiction treatment, (b) attended self-help groups within the past year, and (c) attended outpatient rehabilitation in the past year. Addiction professionals most often identified the psychoanalytic perspective of substance use when a client’s previous treatment experience was that he had attended inpatient/residential rehabilitation in the past year. The disease perspective of substance use was least often associated with any level of a client’s previous treatment experience. Again, this is surprising given the norms in United States addiction treatment.

It could be said that the sociocultural perspective was linked to previous treatment experiences that were less intense, whereas the psychoanalytic perspective was linked to previous treatment experiences that were more intense. Perhaps respondents linked the psychoanalytic perspective with substance use interpreted to be more severe, and the
sociocultural perspective with substance use interpreted to be less severe. It was hypothesized that a client’s previous treatment experience would influence addiction professionals’ selection of a theoretical perspective, and this hypothesis was supported by the current study’s findings.

**Understanding of substance use.** The current study is the first known to investigate the influence of a fictitious client’s understanding of substance use on addiction professionals’ selection of a theoretical perspective according to their interpretation of a fictitious client’s understanding of substance use. A statistically significant relationship was found between a client’s understanding of substance use and addiction professionals’ selection of a theoretical perspective. When a client’s understanding of substance use was intended to represent the disease perspective, respondents most often selected the psychoanalytic perspective as the theoretical perspective that best described the client’s use. When a client’s understanding of substance use was intended to represent the psychoanalytic or cognitive behavioral perspectives, respondents most often selected the sociocultural perspective as the theoretical perspective that best described the client’s use. When a client’s understanding of substance use was intended to represent the sociocultural perspective, the vast majority of respondent selections (60%) represented the option of being unsure about which theoretical perspective best described the client’s use.

One reason for these “mismatches” could be that descriptions provided to respondents weren’t thorough, or clear enough. Another explanation could be that respondents’ levels of familiarity with each of the theories weren’t quite as high as
reported. It was hypothesized that a client’s understanding of substance use would influence addiction professionals’ selection of a theoretical perspective. In this regard, the current study’s findings supported this hypothesis. However, it was also hypothesized that respondents would select the predetermined (or correct) theoretical perspective that was intended to match the client’s understanding of substance use. This hypothesis was not supported by the current study’s findings, and these results are discussed in the following section.

**Hierarchical Regression Analysis**

Hierarchical regression of addiction professionals’ selection of the predetermined (or correct) theoretical perspective on the client’s understanding of substance use was conducted at the vignette and respondent levels. Analyses at both levels were conducted using the collapsed version of the dependent variable (see Table 5).

**Understanding of substance use at the vignette level.** This secondary research question investigated the effect of a client’s understanding of substance use on addiction professionals’ selection of the predetermined (or correct) theoretical perspective according to their interpretation of a fictitious client’s understanding of substance use at the vignette level. The current study was the first known study to investigate such a relationship. Findings of the current study showed that addiction professionals were most often incorrect in their selection of the predetermined theoretical perspective. That is, they did not correctly identify the predetermined theoretical perspective that best represented the client’s description of use. Again, this could be because of an instrumentation error: that explanations were not thorough or clear.
However, an inspection of the results identified client variables that were more predictive of a correct or incorrect response than others. Respondents were less likely to be correct in their selection of the predetermined theoretical perspective when the client’s drug of choice was tranquillizers than when the client’s drug of choice was alcohol. This might be because alcohol use disorders are better understood, or more commonly seen, than tranquilizer use disorders. They also were less likely to be correct when a client’s previous treatment experience was either (a) attended self-help groups within the past year or (b) attended inpatient/residential rehabilitation in the past year than when a client had never received any kind of addiction treatment. Respondent selections were more likely to be correct when a client’s understanding of substance use was explained by the psychoanalytic or sociocultural perspectives than when a client’s understanding of substance use was explained by the disease perspective. This is surprising, again, because the disease perspective is the most known perspective for understanding addiction in the United States. It could be that respondents were familiar with biopsychosocial perspectives of addiction and because of that familiarity, they did not want to limit their selection to “disease only” ideology. Lastly, the more vignettes a respondent saw, the more likely they were to be correct in their responses.

It was hypothesized that a client’s understanding of substance use would influence addiction professionals’ selection of the predetermined theoretical perspective. In this regard, findings of the current study supported this hypothesis (hypothesis #1). However, it was also hypothesized that when a client’s understanding of substance use represented the disease, psychoanalytic, cognitive behavioral, or sociocultural
perspectives, respondents would select that same perspective (i.e., the predetermined match) as the theoretical perspective that best explained the client’s description of use. This hypothesis was not supported by the current study’s findings.

Understanding of substance use at the respondent level. This secondary research question investigated the effects of respondent variables on their selection of the predetermined theoretical perspective according to their interpretation of a client’s understanding of substance use at the respondent level. The current study is the first known study to investigate such a relationship. Two respondent variables were found to be statistically significant in predicting addiction professionals’ likelihood of selecting the predetermined (or correct) theoretical perspective.

Respondents who held a master’s degree were less likely to select the predetermined theoretical perspective than respondents who held an associates or bachelor’s degree. It is surprising to note that respondents who held a doctoral degree were no more likely than respondents who held an associates or bachelor’s degree to select the predetermined theoretical perspective. Respondents who had received addiction-specific training in treatment planning were more likely to be correct in their selection of the predetermined theoretical perspective than those without such training. Respondents also were more likely to select the correct theoretical perspective when they were presented with a vignette intended to represent the psychoanalytic or sociocultural perspectives of substance use than when they were presented with a vignette intended to represent the disease perspective. Because this was a tertiary analysis, research hypotheses were not identified.
Research Question Two

The second research question explored the effects of a client’s drug of choice, previous treatment experience, understanding of substance use, and preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a client’s preferred treatment goal. Chi-square analysis was used for this research question and data were analyzed using the uncollapsed version of the dependent variable, addiction professionals’ recommended treatment approach (see Figure 2). That is, the effect of each independent variable on the dependent variable, regardless of correct/incorrect responses, was explored.

Additional considerations explored the likelihood of respondents to recommend a predetermined (or correct) treatment approach according to their interpretation of a client’s preferred treatment goal. This question was explored at the vignette level and analysis was conducted with a collapsed version of the dependent variable (see Figure 2 and Table 6). That is, the effect of one specific independent variable, a client’s preferred treatment goal, on the dependent variable was explored and responses were either correct or incorrect (i.e., predetermined).

In a like manner, the effects of respondent variables on predetermined responses were also investigated. The effects of respondent variables were explored at the respondent level and analysis was also conducted using a collapsed version of the dependent variable (see Figure 2). That is, the effects of respondent variables on their recommendation of a correct/incorrect (i.e., predetermined) treatment approach were
explored. Hierarchical regression analysis was used to analyze the data set with the collapsed version of the dependent variable.

Chi-Square Analysis

Chi-square analysis of data from the current study found statistically significant relationships between a client’s (a) understanding of substance use and (b) preferred treatment goal, and addiction professionals’ recommended treatment approach. No statistically significant relationships were found between a client’s (a) drug of choice or (b) previous treatment experience, and addiction professionals’ recommended treatment approach.

Understanding of substance use. The current study is the first known study to investigate the relationship between a client’s understanding of substance use and addiction professionals’ recommended treatment approach. Results from the current study showed that across all client understandings of substance use (i.e., disease, psychoanalytic, cognitive behavioral, sociocultural), respondents were most likely to recommend motivational interviewing as the most appropriate treatment approach for a client’s preferred treatment goal. In the opposite direction, across all client understandings of substance use, respondents were least likely to recommend contingency management as the most appropriate treatment approach for a client’s preferred treatment goal. It is difficult to explain these connections because linking theory and treatment approach was beyond the scope of the current study. Instrumentation did not consider this relationship. One might guess, though, that because
respondents were more familiar with motivational interviewing than contingency management, they recommended it more often.

Further analysis showed that the top two treatment recommendations for a client whose understanding of substance use was intended to represent the disease perspective were motivational interviewing and 12-step facilitation. The top two treatment recommendations for a client whose understanding of substance use was intended to represent the psychoanalytic perspective were motivational interviewing and adjunctive pharmacotherapy. The top two treatment recommendations for a client whose understanding of substance use was intended to represent the cognitive behavioral or sociocultural perspectives were motivational interviewing and harm reduction. Relapse prevention and contingency management were the treatment approaches recommended least often, regardless of a client’s understanding of substance use; however, relapse prevention was the third most recommended treatment approach for a client whose understanding of substance use was intended to represent the disease perspective.

It is worth noting that motivational interviewing spanned each theoretical perspective. Again, this could be because of respondents’ reported familiarity with the approach, but one also might wonder if motivational interviewing was used as a “catch all” treatment approach; there are many misunderstandings about the use of motivational interviewing and often people claim to be using it when they are not (Miller & Rollnick, 2009). Speculation about why the second choice treatment recommendations were made is somewhat challenging. It makes sense that 12-step facilitation was linked to the disease perspective because this modality is most common in the United States (NIDA,
What is challenging is trying to explain the links between (a) the psychoanalytic perspective and adjunctive pharmacotherapy, and (b) the cognitive behavioral or sociocultural perspectives and harm reduction. Somehow, these three theoretical perspectives were linked to lesser known, lesser used, and often controversial, treatment approaches. It was hypothesized that a client’s understanding of substance use would influence addiction professionals’ recommended treatment approach. The findings of the current study supported this hypothesis.

**Preferred treatment goal.** The current study is the first known study to explore the influence of a client’s preferred treatment goal on addiction professionals’ recommended treatment approach according to their interpretation of a fictitious client’s preferred treatment goal; however, existing literature indicates that a client’s treatment preferences influence addiction professionals’ decision making (Breslin et al., 2000; Lordan et al., 1997; Wallander & Blomqvist, 2009). Lordan et al. (1997) found that some addiction care providers considered why clients were seeking treatment, as well as what their treatment preferences were, before recommending treatment placements. Breslin et al. (2000) found that, although less considered than other factors, matching client needs and preferences with treatment recommendations was important to some clinicians.

Clinicians in Breslin et al.’s study considered recommending short-term over long-term treatment when clients “fit” that respective treatment group. They referred to “fit” as being able to address special needs (e.g., women, gay men, cocaine use). Individuals who met these special needs criteria were asked specifically if they would prefer a short-term or long-term treatment approach.
Wallander and Blomqvist (2009) found a relationship between a client’s treatment preference and providers’ treatment recommendations. In their study, fictitious clients had the following treatment preferences: (a) no treatment preference, (b) a preference for outpatient treatment, or (c) a preference for inpatient treatment. A client’s treatment preference was found to be the client variable that most predicted respondents’ recommended treatment approaches. Clients who preferred to stay at home during treatment were often recommended outpatient treatment, and clients who preferred to leave home during treatment were almost four times as likely to be referred to inpatient treatment.

The current study found that across all preferred treatment goals (i.e., no change, keep using at the same levels but decrease the negative consequences, controlled use, or stop using), respondents were most likely to recommend motivational interviewing as the most appropriate treatment approach. Likewise, across all preferred treatment goals, respondents were least likely to recommend contingency management. Further inspection of the data showed that the overwhelming majority of respondents recommended motivational interviewing when the client’s preferred treatment goal was that he didn’t really have to change anything. When a client’s preferred treatment goal was to (a) keep using at the same levels, but decrease the negative consequences of use, or (b) to keep using, but in a controlled way, respondents recommended the use of motivational interviewing and harm reduction most often. Relapse prevention and 12-step facilitation were recommended most often when a client’s goal was to stop using altogether. It was hypothesized that a client’s preferred treatment goal would influence
addiction professionals’ recommended treatment approach. The findings of the current study supported this hypothesis.

**Hierarchical Regression Analysis**

Hierarchical regression of addiction professionals’ recommendation of a predetermined treatment approach on the client’s preferred treatment goal was conducted at the vignette and respondent levels. Analyses at both levels were conducted using the collapsed version of the dependent variable (see Table 6).

**Preferred treatment goal at the vignette level.** This secondary research question investigated the effect of a client’s preferred treatment goal on addiction professionals’ selection of a predetermined (or correct) treatment approach according to their interpretation of a fictitious client’s preferred treatment goal at the vignette level. The current study is the first known study to investigate such a relationship. Findings of the current study showed that addiction professionals were most often incorrect in their selection of a predetermined treatment approach. That is, they did not correctly identify a predetermined (or correct) treatment approach for the fictitious client’s preferred treatment goal.

However, further inspection of the data shows that when a client’s preferred treatment goal was to stop using altogether, respondents correctly identified a predetermined treatment approach most of the time; they were most likely to be correct in their response when presented with this client goal than any of the other client goals. This makes sense because, generally speaking, abstinence is the primary goal for addiction treatment in the United States (NIDA, 2012). Respondent selections were also
more likely to be correct when a client’s preferred treatment goal was to stop using altogether than when a client’s preferred treatment goal was that he didn’t really have to change anything. This is a little surprising given the overwhelming recommendation of motivational interviewing, which was predetermined to be the most appropriate treatment approach for a client who didn’t really want to change anything. When a client’s preferred treatment goal was to keep using at the same levels, but decrease the negative consequences of use, respondents were less likely to select a predetermined treatment approach than when a client’s goal was that he didn’t really have to change anything.

It was hypothesized that when a client’s preferred treatment goal was that he didn’t really have to change anything, respondents would recommend motivational interviewing as the most appropriate treatment approach for that goal. This hypothesis was supported by less than half of respondent selections. That is, less than half of respondent selections recommended motivational interviewing for this treatment goal.

It was hypothesized that when a client’s preferred treatment goal was that he could keep using at the same levels, but decrease the negative consequences of use, respondents would recommend harm reduction as the most appropriate treatment approach for that goal. This hypothesis was supported by a small minority of respondent selections. That is, a small minority of respondent selections recommended harm reduction for this treatment goal. Perhaps many respondents do not endorse harm reduction approaches.

It was hypothesized that when a client’s preferred treatment goal was to keep using, but in a controlled way, respondents would recommend harm reduction,
contingency management, or adjunctive pharmacotherapy as the most appropriate treatment recommendation for that goal. This hypothesis was supported by less than half of respondent selections. That is, less than half of respondent selections recommended harm reduction, contingency management, or adjunctive pharmacotherapy for this treatment goal.

It was hypothesized that when a client’s preferred treatment goal was to stop using altogether, respondents would recommend 12-step facilitation, relapse prevention, or adjunctive pharmacotherapy as the most appropriate treatment recommendation for that goal. This hypothesis was supported by over half of respondent selections. That is, over half of respondent selections recommended 12-step facilitation, relapse prevention, or adjunctive pharmacotherapy for this treatment goal.

Again, many of these “mismatches” could be linked to the study’s instrumentation. Explanations provided to respondents may not have been thorough, or clear. Familiarity with these treatment approaches may have been less than reported. Some responses may have reflected “catch all” treatment approaches.

**Preferred treatment goal at the respondent level.** This secondary research question investigated the effects of respondent characteristics on addiction professionals’ recommendation of a predetermined treatment approach according to their interpretation of a fictitious client’s preferred treatment goal at the respondent level. The current study is the first known study to investigate such a relationship. Findings of the current study showed that no respondent variables yielded statistically significant results. That is, respondent variables (see Figure 3) did not have a statistically significant influence on
their recommendation of a predetermined treatment approach. Because this was a tertiary analysis, research hypotheses were not identified.

Further inspection of the data shows that certain vignette variables influenced respondents’ likelihood to identify correct or incorrect responses. Respondents were less likely to select a predetermined treatment approach when the fictitious client vignette presented a client’s preferred treatment goal of continuing to use at the same levels, but decreasing the negative consequences of use, than when a client goal was that he didn’t really have to change anything. Additionally, respondents were more likely to be correct in their selection of a predetermined treatment approach when the fictitious client goal was to stop using altogether than when the fictitious client’s goal was that he didn’t really have to change anything. These findings mirror the aforementioned findings and, again, explanations may be linked to respondent familiarity or what is most commonly used in addictions treatment today.

Implications

The following section identifies the implications of the current study. These implications are discussed in relation to counselor education, clinical practice, and clinical supervision.

Counselor Education

Counselor education programs impact their graduates’ understanding of substance use disorders and their treatments. Unfortunately, many substance abuse counselors with a graduate-level education, even from accredited institutions, lack addiction-specific training (Fulton, Hartwig, Ybañez-Llorente, & Schmidt, 2016). Currently, only 1% of
master’s degree programs accredited by the Council for Accreditation of Counseling and Counseling Related Educational Programs (CACREP) offer a CACREP-approved Addictions Counseling track (CACREP, 2016a).

Results of the current study showed that addiction professionals with a master’s degree were less likely than those with associate’s or bachelor’s degrees to identify treatment approaches that were predetermined to be the most appropriate for specified client goals. However, those with addiction-specific training in treatment planning were more likely than those without addiction-specific training in treatment planning to identify treatment approaches that were predetermined to be the most appropriate for specified client goals. Surprisingly, individuals with doctoral degrees were no more likely than those with associate’s or bachelor’s degrees to be correct in their treatment recommendations.

The results of the current study suggest the importance of including addiction-specific training within master’s level counseling programs. Addiction-specific training increases addiction professionals’ ability to provide personalized care: care that considers a client’s preferred treatment goal when recommending treatment approaches. The National Institute on Drug Abuse has said that there is a need for personalized care when treating substance use disorders (NIDA, 2012). It is difficult to personalize care without being exposed to more than one way of treating something. Two areas of addiction-specific training that can facilitate personalized care were explored in the current study, and the CACREP (2016) standards for addiction counseling require
students to be exposed to these two areas: (a) theories and models of addiction, and (b) individualized strategies and treatment modalities (CACREP, 2016b).

**Clinical Practice**

Historically, the treatment of substance use disorders was provided by individuals who themselves were in recovery (Ham, LeMasson, & Hayes, 2013), and that population represents just under half of respondents in the current study. Although many providers in recovery do obtain addiction-specific training, as was the case in the current study, there continues to be a great number of paraprofessionals working in the field of addiction treatment (West & Hamm, 2012). Many of those paraprofessionals have acknowledged insufficient training and that they often rely on personal experiences and self-disclosure in their counseling practice (Ham et. al., 2013). Individuals have also said they rely heavily on onsite training (Fulton et al., 2016). Unfortunately, this onsite training has often been described as subpar (Olmstead, Abraham, Martino, & Roman, 2012). Insufficient training, in formal education and field experience, could explain, in part, the current study’s trend of addiction professionals’ likelihood to incorrectly identify theoretical perspectives and treatment approaches that were determined to be congruent and appropriate for respective client variables.

**Clinical Supervision**

The majority of respondents in the current study were receiving supervision, and those who were not receiving supervision were providing supervision to others. A state-by-state review of requirements for the supervisory endorsement in the United States showed no emphasis on supervisors needing to have addiction-specific training
(American Counseling Association [ACA], 2016). Therefore, graduate counseling students who are being supervised for practica and internship experiences are likely receiving supervision from those without addiction-specific training. And, although the current study did not find a statistically significant relationship between supervisory status and recommended treatment, inadequate supervision remains a concern in terms of counselor competency.

Olmstead et al. (2012) noted that competency-based supervision is rarely provided to those working in the addiction treatment field. Such supervision is a prerequisite for ensuring the safety of clients and protecting the profession (West & Hamm, 2012). A unique supervisory concern in the field of addiction counseling is that many supervisees may, themselves, be in recovery. As noted before, this was the case for almost half of respondents in the current study. An in-recovery-status increases the possibility of dual relationships (Gallagher, 2010; Hecksher, 2007; Taleff, 2010) between supervisees and their clients because the potential for encountering one another at a mutual-help group becomes reality. In addition, a recovering supervisee may view his or her nonrecovering supervisor as unqualified to provide addiction treatment (Anderson, 2001) because they lack real-life experience. Given this, careful monitoring of the supervisee’s use of self-disclosure and potential subjectivity in case conceptualization or treatment planning is necessary (Hecksher, 2007).

**Limitations**

The current study had seven limitations. First, respondents were not permitted to select multiple treatment options when asked to recommend a treatment approach that
was most appropriate for a respective client goal. This limitation is a result of the study’s design and does influence the study’s external validity. External validity is influenced because respondents may, in fact, be able to offer multiple treatment approaches simultaneously in real-world practice. This is a noteworthy limitation because the factorial survey approach is credited for producing high levels of external validity, given that respondent decisions are said to mirror those made in real life (Stokes & Schmidt, 2012; Taylor, 2006).

A second limitation was identified by the perceived simplicity of the vignettes. Expert reviewers said they would have liked to have more information about the fictitious client (e.g., “method of use, frequency of use, for how long, previous attempts to quit, withdrawal symptoms . . .”). It was also noted that the simplicity of vignettes “detract[ed] a little from them seeming real.” This is also an important limitation to address because it has been noted that one of the strengths of the factorial survey approach is that it randomly constructs vignettes that are intended to be lifelike, representing real-life scenarios (Rossi & Anderson, 1982; Rossi & Nock, 1982; Taylor, 2006).

A third limitation deals with a perceived inconsistency between theoretical perspectives and available treatment approaches. One member of the expert review panel believed that the available treatment approaches could only be used with two of the four identified theoretical perspectives: cognitive behavioral or disease. If respondents thought similarly, they may have limited their consideration of treatment approaches to those that “fit” the theoretical perspective they selected. That is, they may only have
considered treatment approaches that they believed to be consistent with their chosen theoretical perspective. However, questions asked of respondents were worded with specific intent, and that intent was not to link theoretical perspectives with treatment approaches, but rather to link (a) theoretical perspectives with what was interpreted as a client’s understanding of substance use and (b) treatment approaches with what was interpreted as a client’s preferred treatment goal.

A fourth limitation noted by some respondents in the pilot study was that the vignettes became repetitive. Respondents in the current study may have characterized their respondent subsamples as repetitive as well, thereby influencing attrition rates.

Studies conducted using the factorial survey approach typically use words or shorter phrases to represent the various levels of independent variables (see Samuelsson & Wallander, 2013; Wallander & Blomqvist, 2009). The vignettes used for data collection in the current study included phrases that were somewhat lengthy. Lengthier phrases are not customary in the factorial survey approach (Rossi & Nock, 1982) but were necessary to explore at least one of the current study’s independent variables: a client’s understanding of substance use. This particular independent variable required lengthier phrasing so that respondents could identify a theoretical perspective that best explained the client’s description of use.

A fifth limitation was that the dependent variables had multiple levels. Furthermore, “correct” and “incorrect” responses were predetermined by the researcher, based on consultation with an expert review panel. Because the dependent variables had multiple levels and there were predetermined correct/incorrect responses, the researcher
had to collapse the dependent variables for the hierarchical regression analysis. Although this method of analysis was theoretically-sound and answered the research questions presented in the current study, it did not represent the traditional methods used in Rossi and Nock’s (1982) factorial survey approach. Traditional analysis would have used hierarchical regression on an uncollapsed version of the dependent variable, thereby allowing the researcher to see how much of an impact each independent variable had on the dependent variables.

A sixth limitation could be with the study’s instrumentation. Textual fragments used to describe a client’s understanding of substance use may not have been thorough, or clear, enough for respondents to accurately assess. Consultation with an expert review panel was used in an effort to avoid such a limitation. Nevertheless, greater detail or specificity may have impacted the results of the current study.

Finally, a seventh limitation is the low response rate. Potential respondents were to receive one initial email inviting them to participate in the study and then three reminder emails to nonrespondents approximately one week apart. Erroneous distribution of the email blasts by a third party (i.e., NAADAC’s Senior List Operations Manager) is suspected. One NAADAC member who received the initial recruitment email and chose not to participate in the study reported to the researcher that she received no further emails (i.e., the reminder emails). Anecdotally, it could be said that several respondents may have received only the initial email requesting participation, but not the three reminder emails.
Recommendations for Future Research

Results of the current study spark several questions that could be considered for further research. One recommendation for future research is to conduct a similar study without the use of predetermined correct/incorrect responses. This would involve more specific questioning. For example, in the current study, it was predetermined that three of the six treatment approaches were most appropriate for a client goal of controlled use. Those three treatment approaches included (a) harm reduction, (b) contingency management, and (c) adjunctive pharmacotherapy. Future research could ask respondents to rank order these three treatment approaches to assess for perceived appropriateness or simply ask respondents which treatment approach they would recommend based on that particular client-identified treatment goal. This would eliminate the correct/incorrect response and, instead, would explore perceived levels of appropriateness or likelihood of recommending one treatment approach over the others.

A second recommendation for future research is to conduct a similar study designed to have greater fidelity to the factorial survey approach (Rossi & Nock, 1982). Levels of the independent variables would need to be adjusted to reflect shorter phrases. Dependent variables would need to be “separated out” so they have only one level. This differs from the current study where each dependent variable had multiple levels, which influenced data analysis in such a way that it deviated from traditional hierarchical regression analysis. Using Likert scales could also eliminate the problems associated with non-traditional data analysis. A similar study that included a greater number of
independent variables, those requested by members of the expert review panel, for example, would be beneficial, as well.

A third recommendation is to explore what standards need to be introduced to graduate-level counseling programs to increase exposure to advanced theories of, and treatments for, substance use disorders. Results of the current study suggest that clinicians with a doctoral degree were no more likely than those with an associate degree or bachelor’s degree to correctly identify theoretical perspectives or treatment approaches determined to be congruent and appropriate for select client variables. And, interestingly, respondents with a master’s degree were less likely than those with associate’s or bachelor’s degrees to be correct in their responses.

A fourth recommendation is to conduct qualitative inquiry, seeking to explore the thought-process behind the decision-making process (e.g., focus groups or think-aloud methodologies). Qualitative studies considering the same variables but focusing on case conceptualization and the reasons decisions were made could add interpretive value to the findings of the current study. To some degree, the current study uncovered respondents’ familiarity with various theories of substance use and evidence-based treatments for substance use disorders and because of this, results of the current study may not necessarily suggest what respondents actually do in practice.

A fifth recommendation is to explore barriers to implementing personalized care in the field of substance use disorders counseling: a field heavily influenced by a treatment-as-usual ideology. What is the influence of workplace philosophy on personalized care implementation? Does this promote or prohibit addiction professionals
with advanced knowledge from freely offering theoretically-sound, empirically-supported, ethical, and personalized client care? Is there pressure to adhere to traditional treatment protocol? How difficult is it to try to “break the mold” by introducing personalized care into field of substance use? The current study found no influence of statistical significance between respondents’ workplace variables and propensity to select predetermined theoretical perspectives or treatment approaches.

A sixth recommendation is that future research aim to answer questions about how to introduce personalized care to the field of substance use disorders counseling. Research could consider the reason for what appears to be continued splintering (i.e., a separation) between the treatment of substance use disorders and other mental health disorders. Studies could challenge the status-quo of “treatment-as-usual” and aim to expose the harmful effects of unethical or unfounded (i.e., traditional, anecdotal) treatment techniques. Investigations could create an argument for and promote, without question, the adoption of treatment modalities that are theoretically-sound, evidence-based, ethical, and personalized.

**Chapter Summary**

This chapter provided a discussion of the current study’s findings in relation to the existing literature. The current study corroborates and adds to the small body of known literature that has investigated the influence of client variables on addiction providers’ decision making. Results of the current study corroborated previous research findings by identifying further that there is a relationship between a client’s drug of choice, previous treatment experience, and treatment preference and addiction
professionals’ decision making. The current study’s findings added to the existing literature by being the first known study to investigate and identify relationships between addiction professionals’ decision making and their interpretation of a fictitious client’s (a) understanding of substance use and (b) preferred treatment goal.

Results of the current study suggest that the graduate-level counseling programs need to increase students’ exposure to addiction-specific content. Agencies providing treatment to those with substance use disorders may well benefit from more stringent gatekeeping practices, ensuring that providers have received specialized training, possess advanced addiction counseling competencies, and feel well-prepared for work in the addiction treatment field. Agencies would also benefit from closely monitoring any supervisory relationships, as well as ensuring the implementation of competency-based supervision.

Future research should focus its attention on matters related to personalized client care within the addictions treatment field. It should also consider matters related to the provision of ethical client care. Two components of this personalized and ethical client care in addictions treatment include: (a) honoring client understandings of their condition (ACA Code of Ethics, 2014) and (b) honoring client preferences (NIDA, 2012). Attention should be given to the relationship between the provision of personalized care and client outcomes. The goal of this attention should be to shift away from the traditional practices promoted by treatment-as-usual towards practices that are theoretically-sound, evidence-based, and individualized.
APPENDICES
Appendix A

IRB Approval


We have assigned your application the following IRB number: 15-321. Please reference this number when corresponding with our office regarding your application.

The Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I/Exempt from Annual review research. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:

- Exemption 1: Educational Settings
- Exemption 2: Educational Tests, Surveys, Interviews, Public Behavior Observation

This application was approved on May 11, 2015.

***Submission of annual review reports is not required for Level I/Exempt projects. We do NOT stamp Level I protocol consent documents.

If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation.

Please contact an IRB discipline specific reviewer or the Office of Research Compliance to discuss the changes and whether a new application must be submitted. https://sites.google.com/a/kent.edu/division-of-research-and-sponsored-programs-intranet/home/office-of-research-compliance
Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact us at Researchcompliance@kent.edu or by phone at 330-672-2704 or 330.672.8058.

Doug Delahanty | IRB Chair | 330.672.2395 | ddelahan1@kent.edu
Tricia Sloan | Administrator | 330.672.2181 | psloan1@kent.edu
Kevin McCrea | Assistant Director | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Director | 330.672.2704 | pwashko@kent.edu
APPENDIX B

RECRUITMENT EMAIL TO PARTICIPANTS
Appendix B

Recruitment Email to Participants

Hello Fellow NAADAC Member!

Please consider taking part in a research study investigating addiction professionals’ decision making. You could be one of ten winners who will receive a $50 gift card for participating!!

Your participation will include:
1) Approximately 25 minutes of your time.
2) Reading 10 short, fictitious case vignettes and then answering two questions about each vignette.
3) Completing a demographic questionnaire.

After completing the above requirements, you will have the opportunity to enter into a drawing that will award ten, $50 gift cards.

Please note: The views and opinions expressed as part of this research study are those of the researcher and do not reflect the position of NAADAC, the Association for Professionals.

This project is being supervised by Dr. Cynthia Osborn (cosborn@kent.edu) and Dr. Betsy Page (bpage@kent.edu), in the Counseling and Human Development Services program at Kent State University, and will serve as my dissertation research. The title of this research study is: The Effects of Client Variables on Addiction Professionals’ Decision Making: A Factorial Survey.

If you are interested in participating, please click the link below. Thank you so much for your consideration!!

https://kent.qualtrics.com/SE/?SID=SV_0kbLMtacysdl3FP

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Kent OH  44242
APPENDIX C

REMINDER EMAIL TO PARTICIPANTS
Appendix C

Reminder Email to Participants

Hello Fellow NAADAC Member!

This serves as a friendly reminder about a research study you have been invited to participate in. If you have already completed the survey, thank you so much for your help!!

If you have not yet completed the survey:
Please consider taking part in a research study investigating addiction professionals’ decision making. You could be one of ten winners who will receive a $50 gift card for participating!!

Your participation will include:
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APPENDIX D

VIGNETTE POOL
# Appendix D

## Vignette Pool

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Appendix E

Factorial Survey

The following 10 fictitious client vignettes describe a Caucasian male in his late 20s seeking treatment for substance use. Client information is purposely limited. Using only the information provided, please answer the corresponding questions about each vignette. Lastly, please complete the demographic questionnaire.

[Note: Respondents viewed 10 randomly assigned fictitious case vignettes that were displayed here. This is an incomplete example of what a respondent subsample might display.]

Vignette 1
The client is seeking treatment for cocaine.
He has never received any kind of substance use treatment.
He believes that the cause of his substance use is depression. He says that his life “sucks” and that it always has. He mentioned growing up with a “jerk of a father” and that his home life was “flat out miserable.” He reported that “nothing has really changed” and that the present is “just as miserable as the past.” He says that using is “just how I cope” with his depression.
His preferred treatment goal is one in which he can keep using, but in a controlled way.

**Question 1**—Based on the client’s belief about his substance use, please select the theoretical perspective that you think best represents his description.

1—Disease
2—Psychoanalytic
3—Cognitive Behavioral
4—Sociocultural
5—I’m not sure

**Question 2**—Although several treatment approaches may be applicable, please select the treatment approach you would recommend as the most appropriate treatment option for this client’s goal.

1—Motivational Interviewing
2—Relapse Prevention
3—Contingency Management
4—12-Step Facilitation
5—Adjunctive Pharmacotherapy
6—Harm Reduction
7—I’m not sure
Vignette 2
The client is seeking treatment for alcohol.
He has attended self-help groups in the past year.
He believes that the cause of his substance use is habit. Substances “give me what I want - the best kind of relief.” Anytime he’s “looking to relax” or when he’s “craving a pick-me-up,” using is a “guaranteed fix.” He says its “great for managing withdrawal, too!”
His preferred treatment goal is one in which he can stop using altogether.

**Question 1**—Based on the client’s belief about his substance use, please select the theoretical perspective that you think best represents his description.

1—Disease
2—Psychoanalytic
3—Cognitive Behavioral
4—Sociocultural
5—I’m not sure

**Question 2**—Although several treatment approaches may be applicable, please select the treatment approach you would recommend as the most appropriate treatment option for this client’s goal.

1—Motivational Interviewing
2—Relapse Prevention
3—Contingency Management
4—12-Step Facilitation
5—Adjunctive Pharmacotherapy
6—Harm Reduction
7—I’m not sure
APPENDIX F

EXPERT REVIEW PANEL
Appendix F

Expert Review Panel

Look over Table 3 (attached). Please pay close attention to the segments for “Client’s understanding of substance use” and “Client’s preferred treatment goals.” Keep in mind that these segments represent client perspectives. In *italics* beside each segment, you will see what is intended to be (1) a matching theoretical perspective and (2) a matching treatment approach, respectively.

1 - Does the client’s description (i.e., segments for “client’s understanding of substance use”) represent the intended theoretical perspective? If not, what would you change?

2 - Does the client’s statement about “preferred treatment goal” match the intended treatment approaches identified? If not, what would you change?

3 - Are the levels of independent variables representative of what you might see in real life? If not, what would you change?

The survey works like this - A computer-generated program randomly assigns different levels of each independent variable to a standard vignette structure. This creates 320 possible vignettes. From the total possible vignettes, each respondent (i.e., participant) receives a unique set of vignettes to respond to. I have attached the instrument (Appendix E) so that you can see how two completed vignettes read. Appendix E presented the reviewers with the following two vignettes:

**Vignette 1**
The client is seeking treatment for cocaine.
He has never received any kind of addiction treatment.
He believes that the cause of his addiction is depression. He says that his life sucks and that it always has. He mentioned growing up with a jerk of a father and that his home life was flat out miserable. He reported that nothing has really changed and that the present is just as miserable as the past. He says that using is just how he copes with his depression.
His treatment preference is one in which he can keep using, but in a controlled way.

**Vignette 2**
The client is seeking treatment for alcohol.
He has attended self-help groups in the past year.
He believes that the cause of his addiction is habit. Substances give him what he wants.
He says that using provides the best kind of relief, so quick and so certain. He noted that anytime he’s looking to relax or when he needs a pick-me-up, using is such a simple solution that delivers every time.
His treatment preference is one in which he can stop using altogether.

As you look over the instrument:

4 - Do the vignettes give you enough information to answer the questions?

5 - Are the vignettes believable (i.e., representative of how clients might present in real life)?

__________________________________________

Please also provide any general comments/suggestions.
APPENDIX G

IRB APPROVAL—PILOT STUDY
Appendix G

IRB Approval—Pilot Study

From: RAGS Research Compliance <researchcompliance@kent.edu>
Date: November 12, 2014 at 2:54:06 PM CST
To: "OSBORN, CYNTHIA" <cosborn@kent.edu>
Cc: "PAGE, BETSY" <bpage@kent.edu>
Subject: IRB Application: wrong number in previous email - #14-558 - please retain this email for your records

Hello, I need to make a correction. In the email you just received, we listed your IRB number as 14-556. That is incorrect.

Your IRB Protocol number is 14-558.

I do apologize for the mix up. If you have any questions or need more clarification just let me know!

Thank you,

Kent State University Office of Research Compliance
224 Cartwright Hall | fax 330.672.2658

Victoria Holbrook | Graduate Assistant | 330.672.2384 | vholbroo@kent.edu
Tricia Sloan | Administrator | 330.672.2181 | psloan1@kent.edu
Kevin McCreary | Assistant Director | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Director | 330.672.2704 | pwashko@kent.edu

For links to obtain general information, access forms, and complete required training, visit our website at www.kent.edu/research.

From: Holbrook, Victoria On Behalf Of RAGS Research Compliance
Sent: Wednesday, November 12, 2014 3:45 PM
To: OSBORN, CYNTHIA
Cc: PAGE, BETSY
Subject: IRB Level I, category 1 & 2 approval for Protocol application #14-556 - please retain this email for your records

RE: Protocol #14-556 - entitled “The Influence of Client Variables on Addiction Professionals’ Clinical Decision Making: A Factorial Survey (Pilot Study)”

We have assigned your application the following IRB number: 14-556. Please reference this number when corresponding with our office regarding your application.

The Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I/Exempt from Annual review research. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:
• Exemption 1: Educational Settings
• Exemption 2: Educational Tests, Surveys, Interviews, Public Behavior Observation

This application was approved on November 12, 2014.

***Submission of annual review reports is not required for Level 1/Exempt projects.

If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation.

Please contact an IRB discipline specific reviewer or the Office of Research Compliance to discuss the changes and whether a new application must be submitted.
http://www.kent.edu/research/researchsafetyandcompliance/irb/index.cfm

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact us at Researchcomplaince@kent.edu or by phone at 330-672-2704 or 330.672.8058.

Kent State University Office of Research Compliance
224 Cartwright Hall | fax 330.672.2658

Victoria Holbrook | Graduate Assistant | 330.672.2384 | vholbroo@kent.edu
Tricia Sloan | Administrator | 330.672.2181 | psloan1@kent.edu
Kevin McCrea | Assistant Director | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Director | 330.672.2704 | pwashko@kent.edu

For links to obtain general information, access forms, and complete required training, visit our website at

www.kent.edu/research
APPENDIX H

INFORMED CONSENT
Appendix H

Informed Consent

Addiction Professionals’ Decision Making: A Factorial Survey

You are invited to take part in a research study investigating addiction professionals’ decision making. Before taking part in this study, please read the consent form below.

Consent Form

Principal Investigator: Dr. Cynthia J. Osborn  
Co-Investigator: Dr. Betsy J. Page and Anne M. McCurdy, Doctoral Candidate, Counseling and Human Development Services, Kent State University.

The purpose of this study is to learn about addiction professionals’ decision making, particularly how client variables (e.g., substance of choice) influence addiction professionals’ theoretical perspectives and treatment recommendations. No deception is involved, and the study involves no more than minimal risk to participants (i.e., the level of risk encountered in daily life).

Participation in the study will take approximately 25 minutes and is entirely anonymous. You will complete a survey and a demographic questionnaire. Instructions for completing the survey and demographic questionnaire are provided online. To complete the survey, you are asked to read 10 brief (one-paragraph) fictitious client case vignettes, each of which describes an adult male client seeking treatment for substance use. Next, you are asked to answer two questions about each vignette. First, you will be asked to select one of four theories that you believe best represents the client’s description of his substance use. Then, from six treatment options, you will be asked to select which one you would recommend as the most appropriate treatment option for the client-identified treatment goal.

Your responses are anonymous and are treated as confidential, and in no case will your individual responses be linked to you. Rather, all data will be pooled and results of the investigation will be published in aggregate form only. This study is being conducted using a secure (https) online platform managed by Qualtrics (www.qualtrics.com).

Your participation in this study is intended to help researchers, educators, health care providers, and students to better understand how client variables influence addiction professionals’ decision making.

Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. You will be given the opportunity to be entered into
a drawing that will award ten, $50 gift cards upon completing the survey and demographic questionnaire.

If you have questions or concerns about this research, you may contact the principal investigator: Dr. Cynthia J. Osborn at (330) 672-0695 (cosborn@kent.edu), or the co-investigators Dr. Betsy J. Page at (330) 672-0696 (bpage@kent.edu) and Anne M. McCurdy at (724) 464-7857 (ashick@kent.edu). This project has been approved by the Kent State University Institutional Review Board (#15-321). If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672-2704.

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the “I Agree” button to begin the survey.

I Agree  I Do Not Agree

* To print a copy of this consent form, click here [hyperlink]
APPENDIX I

DEMOGRAPHIC QUESTIONNAIRE
Appendix I

Demographic Questionnaire

Please complete the following questionnaire.

1—Sex:
Male
Female

2—Race/Ethnicity—Please check all that apply.
White
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Pacific Islander
Hispanic/Latino
Other [Text Box]

3—Religious/Spiritual Affiliation:
Christianity
Judaism
Islam
Hinduism
Buddhism
Non-Religious
Other [Text Box]

4—What is your highest level of education?
High school diploma
Associate’s degree
Bachelor’s degree
  Major: [Text Box]
Master’s degree
  Concentration: [Text Box]
Doctoral degree
  Concentration: [Text Box]
Other [Text Box]
5—Have you received training/education in the following areas? Please check all that apply.
Theories of Addiction
Counseling Procedures and Strategies with Addicted Populations
Group Process and Techniques Working with Addicted Populations
Assessment and Diagnosis of Addiction
Relationship Counseling with Addicted Populations
Pharmacology
Prevention Strategies
Treatment Planning
Legal and Ethical Issues Pertaining to Chemical Dependency

6—Do you hold a credential as an Alcohol and Other Drug Counselor?
Yes
No

7—What professional license(s) do you currently hold? Please check all that apply.
Professional Counselor
Social Worker
Marriage and Family Therapist
Psychologist
Psychiatrist
Other [Text Box]

8—What is your primary work setting?
School
   Elementary school
   Middle school/ Junior High
   High school
College/ University
Detoxification
   Hospital-Based
   Residential Facility
Residential/ Inpatient Facility
Outpatient Facility
Halfway house (or) ¾ House
Psychiatric Hospital
Community Mental Health Center
College/ University Health Center
Other [Text Box]
9—If you practice in a clinical setting, please select the option that best represents your work setting’s treatment philosophy. If you do not practice in a clinical setting, please select “Not applicable” and proceed to question 12.

Disease
Psychoanalytic
Cognitive Behavioral
Sociocultural
Other [Text Box]
Not applicable

10—Are you permitted to work from a treatment philosophy that differs from the philosophy adopted or endorsed or required by your work setting?
Yes
No
Somewhat

11—Are you permitted to offer treatment approaches that differ from the treatment approaches adopted by your work setting?
Yes
No
Somewhat

12—What is your preferred theoretical orientation? (Please select one)

Adlerian
Behavior
Cognitive
Cognitive-behavioral
Existential
Family and Couples
Feminist
Gestalt
Narrative
Person/Client-centered
Psychoanalytic/Psychodynamic
Reality/Choice
Solution-focused
Spiritual/Religious
Other [Text Box]
13—Do you routinely *receive* supervision?
Yes
No

14—Do you routinely *provide* supervision?
Yes
No

15 - How familiar are you with the following theories of addiction?

Disease
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Psychoanalytic
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Cognitive Behavioral
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Sociocultural
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

16 - How familiar are you with the following treatment approaches for substance use disorders?

Motivational Interviewing
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Relapse Prevention
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar
Contingency Management
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Twelve-Step Facilitation
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Adjunctive Pharmacotherapy
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

Harm Reduction
1 = Not at all familiar
2 = Somewhat familiar
3 = Very familiar

17—Do you identify as someone in recovery from a substance use disorder?
Yes
No

18 - Do you have a friend(s) or a family member(s) who identifies as someone in recovery from a substance use disorder?
Yes
No

19 - Age:
[Text Box]

20—Please select the state in which you are employed.
AL
AK
AZ
AR
CA
CO
CT
DE
FL
GA
THANK YOU!!!
Would you like to enter a drawing to **win a $50 gift card**? If so, please click [here](#) and enter your email address. Your email address will not be shared with the researcher or anyone at NAADAC. A random drawing will determine the winners. A third-party representative from Kent State University’s Research and Evaluation Bureau will notify the winners by email.

**Please note**: Your responses are anonymous and in no case will your individual responses be linked to you; however, to process the gift cards, winners will be asked to disclose their name and mailing address to the researcher. This information will be treated as confidential and will be used only to distribute the award.
APPENDIX J

RESEARCH PARTICIPANT RECEIPT 1 (RPR-1)
Appendix J

Research Participant Receipt 1 (RPR-1)

Kent State University (KSU) is required to maintain the confidentiality of information about research study participants while still complying with record keeping requirements of the State of Ohio, the Internal Revenue Service (IRS), and funding agencies. This form serves as documentation of receipt of compensation by individuals participating in research studies conducted by KSU personnel and is used to obtain information to comply with IRS reporting requirements.

1. I, __________________________, have received/or am requesting compensation in the form and amount indicated below:

- □ Cash $___________
- □ Check $___________
- X Gift Certificate/Card $50.00

Research Participant’s Signature ____________________________ Date ______________

TO KSU PERSONNEL:
This form is to be used for research participants are receiving ≤$75 and the total of payments received for participation in the entire project < $600. If a research participant chooses not to provide their name they can choose to participate in the research without receiving compensation.

If a KSU check needs to be issued for payment, complete a Check Request form and submit to Accounts Payable, Schwartz Center Room 237. Do not attach a copy of this form to the request.

RPR-1 (revision 1.0)
For use when a research participant receives ≤ $75 and total payment for participation in research < $600
REFERENCES
REFERENCES


Jerry, J. M., & Collins, G. B. (2013). Medication-assisted treatment of opiate dependence is gaining favor. *Cleveland Clinic Journal of Medicine, 80*(6), 345-349. doi: 10.3949/ccjm.80a.12181


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