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Abigail R. Vayda
Clinician Perceptions
of Harm Reduction,
Psychotherapy and the
Role of Traditional
Abstinence Models

ABSTRACT

This study sought to better understand clinicians' perceptions of harm reduction, psychotherapy, and the role of traditional abstinence models when working with actively using clients. This study analyzed the results from a survey completed by 52 practicing clinicians in the United States. The survey contained demographic questions and Likert scale questions measuring attitudes toward harm reduction, abstinence, and psychotherapy with actively using clients. In addition to rating questions, there was also one open-ended question allowing participants to express their understandings of the development of a substance use disorder. The overall response to this survey was a positive attitude toward harm reduction techniques when working with this population. However, abstinence-based models of care are currently the widely accepted and utilized approach.

Clinician Perceptions of Harm Reduction, Psychotherapy and the Role of Traditional Abstinence Models

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2016

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CHAPTER 1

INTRODUCTION

The purpose of this study is to better understand clinicians' perceptions of psychotherapy with actively using clients. Specifically, this researcher is interested in clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models. This study included a survey that sought to determine clinician's attitudes toward theories of harm reduction and traditional abstinence models of care when working with clients struggling with a substance use disorder. For the purposes of this study substance use disorder was defined as "a condition in which the use of one or more substances leads to a clinically and functionally significant impairment or level of distress (SAMSHA, 2015)."

Data reported by the Substance Abuse and Mental Health Services Administration in 2014 found that 8.1% of the U.S. population aged 12 or older, or an estimated 21.5 million persons, met diagnostic criteria for a substance use disorder in the past year (SAMHSA, 2014). This includes 17.0 million people with an alcohol use disorder, 7.1 million with an illicit drug use disorder, and 2.6 million reporting both an alcohol and an illicit drug use disorder. In addition, 23.5 million more Americans are living in long-term recovery from addiction (Williams, 2015). Given these statistics it is likely if not inevitable that mental health clinicians will encounter individuals seeking treatment for a substance use disorder while in practice.

Abstinence only treatment is the widely accepted treatment method across the United States and non-abstinence goals of treatment are controversial within the field. Upwards of 80% of rehab centers employ 12-step facilitation and philosophy as the foundation of treatment (Fletcher, 2013). Treatment options are often restrictive, limited, or difficult to access for individuals who are actively using substances. Harm reduction theory and practice is one option

that offers those who are not able or willing to commit to the abstinence approach offered by the majority of drug and alcohol treatment centers a chance to receive treatment in a de-stigmatizing manner.

This study analyzed the results from a survey of 52 practicing clinicians in the United States. The survey contained demographic questions and Likert scale questions measuring attitudes toward harm reduction, abstinence, and psychotherapy with actively using clients. There was also one open-ended question allowing participants to express their understandings of the development of a substance use disorder.

The results of this study could further knowledge of the current treatment approaches and perceptions of treatment options by mental health clinicians who work with clients struggling with addiction. Given the likelihood that all clinicians will work with clients who struggle with addictions, furthering the fields understanding of different approaches to treatment is vital. This study investigates clinicians' perceptions of working with clients struggling with addiction and their attitudes toward harm reduction approaches.

This thesis is organized in five chapters. Following the first introductory chapter, chapter II presents a comprehensive review of the pertinent literature to this thesis, including topics of stigma, substance abuse treatment trends, and harm reduction theory. Chapter III describes the methodology used within this study, including the participant sample and means of data collection and analysis. Chapter IV presents the findings of this study, including quantitative and qualitative data as well as descriptive and inferential statistics. Finally, Chapter V discusses this study's findings, explores potential implications of the findings, and offers suggestions for future research.

CHAPTER II

LITERATURE REVIEW

Introduction

This literature review will begin with research addressing the meaning and uses of stigma with a focus on the stigmatization of addiction. The literature review will explore psychotherapy and current treatment models for individuals with addiction including 12-step models and medication-assisted treatment. The review of literature will conclude with a discussion of harm reduction theory, specifically in terms of interventions for substance use.

Stigma and Addiction

“Stigma” is an ancient Greek word referring to a branding used to mark unruly criminals for identification (Lloyd, 2013). The symbolic meaning of the word describing permanent dishonor and shame remains today. Jones et al. (1984) emphasizes while stigma is a universal phenomenon across the globe, what is stigmatized varies across cultures. Jones (1984) continues stating the two key factors of this variation include perceived blame and dangerousness of the issue. Stigma can be understood through the different ways it manifests on self, social, and structural levels (Livingston, Milne, Fang, & Amari, 2012). Self-stigma encompasses feelings of internalized shame based on having a stigmatized identity. Self-stigma may include attempts to hide this stigmatized part of self for the fear of negative reactions from others while social stigma describes how the population relates to the stigmatized group based on stereotypes. Structural stigma pertains to the rules, policies and procedures that affect the stigmatized group, which often reflect the broader social discourse on how certain stigmatized groups should be viewed and treated (Livingston et al., 2012).

Stigma is often used as a tool to marginalize unhealthy behaviors such as substance use. Stigmatizing beliefs and attitudes toward certain groups such as those struggling with substance use disorders are widely accepted and supported, perpetuated through media, and embodied in policy. In June of 1971, President Nixon declared a “war on drugs” citing drug abuse as “public enemy number one in the United States” and created mandatory sentencing and no-knock warrants (Jarecki, 2012). Media helped create a dangerous image of addiction and fear of drug users. In the next 40 years, the War on Drugs has resulted in more than 45 million arrests and more than 1 trillion dollars spent (Jarecki, 2012). Today, there are more people behind bars for nonviolent drug offenses than were incarcerated for all crimes, violent or otherwise, in the 1970s (Jarecki, 2012). The U.S. incarcerates more people than any country in the world. In 1980, the total U.S. prison and jail population was about 500,000 and today, it is more than 1.5 million. Black Americans represent 56% of those incarcerated for drug crimes, even though they comprise only 13% of the U.S. Population. Additionally, 70% of the American prison population identify as persons of color (Jarecki, 2012).

The War on Drugs has attempted to fix a health, mental health, and systemic issue permeated with racism and poverty as a legal and moral problem. Minimal funding and support has gone into the prevention and treatment of addiction but rather a punitive approach to the epidemic reaps profits. The penal system reduces the wage and employment prospects for released prisoners. Laws against housing, employment, denial to vote, and often exclusion from financial aid for school create a cycle where individuals spend their lives entering and re-entering prisons. Charles Lloyd noted, “criminalization of substance-using behaviors exacerbates stigma and produces exclusionary processes that deepen the marginalization of people who use illegal substances” (Lloyd, 2013, p. 107).

Many studies have been done to assess public perception and the stigmatization of individuals with substance use disorders. One study measured the responses of 815 individuals after reading a vignette about a person who was either physically handicapped, had a mental illness, or struggled with drug addiction. Participants were then asked a series of questions to assess judgment, blame, and helping behavior. The results of this study showed that the individuals in the vignette with a substance use disorder were viewed as significantly more responsible for their disorder in comparison to people with mental illness or those with a physical handicap (Corrigan, Kuwabara, & O'Shaughnessy, 2009). Participants also viewed those with drug addiction as most able to overcome their disorder in comparison and were therefore less likely to rate them as deserving of assistance from the community. Results also showed participants were more likely to avoid or be fearful of the person with an active substance use disorder and not participate in pro-social behaviors in association with this person (Corrigan et al., 2009).

A similar web survey of 709 participants measured individual's perceptions of those with substance use disorders or mental illness (Barry, McGinty, Pescosolido, & Goldman, 2014). Of the 709 participants, 347 individuals were randomly assigned to answer survey questions regarding drug addiction while 362 were assigned to answer questions regarding mental illness. Survey questions explored social distance, acceptability of discrimination, perceptions of adequacy of treatment, and policy support. The results indicated that the American public holds significantly more negative attitudes toward substance users than individuals with a mental illness. For example, of those assigned the substance use survey, 90% of participants would, if given the power, be unwilling to have an individual with a drug addiction marry into their family. Furthermore, 78% responded if given the choice they would not work with someone with

a drug addiction history and 64% of participants stated that employers should be allowed to deny employment on the basis of drug addiction history (Barry et al., 2014). For questions of policy and government assistance, respondents were also more likely to oppose insurance parities, increased government spending for treatment, and increased government spending on job support programs for individuals with addictions versus those with mental illness (Barry et. al., 2014).

Substance use disorders are often linked to a range of stigmatized health conditions including HIV/AIDS. One study measured participants responses through fMRI scanning as they watched video clips of individuals experiencing pain (Decety, Echols, & Correll, 2010). Participants were shown a healthy person, a person with AIDS as a result of an infected blood transfusion, and a person with AIDS as a result of intravenous drug use all experiencing extreme physical pain. fMRI scans showed significant more empathy levels and greater sensitivity toward the pain of the healthy individual and the individuals with AIDS through transfusion and significantly less activation in these brain areas for the person experiencing pain who had AIDS resulting from intravenous drug use. Perhaps based on our societal views of individuals with substance use disorder as blameworthy for their disorder and therefore any resulting health problems as well as our societies criminalization and perceived dangerousness of those with addictions, the results of this study indicate that individuals experience less empathy toward those suffering with addictions.

Trends in Substance Abuse Treatment

Abstinence-only treatment is the widely accepted and implemented addiction treatment method in the United States. A national survey done in 2013 by SAMHSA was completed by 14,148 eligible facilities and had a one-day census of 1,249,629 clients enrolled in substance abuse treatment (United States Department of Health and Human Services, 2013.) This study found

that 97% of all residential (non-hospital) beds and all hospital inpatient beds designated for substance abuse treatment were in use at the time of the survey administration. The most common used therapeutic approaches included relapse prevention, cognitive-behavioral therapy, motivational interviewing, brief intervention, 12-step facilitation, contingency management or motivational incentive.

12-Steps

Alcoholics Anonymous and Narcotics Anonymous programs are both self-described as a fellowship of people with a desire to stop drinking or using drugs who come together to help each other in recovery from addictions by sharing experiences and hope. Both groups engage in reading of literature such as “The Big Book” (Alcoholics Anonymous, 2001) and in the process of working through steps, which are as follows:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure

them or others.

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

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

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

For many, working the 12-steps and attending AA or NA meetings has been a significant part of recovery from addiction and allowed individuals to become a part of a community.

There are also many critiques of the 12-step model. A main critique includes question of efficacy, stating success rate of AA (meaning individuals getting and staying sober) between 5 and 10% (Dodes, 2014). Other critiques include the 12-steps focus on religion and spirituality, the language of addiction as being a moral defect, the implementation of the disease-model of addiction meaning addiction is a chronic condition that can go in remission, individuals must embrace an identity as an addict, and often relapse and those struggling in recovery can be seen as not working the program effectively.

The 12-step model certainly does work for some individuals. However, upwards of 80% of rehab centers employ 12-step facilitation and philosophy as the foundation of treatment (Fletcher, 2013). Since substance abuse is so highly criminalized, meetings are also often a court-mandated treatment. Meetings are also often mandated by treatment centers or other social service agencies. The 12-step model is an important piece of the recovery process for many but attending meetings regularly and working the steps is seen by many in the medical or mental

health field as the only way to overcome addiction which can become problematic for those who don't want to or don't find attending useful to their recovery.

Medication-Assisted Treatment

Medication-assisted treatments (MAT) have become a vital part of recovery for some individuals. The most common medications used in the treatment of opioid addiction are methadone and buprenorphine (SAMHSA, 2013). Both drugs work by tricking the brain into thinking it is receiving opiates while not getting high or causing withdrawal. This results in reduced cravings. Naltrexone is a third medication that can be used for opiate and alcohol addiction. Naltrexone works by blocking the effect of opioids or alcohol. Antabuse is another medication often used for alcohol addiction. Antabuse causes a negative reaction if alcohol is consumed. Even though medication-assisted treatments have been proved effective in helping clients recover and helps reduce the risk of overdose, they remain underutilized. Medication-assisted treatments are available in less than half of private-sector treatment programs and of the 2.5 million individuals in the United States 12 years of age or older who abused or were dependent on opioids, fewer than 1 million of these individuals received this form of treatment (Volkow, Frieden, Hyde, Cha, 2014).

There are several reasons why MAT are underused. First, medication-assisted treatment is highly stigmatized. It is often seen as replacing one drug for another by not only the public, but by medical and mental health providers as well. Some believe an individual is not in recovery or not truly sober if they are using medications. Recovery programs and treatment centers that focus on the 12-step approach or other abstinence-only methods are less likely to support medication-assisted therapies (Roman, Abraham, & Knudsen, 2013). Other barriers to MAT include access to a prescriber and healthcare. Most of these medications must be taken daily and are usually

dosed and distributed at a treatment center, meaning an individual needs to have access to a prescriber or treatment center within their area.

Harm Reduction Theory

Abstinence only treatment is the widely accepted treatment method across the United States. Abstinence only treatment is an extremely important part of the recovery process and abstinence communities offer continued support for those in long-term recovery. However, there are far fewer options in place for individuals who are actively using to receive care. There seems to be a belief that addiction and mental health treatment cannot occur until the individual is no longer dependent upon substances. Harm reduction theory offers those who are not able or willing to commit to the abstinence approach offered by the majority of drug and alcohol treatment centers a chance to receive treatment in a de-stigmatizing manner. Harm reduction and related policies encourage, support, and provide pragmatic and humanistic tools for actively using clients to survive addiction.

Harm reduction in association with addiction began in the United States in the 1980s and 1990s as a public health strategy to reduce the spread of HIV through clean syringe access (Heather, Wodak, Nadelmann, & O'Hare, 1993). Harm reduction may include services such as needle exchange, medication management, education about safer use, and moderation of use as treatment goal (Tatarsky, 2003). Harm reduction in addictions treatment embraces meeting a client where they're at in terms of needs and goals including, but not limited to, abstinence (Tatarsky, 2003). By accepting goals besides abstinence, actively using clients can receive treatment in a way not accessible through traditional abstinence modeled approaches. Behavior change is seen as incremental and based on the premise that people are more likely to maintain changes if they have the power both to shape and implement their goals (Ruefli & Rogers, 2004).

A study assessing clinician's attitudes towards non-abstinence goals found variation of results depending on specific drug of choice or whether or not the individual met criteria for substance abuse versus dependence. Larger proportions of respondents rated non-abstinence as acceptable as a final goal for clients diagnosed with alcohol abuse (30%) or cannabis abuse (24%) than for clients diagnosed as abusing other drugs such as heroin, cocaine, amphetamines, or ecstasy (11 to 13%). For a dependence diagnosis, the percentage of clinicians who viewed non-abstinence as an acceptable goal dropped significantly to 12% for someone with alcohol dependence, 13% for cannabis dependence, and only 8-9% for other drugs (Rosenberg & Davis, 2014).

Many mental health and addiction treatment providers currently have limited exposure to harm reduction practice through their education or workplace. Perilou Goddard (2003) proposed educating treatment providers about the philosophy and practice of harm reduction is a necessary step in increasing the availability of non-abstinence alternatives. Further, the study sought to examine if provider's attitudes toward harm reduction practices would shift with exposure to education regarding the model. Participant's completed a survey before and after a 2-hour continuing education seminar. Post-test results showed statistically significant changes in which clinicians felt more positive toward the use of harm reduction after learning about the approach (Goddard, 2003).

Summary

Research finds that the stigmatization of addiction permeates American society and therefore, mental health clinicians hold these prejudices as well. Along with criminalization and stigma, the limited and restrictive treatment options mean individuals struggling with addiction

often have limited access to care or support.

This researcher is conducting a study on clinician perceptions on psychotherapy with actively using clients with a focus on clinician attitudes toward harm reduction and abstinence models of treatment. It is this researcher's hope that the results of this study can help further knowledge of clinician perceptions of treatment options when working with individuals struggling with addiction. This researcher hypothesizes that clinicians overall will believe that actively using individuals can make use of psychotherapy and have positive attitudes toward harm reduction practices.

CHAPTER III

METHODOLOGY

The purpose of this study was to better understand clinician perceptions of psychotherapy with actively using clients. Specifically, this researcher was interested in clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models. A mixed-method survey was used to analyze clinician perspectives of psychotherapy with clients struggling with a substance use disorder. Having an open-response question allowed the opportunity for participants to express individual experiences and beliefs in a detailed, qualitative manner while using a survey allowed for larger, more diverse sample to be reached in order to maximize generalizability (Engel & Schutt, 2013). The analysis compared how clinician perceptions may or may not differ based on participant's demographics.

Sample

To qualify for inclusion in this study, clinicians or therapists had to have or be currently working toward a Master's or Doctorate Degree in social work, mental health counseling, alcohol and drug counseling, or psychology and practice within the United States. Since the purpose of this study is to better understand clinician perspectives of psychotherapy with actively using clients, clinicians must have had or currently work with clients who meet criteria for a substance use disorder. Substance use disorder was defined for the purposed of this study as "a condition in which the use of one or more substances leads to a clinically and functionally significant impairment or level of distress (SAMSHA, 2015)." In order to complete the mixed method survey, participants also had to be literate in English, have access to a computer and the Internet, and have the necessary computer skills to navigate an online survey.

This study utilized a mixed method survey design and nonprobability convenience and snowball sampling methods were used to recruit practicing clinicians. This researcher utilized placement at Clinical & Support Options and after approval from the clinic director, a recruitment email was sent out to clinicians at the Greenfield outpatient clinic via staff email. The email request included the purpose of the study, inclusion criteria, nature of participation, and a link to the survey through Qualtrics (Appendix B). This researcher also sent out a recruitment email (Appendix C) to past colleagues requesting completion of the survey and assistance in identifying other potential participants. This researcher sent a protocol change request to the Human Subjects Review Board requesting approval to use Facebook to continue to recruit participants. Upon approval (Appendix I), this researcher posted this survey with a brief explanation of the study's purpose, inclusion criteria, and nature of participation (Appendix D) to the Smith College School for Social Work Speakeasy group, which is a private Facebook group for current Smith College School for Social Work students and alums.

Snowball sampling was also used to recruit participants. Snowball sampling refers to a sampling method in which existing participants are asked to identify other potential participants within their network and speak to them, thus the sample "snowballs" in size (Engel & Schutt, 2013). This researcher utilized snowball sampling by requesting that individuals forward the recruitment email to other individuals that might have an interest in participating.

Data Collection

Possible participants through Clinical & Support Options as well as through this researcher's network received an email with the survey link in February 2016. A follow-up reminder email was also sent out in March 2016. The survey was also posted to the Facebook group Smith College School for Social Work Speakeasy in March 2016. This survey was mixed-

methods and was created by the researcher via Qualtrics. The survey assured confidentiality as it was anonymous and had no means of collecting identifying information from participants.

This is a quantitative, mixed-methods, survey based study. Potential participants received an email including information regarding the purpose of the study, inclusion criteria, nature of participation, and a link to the survey through Qualtrics. When directed to the Qualtrics website, participants first were prompted to answer two screening questions to assure that they met inclusion criteria (Appendix E). If participants answered, “yes” to these questions, they were directed to the Informed Consent form (Appendix F). If potential participants answered “no” to any of the screening questions or did not consent to participate, they were thanked for their interest, informed that they do not meet eligibility requirements, and directed away from the survey (Appendix G).

Only after consenting to participate individuals completed seven demographic questions including identifying their age, gender, race/ethnicity, number of years in practice, practice setting, and approximate portion of caseload who struggle with a substance use disorder. Participants did not need to answer any questions they did not feel comfortable with to continue to the survey. Participants were then directed to complete the survey (Appendix H), which included ten Likert scale questions rating clinician’s beliefs regarding harm reduction and abstinence based approaches to psychotherapy. Response options to these Likert scale questions included strongly agree, agree, disagree, and strongly disagree. This researcher chose to not include a neutral response choice due to the limited number of questions in the survey. An open-response question also asked participants which theories they draw from in their work. Finally, participants were asked to respond to an open response question asking for their thoughts regarding development of a substance use disorder and the theories and modalities they use in

their work with this population. The participant was then thanked for their participation and the survey was complete.

Data Analysis

This survey included a combination of Likert scale and open-response questions. Data was analyzed using both quantitative and qualitative measures. The Smith College School for Social Work's statistician, Marjorie Postal, assisted in data analysis. Descriptive statistics were used to analyze the demographic and Likert scale survey questions by frequency. Inferential statistics were used to analyze the relationship between demographic characteristics and the Likert responses. This researcher analyzed the open-ended, qualitative responses thematically.

Ethics and Safeguards

The study was approved by the Smith College Human Subjects Review Board (Appendix A). Participation in the study had potential benefits such as allowing participants to reflect upon their experiences working with actively using clients and explore their attitudes toward harm reduction and abstinence-based approaches. This study may have given clinicians a chance to consider alternative treatment styles and potentially reflect on their experiences when working with this population. Participants were able to skip any questions after the eligibility questions and informed consent. There were no foreseeable or expected risks to participation.

All data was collected anonymously and electronically via the online questionnaire site, Qualtrics. Qualtrics designated a code number to all participants' responses. This researcher reviewed all qualitative data and deleted any information that negated anonymity. As per federal regulations, all research materials will be stored in a secure location for three years and then destroyed. All electronically stored data will be password protected during the storage period.

Limitations

This researcher chose non-probability convenience sampling and snowballing methods due to limited time and resources available. Due to this sampling method, there is lack of diversity in the sample with 94% of participants identifying as white and 86.5% identifying as female. Therefore, the participants in this study are not representative of the population and results cannot be generalized.

CHAPTER IV FINDINGS

The purpose of this study was to examine clinician perceptions of working with actively using clients and attitudes toward harm reduction and traditional abstinence models of care. Participants were asked to complete a brief survey regarding their perspectives on treatment of this population. The survey included a series of Likert-scale questions as well as two open-ended questions. A total of fifty-two individuals completed the survey.

This chapter will include three different sections of findings of this study. The first section will describe the demographics of the sample including age, race, gender, practice setting, degree type, number of years in practice, and percentage of caseload meeting criteria for a substance use disorder. Next, the quantitative data of the survey will be examined. Within this section, descriptive statistics of the data will first be reviewed and secondly the inferential statistics will examine the relationship between variables. This chapter will conclude with a report of the qualitative data, including a review of the open-ended questions.

Demographics

Age Demographics

The majority of participants were between ages 25 and 54 (79.9%) with only 18.2% of participants from other age categories. Table 1 presents the distribution of ages for this sample. No participants identified in age ranges 18-24 or 75 years or older.

Table 1

Age Demographic

Age Range	Frequency	Percent
25-34 years	19	34.5
35-44 years	12	21.8
45-54 years	13	23.6
55-64 years	5	9.1
65-74 years	5	9.1
Undisclosed	1	1.8

Race Demographics

A major limitation of this study was lack of racial diversity with 90.9% (n=50) of participants identifying as White. 1.8% (n=1) reported their race as Black or African American, 3.6% (n=2) reported identifying as multi-racial, and 3.6% (n=2) chose not to disclose their race.

Gender Demographics

The majority of this sample identified as female, 81.8% (n=45). 5.5% (n=3) identified as male and 7.3% (n=4) identified as transgender. 5.5% (n=3) chose not to disclose their gender.

Practice Setting Demographics

This question was an open-ended question allowing participants to write-in their work setting. This researcher then categorized answers as shown in table 2.

Table 2

Practice Setting Demographics

Practice Setting	Frequency	Percent
Hospital Setting	17	31.5
Outpatient clinic / community mental health	27	50.0
College Counseling	2	3.7
Private Practice	3	5.5
Non-profit, unspecified	2	3.7
Residential treatment facility	1	1.8
Outpatient department of psychiatric hospital	2	3.7

Degree Type Demographics

This question was an open-ended question allowing participants to write-in their degree type. Table 3 reviews this samples degree type.

Table 3

Degree Type Demographics

Degree Type	Frequency	Percent
Master's in Social Work	33	60.1
Mater's in Social Work, LCSW	1	1.8
Master's in Social Work, LICSW	5	9.1
MA in Counseling Psychology	4	7.3
Psy D	2	3.6
Licensed Mental Health Counselor	5	9.1
Clinical Mental Health Counselor	2	3.6
Licensed Psychologist	1	1.8
Master's in Social Work in progress	2	3.6

Years in Practice Demographics

Table 2 details the number of years individuals within this sample have been in practice. The majority of participants, 56.4% (n=31), have been in practice for 1-9 years.

Table 4

Years in Practice Demographics

Year Range	Frequency	Percent
Less than 1 year	5	9.1
1-4 years	20	36.4
5-9 years	11	20.0
10-14 years	6	10.9
15-19 years	2	3.6
20-24 years	5	9.1
25 or more years	5	9.1
Undisclosed	1	1.8

Caseload with SUDS Demographics

As the purpose of this study was to understand clinician perspectives of working with actively using clients, this question sought to find the approximate percentage of participant’s caseloads that met criteria for a substance use disorder. 32.7% (n=18) reported less than 25% of their current caseload met criteria for a substance use disorder, 27.3% (n=15) reported 25-50%, 23.6% (n=13) 50-75%, 14.5% (n=8) more than 75%, and 1.8% (n=1) undisclosed. Therefore 60% of participants reported currently having 50% or less of their caseload meeting criteria for a substance use disorder while 38.1% of participants reported working with a caseload with 50% or higher meeting criteria for a substance use disorder.

Quantitative Findings

The first two Likert-scale questioned focused on clinician knowledge including receiving sufficient training in working with individuals with a substance use disorder and understandings

harm reduction theory as it relates to substance use. The results of each question are shown in the tables below.

Table 5

I feel that I have received sufficient training and education on working with individuals with a substance use disorder.

Level of Agreement	Frequency	Percent
Strongly Agree	13	25.0
Agree	26	50.0
Disagree	13	25.0
Strongly Disagree	0	0

Table 6

I understand harm reduction theory as it applies to substance use.

Level of Agreement	Frequency	Percent
Strongly Agree	21	40.4
Agree	27	51.9
Disagree	3	5.8
Strongly Disagree	1	1.9

As seen above, a majority (75%) strongly agreed or agreed that they received sufficient training on working with this population and 92.3 strongly agreed or agreed that they understood harm reduction theory as it applies to substance use. However, 25% of participants felt they had not received sufficient training or education on working with individuals with a substance use

disorder and 7.7% felt they did not understand harm reduction theory as it applies to substance use.

The next question asked clinicians their feelings on working with clients who continue to actively use substances.

Table 7

*If given the choice, I would choose **not** to work with a client with substance use disorder who continues to use.*

Level of Agreement	Frequency	Percent
Strongly Agree	3	5.8
Agree	11	21.2
Disagree	33	63.5
Strongly Disagree	5	9.6

The majority of participants (73.1%) would choose to work with a client with a substance use disorder who continues to use while 27% of participants *if* given the choice, would choose not to work with a client who continues to use substances.

Next, clinicians were asked opinions on clients coming to treatment under the influence. Results of this question are shown below.

Table 8

If a client comes to therapy under the influence of drugs or alcohol, a clinician should ask the client to reschedule.

Levels of Agreement	Frequency	Percent
Strongly Agree	7	13.7
Agree	20	39.2
Disagree	24	47.1
Strongly Disagree	0	0

The results of this question show that 52.9 percent of participants strongly agreed or agreed that a client should reschedule if they come to therapy under the influence. Interestingly, a similar percentage (47.1%) opposed this statement, feeling that the therapy session could continue.

The next six Likert-scale questions focused on pillars of harm reduction or abstinence focused treatment. These questions sought clinician opinions on treatment goals, relapse, medication-assisted therapies, and safer use strategies. The results to each question can be seen in the following tables:

Table 9

Clients seeking psychotherapy for a substance use disorder should be given the options of treatment goals such as abstinence, safer use, or moderated use.

Levels of Agreement	Frequency	Percent
Strongly Agree	20	38.5
Agree	25	48.1
Disagree	5	9.6
Strongly Disagree	2	3.8

A majority (86.6%) strongly agreed or agreed that clients should be given the options of treatment goals such as abstinence, safer use, or moderated use while 13.4% disagreed that clients should receive these options.

Table 10

Individuals who continue to relapse should not be allowed to remain in treatment for substance abuse.

Levels of Agreement	Frequency	Percent
Strongly Agree	0	0
Agree	0	0
Disagree	19	36.5
Strongly Disagree	33	63.5

All participants disagreed or strongly disagreed that individuals who continue to relapse should not be allowed to remain in treatment.

Table 11

Individuals can make use of psychotherapy even if they are still actively using substances.

Levels of Agreement	Frequency	Percent
Strongly Agree	15	28.8
Agree	33	63.5
Disagree	4	7.7
Strongly Disagree	0	0

The vast majority of participants (92.3%) strongly agreed or agreed that individuals can make use of psychotherapy even if they are actively using while 7.7% of participants felt that individuals could not make use of psychotherapy while actively using substances.

Table 12

Medication-assisted therapies for opiate addictions (such as Suboxone) are an appropriate treatment option.

Levels of Agreement	Frequency	Percent
Strongly Agree	28	53.8
Agree	23	44.2
Disagree	1	1.9
Strongly Disagree	0	0

The vast majority of participants (98%) strongly agreed or agreed that medication-assisted therapies are an appropriate course of treatment.

Table 13

Clinicians should offer their clients who are actively using substances information about safer use strategies.

Levels of Agreement	Frequency	Percent
Strongly Agree	30	57.7
Agree	19	36.5
Disagree	3	5.8
Strongly Disagree	0	0

The vast majority of participants (94.2%) strongly agreed or agreed that clinicians should offer information on safer use strategies to their actively using clients while 5.8% of participants disagreed with this statement.

Table 14

Abstinence should be the treatment goal for individuals struggling with addiction.

Levels of Agreement	Frequency	Percent
Strongly Agree	0	0
Agree	9	40
Disagree	12	55
Strongly Disagree	1	5

- Due to an error, only 22 total responses were recorded.

Finally, this researcher also asked participants about the theories they generally draw from in their work. The results are shown in the table below.

Table 15

What theories or Modalities do you generally draw from in your work?

Theory	Frequency	Percent
Motivational Interviewing	20	14.38
Cognitive Behavioral Therapy	18	12.94
Acceptance Commitment Therapy	11	7.91
Dialectal Behavioral Therapy	13	9.36
Mindfulness based	7	5.03
Harm Reduction	7	5.03
Psychodynamic	10	7.19
Trauma-informed	7	5.03
Ego psychology	3	2.16
Narrative therapy	4	2.88
Self-compassion	2	1.44
Relational	7	5.03
12-step	6	4.32

Solution-focused	3	2.16
Family Systems	4	2.88
Attachment	7	5.03
Client centered	3	2.16
Positive psychology	4	2.88
Art Therapy	1	0.73
EMDR	1	0.73
Hypnotherapy	1	0.73

Forty-six participants responded to this question for a total of 21 theories named.

Descriptive Statistics

In addition to the quantitative data acquired in this study, this researcher was also interested in the relationships that existed among variables. This researcher was interested in the relationships between work setting and perception of harm reduction theory as well as the percentage of clinician’s caseloads presenting with a substance use disorder and the participants attitudes toward harm reduction theory. This researcher hypothesized that there would be a positive correlation between the percentage of a clinician’s caseload presenting with a substance use disorder and perception of harm reduction, meaning the more individuals with a substance use disorder a clinician worked with the more they might use harm reduction and therefore have more positive attitudes toward the theory the treatment. This researcher also hypothesized that those in hospital settings may be less likely to use harm reduction models in treatment and therefore have a more negative perception of harm reduction as opposed to clinicians in non-hospital settings.

With the assistance of Smith College School for Social Work's statistician, Marjorie Postal, this researcher first looked at the relationship between a clinician's percentage of caseload presenting with a substance use disorder and perception of harm reduction. This was done by looking at the questions within the survey that most reflected attitudes toward the main tenants of harm reduction theory. These questions included questions 16-21 and question 28 in the survey and will be presented below.

Q16. If a client comes to therapy under the influence of drugs or alcohol, the clinician should reschedule.

Q17. Clients seeking psychotherapy for a substance use disorder should be given the options of treatment goals such as abstinence, safer use, or moderated use.

Q18. Individuals who continue to relapse should not be allowed to remain in treatment for substance abuse.

Q19. Individuals can make use of psychotherapy even if they are still actively using substances.

Q20. Medication-assisted therapies for opiate addictions (such as Suboxone) are an appropriate treatment option.

Q21. Clinicians should offer their clients who are actively using substances information about safer use strategies.

Q28. Abstinence should be the treatment goal for individuals struggling with addiction.

The correlation looks to see if there is a relationship between the two ordinal scales. The first scale being the percentage of caseload with a substance use disorder (ranging from 1=less than 25% to 4=75% or more) and the Likert scale to the perception questions (1=strongly agree through 4=strongly disagree.) First, this researcher sought to find if there was a significant

relationship between these variables by looking at the p-value. If p is less than .05 the correlation is significant while if it is greater than .05, there is no significance. There were no significant correlations found between perception of harm reduction and percentage of caseload with a substance use disorder when looking at questions 16-21, and question 28. There were significant correlations between percentage of caseload with a substance use disorder and questions 18, 19, and 21. Taking the significant correlations, we then looked at the rho value, which tells us the direction and strength of this relationship. Below are the results for the correlations between perception in harm reduction in questions 18, 19, and 21 and percentage of caseload with substance use disorder (SUDS).

Individuals who continue to relapse should not be allowed to remain in treatment.

There is a significant, negative weak correlation between percentage of SUDS and this question. This suggests that the more people with SUDS that a clinician works with, the more they agree that individuals who continue to relapse should not be allowed to remain in treatment. The opposite is also true, the lower the percentage of caseload with SUDS, the more they disagree with this question.

Individuals can make use of psychotherapy even if they are still actively using substances.

There is a significant, positive weak correlation between percentage of SUDS and this question. This suggests that the more people with SUDS that a clinician works with, the less they believe psychotherapy is useful if the client is actively using substances. The opposite is also true, as the percentage of caseload with SUDS goes down, the participant agrees more with this question.

Clinicians should offer their clients who are actively using substances information about safer use strategies.

There is a significant, positive weak correlation between percentages of SUDS and this question. This suggest that the more people with SUDS on a clinician's caseload, the less they believe clinicians should offer information on safer use strategies. The opposite is also true, meaning that the less individuals with SUDS on a clinician's caseload, the more they agree with this question in offering information on safer use strategies.

This researcher's initial hypothesis was that an increase in the percentage of a clinician's caseload with SUDS would increase the use and therefore the agreement with harm reduction theory as it applies to addiction treatment. However, the significant correlations for questions 18, 19, and 21 oppose this hypothesis. The results of this analysis show that with an increase in percentage of caseload with SUDS there is a decrease in overall agreement with the some of the main tenants of harm reduction such as an individual's ability to remain in treatment when relapse occurs, the ability of an individual to make use of psychotherapy while actively using substances, and providing individuals who are actively using information regarding safer use strategies.

Next, this researcher was interested in the relationship between work setting and perception of harm reduction while working with actively using clients. To do so, work setting was simplified and categorized into hospital verse non-hospital settings and t-tests were run (see table 16.) A t-test tells us whether two groups (hospital versus non-hospital) have the same mean on a variable (perception of harm reduction) and looks to see if there were any differences in perception within question 16-28 and working within a hospital or non-hospital setting. There were no significant differences found in questions 16, 18, 20, 21, or 28. There were significant differences found in questions 17 and questions 19. Below are the results of differences in these questions.

Clients seeking treatment should be given the options of treatment goals such as abstinence, safer use, or moderated use.

Those in a hospital setting had a higher mean response to this question ($m=2.13$) than those in non-hospital settings ($m=1.63$), meaning that clinicians who work in a hospital setting disagree more with clinician's offering options of treatment goals such as abstinence, safer use, or moderated use than those working in non-hospital settings.

Individuals can make use of psychotherapy even if they are still actively using substances.

Those in a hospital setting had a higher mean response to this question ($m=2.06$) than those in other settings ($m=1.69$), meaning that clinicians who work in hospital settings disagree more that individuals can make use of psychotherapy when actively using than clinicians in non-hospital settings.

Although there were no significant differences found in questions 16, 18, 20, 21, or 28, the significant differences found in questions 17 and 19 suggest it is possible that those working in hospital settings may be less likely to agree with tenants of harm reduction such as choice and options of treatment goals and the belief that actively using individuals can make use of psychotherapy. This researcher's initial hypothesis was that those in hospital settings may be less likely to use harm reduction models of treatment and therefore have a more negative perception of harm reduction. This hypothesis was founded for questions 17 and 19 of this survey.

Table 16: T-test

Group Statistics

hospital setting		N	Mean	Std. Deviation	Std. Error Mean
I feel that I have received sufficient training and education on working with individuals with a...	hospital	6	1.94	.680	.170
	non hospital	35	2.03	.747	.126
I understand harm reduction theory as it applies to substance use.	hospital	16	1.88	.619	.155
	non hospital	35	1.60	.695	.117
If given the choice, I would choose not to work with a client with substance use disorder who con...	hospital	16	2.88	.619	.155
	non hospital	35	2.71	.750	.127
If a client comes to therapy under the influence of drugs or alcohol, a clinician should ask the...	hospital	16	2.25	.775	.194
	non hospital	34	2.38	.697	.120
Clients seeking psychotherapy for a substance use disorder should be given the options of treatme...	hospital	16	2.13	.885	.221
	non hospital	35	1.63	.690	.117
Individuals who continue to relapse should not be allowed to remain in treatment for substance ab...	hospital	16	3.63	.500	.125
	non hospital	35	3.66	.482	.081
Individuals can make use of psychotherapy even if they are still actively using substances.	hospital	16	2.06	.574	.143
	non hospital	35	1.69	.530	.090
Medication-assisted therapies for opiate addictions (such as Suboxone) are an appropriate treatme...	hospital	16	1.56	.629	.157
	non hospital	35	1.43	.502	.085
Clinicians should offer their clients who are	hospital	16	1.56	.727	.182

actively using substances information about safer u...	non hospital	35	1.43	.558	.094
Abstinence should be the treatment goal for	hospital	5	3.20	1.789	.800
individuals struggling with addiction.	non hospital	20	4.55	1.877	.420

Qualitative Findings

The final section of this survey consisted of an open-ended question. This researcher chose to include an open-ended question in order to give participants an opportunity to share more in-depth thoughts and opinions. This researcher analyzed the results of this question through qualitative methods. Upon review of the results, this researcher was able to categorize responses into themes.

The question asked participants to **describe “how do you understand the development of a substance use disorder?”** There were a total of fifty-five responses and a wide variety of participant’s responses made clear the complexities of addiction and its development. For the purpose of analyzing the results of this question, this researcher identified three main themes within the results.

The first theme noted by this researcher is the complex interplay of nature and nurture. Many participants described this interplay between genetics and environment, “substance dependence is the result of a complex interaction between a combination of biological, psychological (e.g., behavior), and social (e.g., attachment history) determinants.” One participant simply stated, “nature and nurture...genetic vulnerability and environment or life experiences.”

Participants further described life experiences and environmental factors such as poverty, lack of community or supports, and history of attachment disruptions and/or trauma. A second

theme presented through this was lack of connection and community. One participant expressed, “I also see substances as an access point to community for many people. For example, several of our clients are gay men who use crystal meth as a way to establish a place in the gay community.” Another participant stated, “I believe substance addiction stems from interrupted attachments to others and feelings of disconnection interpersonally as well as a lack of soothing internal objects.”

The third theme this researcher found was the understanding that addiction develops as a coping skill to manage internal and/or physical pain. Many participants felt that substance misuse is an attempt to cope often with effects of trauma. One participant stated, “I believe strongly that substance use and addiction is about a person's best attempt at coping with a situation that is otherwise painful for them. I think this is the case whether the pain is from trauma, grief, loneliness, boredom, low self-worth, etc.” Another participant expressed, “I see substance use as a maladaptive strategy for relief from discomfort, which is innately reinforcing.” One participant described addiction developing from using a substance to cope with “uncomfortable internal experiences (such as thoughts, feelings, emotions, bodily sensations-including physical pain.”

CHAPTER V

DISCUSSION

The purpose of this study was to better understand clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models when working with actively using clients. This study looked at clinician attitudes towards tenants of harm reduction and abstinence-based treatment such as acceptable treatment goals, role of relapse, medication-assisted therapies, and inclusion of safer use strategies. This researcher sought to answer the following questions: Do clinicians believe that clients who are actively using can make use of psychotherapy? For this sample, do clinicians hold positive or negative attitudes toward harm reduction techniques in relation to addiction? Is there a relationship between clinician's attitude toward harm reduction and their work setting? Is there a relationship between clinician's attitude toward harm reduction and the percentage of their caseload who are struggling with a substance use disorder?

This chapter will explore consistencies and inconsistencies between the major findings of the study, researcher expectations, and previous literature. After the comparison between the major findings of this study and previous literature, this chapter will discuss limitations of this study. This thesis will conclude with a discussion on this study's implications for the field of social work and recommendations for future research.

Quantitative Findings

As previously stated, data reported by the Substance Abuse and Mental Health Services Administration in 2014 found that 8.1% of the U.S. population aged 12 or older, or an estimated 21.5 million persons, met diagnostic criteria for a substance use disorder in the past year (SAMHSA, 2013). In addition, 23.5 million more Americans are living in long-term recovery

from addiction (Williams, 2015). Given this data, it is inevitable that mental health clinicians will work with clients struggling with addiction. Interestingly, of the 52 participants in this study's sample, 25% felt that they did not receive proper education or training regarding working with this population and approximately 8% of this sample felt they did not have knowledge about harm reduction methods in relation to substance use. Although this is a small sample and is not generalizable, 25% is a large percentage of individuals who feel that addiction was not a focus in their education or training. It would have been interesting to analyze if there were a relationship between those reporting no knowledge of harm reduction theory in regards to substance use and attitudes toward harm reduction tenants in the following scaled questions. Perilou Goddard (2003) found statistically significant changes in clinician attitudes toward harm reduction methods after a simple 2 hour continuing education program. The findings of this research and previous research support the importance of clinician access to continuing education.

There is limited research on clinician perceptions of psychotherapy with actively using clients and limited data on clinician attitudes toward harm reduction and traditional abstinence based approaches. Previous literature suggests abstinence-based approaches are the foundation of the majority of substance use programs and substance abuse policies within the United States (Fletcher, 2013) and clinicians, as well as those seeking treatment, may have limited access to alternative options. Previous research suggests that percentage of clinicians who find non-abstinence treatment goals agreeable are low, from 30%-8% depending on specific substance of choice (Rosenberg & Davis, 2014). However, in this research, the majority of clinicians had positive attitudes towards aspects of harm reduction treatment. In fact, 86.6% of participants strongly agreed or agreed that individuals seeking treatment should have options in treatment

goals such as abstinence, moderated use, or safer use. Similarly, the vast majority of participants (98%) strongly agreed or agreed that medication-assisted treatments such as Suboxone for opioid dependence are an appropriate treatment option. The majority of clinicians in this sample (92.3%) also strongly agreed or agreed that individuals can make use of psychotherapy if they are still actively using.

Relationship Between Caseload and Perception of Harm Reduction.

This researcher was interested in exploring if a relationship existed between the percentage of a clinician's caseloads presenting with a substance use disorder and the participants attitudes toward harm reduction theory. This researcher hypothesized that the more individuals with a substance use disorder a clinician worked with, the more they might use harm reduction and therefore have more positive attitudes toward the theory the treatment.

A significant correlation was found between clinician perception of harm reduction and the Likert scale question **“individuals who continue to relapse should not be allowed to remain in treatment.”** There was a negative correlation between the percentage of SUDS and perception in this question. This suggests that the more people with a substance use disorder on a clinician's caseload, the more they agree that individuals who continue to relapse should not be allowed to remain in treatment. This result was surprising to this researcher. Although no qualitative data was collected from these questions, this researcher might postulate that clinicians who see a high percentage of individuals with SUDS may see more frequent relapses, have higher levels of frustration regarding this, and possibly feel burnt out. In this researcher's previous field work it was common for clinicians to become frustrated and take personally a client's continued relapses. Relapse is still seen by some as a personal failure and those messages are still both very active in the client as well as the clinician. It may also be possible that

clinicians with a higher caseload of individuals with SUDS may work at a substance-abuse facility. As previously stated, the majority of these programs are abstinence-based (Fletcher, 2013) so continued relapse may mean the individual cannot remain in treatment due to the facility policies.

A significant positive correlation was found between the percentage of SUDS and perception in the question, **“individuals can make use of psychotherapy even if they are still actively using substances.”** This suggests that the more individuals with a substance use disorder on a clinician’s caseload, the less they believe psychotherapy is useful if the client is still actively using. Similarly, a positive correlation was also found between percentage of SUDS and perception in the question, **“clinicians should offer their clients who are actively using substances information about safer use strategies,”** suggesting that the more individuals with SUDS on a clinician’s caseload, the less they believe clinicians should offer clients safer use strategies. These results were unexpected by this researcher and it is a bit troublesome that in this research, the more clients with a substance use disorder clinicians see the less they believe actively using clients can make use of psychotherapy. Similarly, with the more individuals with SUDS on a caseload, clinicians are less likely to offer their actively using clients safer use strategies. As previously mentioned, this researcher hypothesizes work setting policies as well as burn out and stigma as possible sources of these results.

Relationship Between Work Setting and Perception of Harm Reduction

This researcher sought to find if a relationship existed between clinician perception of harm reduction and if the clinician worked in a hospital or non-hospital setting. This researcher hypothesized that those in hospital settings may be less likely to use harm reduction models in

treatment and therefore have a more negative perception of harm reduction as opposed to clinicians in non-hospital settings.

Significant results were found in the question “**Clients seeking treatment should be given options of treatment goals such as abstinence, safer use, or moderated use.**” Those in hospital setting had a higher mean response than those in non-hospital settings suggesting that clinicians who work in hospital settings disagree more with this statement. Significant results were also found for the question “**individuals can make use of psychotherapy even if they are still actively using substances.**” For this question, those in hospital setting had a higher mean response than in other setting, suggesting clinicians working in hospital setting disagree more with this statement.

The results of this analysis support this researcher’s hypothesis. As previous literature suggests, substance use facilities and hospital residential and inpatient substance abuse treatment centers center treatment on abstinence goals and 12-step facilitation models (SAMHSA, 2014). This researcher might assume that due to this, clinicians in these work settings might have less knowledge and use of harm reduction approaches.

Study Limitations

A major limitation of this study was the small, homogenous sample. Due to resource limitations, 52 participants were recruited through convenience sampling and primarily through this researcher’s previous field placements. The participants in this study were overwhelmingly white (90.9%, n=50) and female (81.8%, n=45.) Although geographic location was not disclosed by participants, this survey was distributed primarily to individuals living within the North East of the United States. Therefore, generalizability is limited. Future research would need to expand the sample size, broaden the geographic region, and diversify the sample in regards to race and

gender for the data to be more generalizable.

There were also limitations within my survey. I believe my wording for my qualitative question was ambiguous and some participants wrote that they did not understand what I was asking for. Although using a survey can often lead to a larger sample size, it limits the researcher's ability to clarify questions. I also think it would have been useful for the purpose of my research questions to include more qualitative questions seeking expansion on answers to Likert scale questions such as, "individuals can make use of psychotherapy even if they are still actively using." Looking back, I would like to know more about why individuals agreed or disagreed with this statement. There were many Likert scale questions for which a qualitative follow-up question would have benefited further understanding of the data. Future research should collect data in a way that allows for more exploration.

Bias. This researcher has worked both in an abstinence-based substance abuse program and within community mental health with actively using clients. This researcher also has substance dependence within her family of origin, many of whom are in long-term recovery. This researcher does have bias in her own beliefs in the importance of harm reduction theory and the positive work that can be done in psychotherapy even if clients are actively using. However, this researcher's expectations were that clinicians may hold negative views of harm reduction techniques as abstinence-based approaches are the major treatment method in the United States. Overall, clinicians in this sample had a positive view of harm reduction techniques.

Implications for Social Work and Future Research

The intended implication of this research to the field of social work was to contribute to enhancing knowledge regarding treatment approaches utilized by clinicians when working with actively using clients and clinician attitudes and perceptions toward these approaches and

working with this population. Specifically, this researcher was interested in clinician perceptions of harm reduction, psychotherapy, and traditional abstinence-based approaches when working with actively using clients. This research can be used as a beginning understanding of alternative treatment options and concerns faced by actively using clients attempting to access care. On a macro level, it is important to consider supporting programs and policies that help actively using clients access treatment and stay safe.

There are many possible areas of future research. While this research focused on clinician perceptions, it is vital to better understand and give voice to individuals who are actively using and seeking mental health or substance abuse treatment by exploring their experiences, what has felt helpful or unhelpful in treatment, what would be useful in policy and program creation that would be designed to serve them, and to further address concerns of stigmatization. As previous research has shown, American society holds negative beliefs regarding individuals who struggle with addiction, and it is important to acknowledge and be aware as social workers our own internalized beliefs and ways of thinking about substance abuse and the individuals who we work with.

Conclusion

The findings of this study suggest that clinicians may hold more positive attitudes toward harm reduction and psychotherapy with actively using clients than this researcher had first hypothesized. Due to the small, homogenous sample this data is not generalizable however, this study begins to understand clinician perceptions on working with actively using clients. Actively using individuals experience an array of stigma which also intersects with an individual's many social locations. I believe having access to non-judgmental, respectful support and treatment that meets individuals where they are is incredibly important and valuable work.

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**APPENDIX A
HSR APPROVAL LETTER**



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January 16, 2016

Abigail Vayda,

Dear Abigail,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee
CC: Quincy McLaughlin, Research Advisor

APPENDIX B
CSO RECRUITMENT STATEMENT

Dear _____,

My name is Abigail Vayda and I am in my final year at the Smith College School for Social Work and a graduate social work intern at Clinical & Support Options outpatient clinic in Greenfield.

I am currently in the process of writing my Master's thesis and am researching clinician's perspectives of psychotherapy with actively using clients. Specifically, I am interested in clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models. I am emailing to ask for your help by completing a short survey.

In order to participate in the study, you must have or be working toward a Master's or Doctorate degree in social work, mental health counseling, alcohol and drug counseling, or psychology, practice within the United States, and have or currently work with clients who meet criteria for a substance use disorder.

The survey is conducted on Qualtrics and your responses are confidential and anonymous. The survey consists of both multiple choice and open-ended questions and should take no longer than 15 minutes of your time.

If you know other clinicians who may be interested in participating in this research, please forward this email.

If you are interested in participating in this project please follow the link below to complete the survey.

Thank you for your time and consideration.

Sincerely,

Abigail Vayda

MSW Candidate '16

Smith College School for Social Work

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. Results of the study may also be used in publications and presentations.

[This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee \(HSRC\)](#)

APPENDIX C
SNOWBALL SAMPLING RECRUITMENT STATEMENT

Hello!

Will you please help me find participants to complete a survey for my Master's Thesis?

I am researching clinician's perspectives of psychotherapy with actively using clients. Specifically, I am interested in clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models.

I am looking for participants who have or are working toward a Master's or Doctorate degree in social work, mental health counseling, alcohol and drug counseling, or psychology, practice within the United States, and have or currently work with clients who meet criteria for a substance use disorder.

The survey is conducted on Qualtrics and responses are confidential and anonymous. The survey consists of both multiple choice and open-ended questions and should take no longer than 10-15 minutes of your time.

If you know other clinicians who may be interested in participating in this research, please forward this email!

If you are interested in participating in this project please follow the link below to complete the survey.

Thank you!
Abigail Vayda
MSW Candidate '16
Smith College School for Social Work

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. Results of the study may also be used in publications and presentations.

[This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee \(HSRC\)](#)

APPENDIX D
FACEBOOK RECRUITMENT STATEMENT

Hello All!

I am continuing to look for participants to complete a short survey for my Master's Thesis!

I am researching clinician's perspectives of psychotherapy with actively using clients. Specifically, I am interested in clinician perceptions of harm reduction, psychotherapy and the role of traditional abstinence models

I am looking for participants who have or are working toward a Master's or Doctorate degree in social work, mental health counseling, alcohol and drug counseling, or psychology, practice within the United States, and have or currently work with clients who meet criteria for a substance use disorder.

The survey is conducted on Qualtrics and responses are confidential and anonymous. The survey consists of both multiple choice and open-ended questions and should take no longer than 10 minutes of your time.

If you know other clinicians who may be interested in participating in this research, please forward this!

If you are interested in participating in this project please follow the link below to complete the survey.

Thank you!
Abigail Vayda
MSW Candidate '16
Smith College School for Social Work

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. Results of the study may also be used in publications and presentations.

[This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee \(HSRC\)](#)

APPENDIX E SCREENING QUESTIONS

The following two questions will determine whether you meet the eligibility criteria for participation in the survey.

For the purposes of this study:

Substance use disorder refers to a condition in which the use of one or more substances leads to a clinically and functionally significant impairment or level of distress.

Psychotherapy is defined as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable."

Q1. Do you have or are currently working toward a Master's or Doctorate degree in social work, mental health counseling, alcohol and drug counseling, or psychology and practice within the United States?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To Thank you for your time and interest ...

Q2. Have you or are you currently working with clients who meet criteria for a substance use disorder?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To Thank you for your time and interest ...

**APPENDIX F
INFORMED CONSENT**

2015-2016

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton,
MA**

.....
Title of Study: Clinician Perceptions of Harm Reduction, Psychotherapy and the Role
of Traditional Abstinence Models

Investigator(s):
Abigail Vayda, MSW Candidate

.....
Introduction

You are being asked to be in a research study of clinician perspectives of psychotherapy with actively using clients.
You were selected as a possible participant because you have or are currently working toward a Master’s or Doctorate degree in social work, mental health counseling, alcohol and drug counseling, or psychology and practice within the United States and have you or are currently working with clients who meet criteria for a substance use disorder.
We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of the study is to explore and better understand clinician perspectives of psychotherapy with actively using clients specifically, perspectives about harm reduction and traditional abstinence models of care.
This study is being conducted as a research requirement for my master’s in social work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things: participate in an online survey which will include two eligibility questions to ensure you meet eligibility requirements for this study, answer seven demographic questions, and complete the survey consisting of ten multiple choice questions and two open response questions. You may skip any questions you do not wish to answer and exit the survey at any time. Completion of the survey should take no longer than fifteen minutes. All survey answers will remain anonymous.

Risks/Discomforts of Being in this Study

There are no foreseeable or expected risks of participation.

Benefits of Being in the Study

The benefits of participation may include having an opportunity to share perceptions about the research topic and reflect upon experiences when working with this population. There will be no payment or gift compensations.

The benefits to social work/society might include enhancing knowledge regarding treatment approaches utilized by clinicians when working with actively using clients, while also recognizing the stigma faced by this population.

Confidentiality

This study is anonymous. We will not be collecting or retaining any information about your identity.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Payments/gift

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You have the right not to answer any single question, as well as withdraw from the study at any time during completion of the survey by simply closing your web browser. If you chose to withdraw by not completing your survey, your data will not be included in the survey as only completed surveys will be used for the study. Because this is an anonymous survey, there will be no way to withdraw once you have clicked on the "submit" button at the end of the survey.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Abigail Vayda at XXX or by telephone at XXX. If you would like a summary of the study results, please contact me, Abigail Vayda, and one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

By selecting "I agree" below, you have indicated that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. Please save this form for your records.

Selecting "I agree" below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Please print a copy of this page for your records.

APPENDIX G
DISQUALIFICATION PAGE

Thank you for your time and interest in this study. Unfortunately, your answers to one or more of the previous questions indicate you are not eligible to participate.

Please share this survey with others who may be interested in participating.

APPENDIX H SURVEY

Demographic Questions

The following seven questions are for demographic purposes.

Q5. What is your age?

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

Q6. How do you identify your racial/ethnocultural identity?

- American Indian or Alaskan Native
- White
- Black or African-American
- Asian
- Native Hawaiian or other Pacific Islander
- Hispanic or Latin(a/o)
- Middle-Eastern
- Multi-racial

Q7. How do you identify your gender?

- Female
- Male
- Transgender

Q8. In what setting do you practice? (eg. private practice)
(Text box answer)

Q9. What is your degree?
(Text box answer)

Q10. How long have you been in practice?

- Less than 1 year
- 1-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20-24 years
- 25 or more years

Q11. Approximately what percentage of your current caseload meet criteria for a substance use disorder?

- Less than 25% (1)
- 25-50% (2)
- 50-75% (3)
- More than 75% (4)

Survey

For the purposes of the study:

Substance use disorder refers to a condition in which the use of one or more substances leads to a clinically and functionally significant impairment or level of distress.

Psychotherapy is defined as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable."

Harm reduction in relation to substance use describes interventions designed to reduce the harmful consequences associated with substance use.

Abstinence in relation to substance use refers to the commitment of an individual to refrain from use of any substances.

Q13. I feel that I have received sufficient training and education on working with individuals with a substance use disorder.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q14. I understand harm reduction theory as it applies to substance use.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q15. If given the choice, I would choose not to work with a client with substance use disorder who continues to use.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q16. If a client comes to therapy under the influence of drugs or alcohol, a clinician should ask the client to reschedule.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q17. Clients seeking psychotherapy for a substance use disorder should be given the options of treatment goals such as abstinence, safer use, or moderated use.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q18. Individuals who continue to relapse should not be allowed to remain in treatment for substance abuse.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q19. Individuals can make use of psychotherapy even if they are still actively using substances.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q20. Medication-assisted therapies for opioid addiction (such as suboxone) are an appropriate treatment option.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q21. Clinicians should offer their clients who are actively using substances information about safer use strategies.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

Q22. Abstinence should be the treatment goal for individuals struggling with addiction.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Q23. How do you understand the development of a substance addiction?
(Text box answer)

Q24. What theories or modalities do you generally draw from in your work?
(Text box answer)

**APPENDIX I
HSR AMENDMENT APPROVAL**



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 24, 2016

Abigail Vayda

Dear Abigail,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,



Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Quincy McLaughlin, Research Advisor