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Exploring Substance Use Disorders Community Outpatient Counselors' Experiences Treating Clients with Co-Occurring Medical Conditions: An Interpretative Phenomenological Analysis

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

by

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## Abstract

### EXPLORING SUBSTANCE USE DISORDERS COMMUNITY OUTPATIENT COUNSELORS' EXPERIENCES TREATING CLIENTS WITH CO-OCCURRING MEDICAL CONDITIONS. AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Lauretta Anne Cathers, Ph.D.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2013

Major Director: Amy Armstrong, PhD, Chair, Rehabilitation Counseling

The Interpretative Phenomenological Analysis study presents the findings from a qualitative study examining substance use disorders (SUD) community outpatient treatment counselors' experiences treating clients with co-occurring medical conditions. Interviews from five SUD community outpatient treatment counselors resulted in four emerging super-ordinate themes. The findings illustrate the relationships between SUDs, medical conditions and other predisposing, enabling and need factors. In order to assist clients in focusing on therapy, counselors work to identify resources to treat the basic needs of the clients, including medical care. Challenges included limited resources, complex system processes, and client fear and apathy. In addition, various unique challenges related to medical conditions treated by potentially habit forming medications and traumatic brain injury were identified. Counselors discussed how their roles and responsibilities have expanded to include case management and additional responsibility for the overall well-being of the clients they serve. They encouraged SUD educators to include more

education on counselor self-care, trauma, pain conditions and the assessment process.

Implications from the study highlight the need for integrated behavioral and physical health care.

Keywords: substance abuse, substance use disorders, substance abuse counseling, integrated health care, motivational interviewing, Interpretive Phenomenological Analysis, health care utilization, disabilities, rehabilitation counseling

## **Chapter 1: Introduction**

The following Interpretative Phenomenological Analysis (IPA) study seeks to explore Substance Use Disorders (SUD) community outpatient counselors' experiences of treating clients with co-occurring medical conditions. Integration of substance abuse treatment and medical care is a hot topic in health care reform. Although previous research established the relationship between substance use and medical care utilization, little is known about what substance abuse counselors experience when treating clients with co-occurring medical conditions. In the following study, participants provide their perceptions of how medical issues are related to substance abuse treatment and outcomes. Information from this study will enhance current understanding of what is occurring within SUD community outpatient treatment and bring SUD counselors' voices into the integrated health care reform discussion.

### **Background and Context**

Substance dependence and abuse, often referred to as Substance Use Disorders (SUD), are complex illnesses affecting more than 22 million people in the United States 12 years of age and older (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) estimated only 2.6 million people received substance use specialty treatment. SUDs are chronic illnesses affecting all aspects of a person's life (McLellan, Lewis, O'Brien, & Kleber, 2000). Often this requires multiple social, behavioral and medical issues to be treated congruently in order to increase a person's ability to achieve positive substance use outcomes, such as

abstinence. However, treatment is segmented with a person having to engage medical care and SUD specialty treatment separately with little coordination and communication occurring between the two systems.

Patients attending general health care practices may or may not report their substance use to a physician. This often leads to a failure to assess and provide SUD specialty treatment (Stout, Rubin, Zwick, Zywiak, & Bellino, 1999) and complicates the treatment of a variety of medical conditions such as heart disease and diabetes (McLellan et al., 2000). In addition, substance abuse counselors often find medical issues directly impact SUD treatment planning by having to take into consideration any physical ailment influencing the patient's substance use. A primary example is the increasing number of individuals being treated for substance dependence and chronic pain. Research has noted chronic pain does increase the likelihood of poorer substance abuse outcomes; especially with opioid dependent clients (Clark, Stoller, & Brooner, 2008).

Recognition of SUDs co-occurring with mental and physical health conditions has sparked debate among policy makers, addiction specialists and the medical community on whether SUDs should be viewed and treated as a chronic disease. SUDs are a result of genetic and environmental factors and a person's behavioral choices. In addition, drug use changes the chemistry and function of the brain (McLellan et al., 2000). These factors, when combined, have characteristics and implications for treatment and recovery similar to other chronic diseases (McLellan et al., 2000). However, SUDs are often treated as acute illnesses (McLellan et al., 2000). Whether or not SUDs are acute or chronic in nature is a critical discussion as the new Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 seeks to broaden the number of insured individuals and increase SUD identification within health care settings (McLellan, 2010; SAMHSA, 2011).

SUD treatment integration with medical and psychiatric care has been shown effective in treating specific complex co-occurring conditions such as HIV (Lombard, Proescholdbell, Cooper, Musselwhite, & Quinlivan, 2009), psychiatric conditions (Drake, Mueser, Brunette, & McHugo, 2004), prenatal care (Sweeney, Schwatz, Mattis, & Vohr, 2000) and physical disabilities (Ebener & Smedema, 2011). However, little attention has been paid to understanding SUD community outpatient counselor experiences treating clients with co-occurring medical conditions. Although the literature provides substantial evidence of the relationship between SUD treatment and medical care utilization, the review of the literature has a substantial gap when exploring this issue from the SUD community outpatient counselor perspective.

Research has demonstrated the relationship between SUDs, medical care utilization and cost (Cherpitel, 1999; Cherpitel & Ye, 2008a, 2008b). In 2011, an estimated 2.5 million emergency department (ED) visits were the result of drug misuse or abuse. Of those, 1.25 million involved illicit drugs, 1.24 million involved non-medical use of pharmaceuticals and 0.61 million involved drugs combined with alcohol (SAMHSA, 2013). In addition to drug related accidents or illnesses, SUDs often lead to a variety of chronic medical problems including emphysema, cardio-pulmonary disease, pneumonia, abscesses, infections, Human Immunodeficiency Virus (HIV), hepatitis and a host of co-occurring mental health disorders (Brody, Slovis, & Wrenn, 1990; Chalk, Dilonardo, Rinaldo, & Oehlmann, 2010; Chitwood, McBride, French, & Comerford, 1999; Trapido, Lewis, & Comerford, 1990;).

Engagement in SUD treatment has also shown to have an impact on medical care utilization and costs. For example, earlier studies on alcoholics have found them to have lower life expectancies, higher mortality rates, and higher rates of medical care utilization prior to entering alcohol treatment (Holder & Blose, 1986; Holder & Blose, 1991). However, health care

utilization often reduced after a person received substance use treatment (Chalk et al., 2010; Holder & Blose, 1986; Holder & Blose, 1991; Holder & Hallan, 1986). Another seminal article by Forsyth, Griffiths and Rieff (1982) found a slightly different pattern of medical costs of alcoholics versus non-alcoholics in outpatient and inpatient medical service utilization. The study found costs for medical care escalated during the two years prior to treatment with a more gradual decline of costs post-treatment. Overall, their main finding showed alcoholism was associated with having other chronic conditions.

Studies have also examined the relationship between addiction and medical care utilization with the potential influence of co-occurring disorders. Mertens, Flisher, Satre and Weisner (2008) study results found a diagnosis of either psychiatric, medical or substance use condition was not related to substance use remission at five years. They also found while primary care visits were not related to the remission outcome in the full sample, they were predictive of remission at five years in a sub-group who had both substance use and a chronic medical condition. Overall, those who were in the integrated care group at six months did have higher abstinence rates. Similarly, Smith, Meyers and Miller (2001) looked at integrated care (substance use treatment and medical care) during and after SUD treatment, and found improved outcomes especially related to abstinence following treatment. This finding is consistent with Weisner, Mertens, Parthasarthy and Moore (2001) and Mertens et al. (2008) findings demonstrating higher odds of abstinence if primary care was integrated into substance use treatment.

Other studies have found evidence that primary care services were predictive of better substance abuse outcomes as they related to medical problems in general, medical problems related to and exacerbated by substance use, and when integrated with a substance abuse

program (Friedmann, Zhang, Hendrickson, Stein & Gerstein, 2003; Saitz, Svikis, D'Onofrio, Kraemer & Perl, 2006; Weisner et al., 2001). One notable study by Green, Polen, Lynch, Dickinson and Bennett (2004) examined predictors for treatment outcomes or changes in alcohol consumption. The authors found those who had reported better health status at baseline were likely to be abstinent from substances at seven month follow-up. Although studies have not been able to confidently link medical conditions as motivating factors in substance use abstinence, they do provide evidence of a critical link between substance use treatment and medical care. However, this evidence fails to describe what is being experienced by SUD treatment providers. Such information may shed light into the relationship between SUDs, medical utilization, and drug treatment outcomes.

The primary issue with earlier studies has been the lack of generalizability. Samples are often limited to patients in health maintenance organizations (HMOs) or Veteran's Administration (VA) health facilities where care is integrated and/or co-located. Few studies have examined medical care utilization and SUD treatment at the community service level. Efforts to gain the community perspective are exemplified by the Benjamin-Johnson, Moore, Gilmore and Watkins (2009) study. The researchers surveyed 254 clients who attended a behavioral health organization in June 2008 to examine medical care need and utilization in a community setting where substance use, poverty, and other barriers may impede receiving medical care. Although 63% reported having a usual source of care, 22% still reported the emergency room or more than one source of care as their usual care. There was no association between usual source of care or medical insurance and ER/doctor visits during the current substance use treatment episode. However, those with chronic illnesses had greater odds of an



emergency room or doctor's visit and having usual source of care (Benjamin-Johnson et al., 2009).

Most studies were conducted utilizing medical and SUD treatment data, providing a limited view of what is being experienced in treating individuals with SUDs and medical conditions. Previous research has identified potential predictors and associations, but does not delve into the experience. SUD community outpatient counselors spend a significant amount of time with their client as they assess needs, and develop and implement their client-centered treatment plans. Therefore, gathering and analyzing SUD community outpatient counselors' experiences can provide a different and invaluable view of what is being experienced within substance use treatment.

### **Purpose Statement**

The purpose of this study is to explore the experiences of SUD community outpatient treatment counselors treating clients with co-occurring medical conditions. Such an exploration is important in order to ascertain what is happening within substance abuse treatment and how co-occurring medical conditions affect the counselor's implementation of evidence based practices. The study provides the opportunity to explore the experiences from the research participant's view to challenge and/or confirm current assumptions and provide a glimpse into the phenomenon of treating individuals with SUDs and co-occurring medical conditions. IPA essentially attempts to make sense of what the SUD counselor is experiencing when treating clients with co-morbidities. By understanding SUD community outpatient counselor's perspective of their experiences, we can identify in what ways counselors are interacting with the phenomenon. Rehabilitation counseling leadership can utilize the results to identify if changes are needed in current evidence based counseling practices (e.g. Motivational Interviewing,

Cognitive Behavioral Therapy, Contingency Management) and to bring voice directly from the field into health integration discussions.

The study included semi-structured interviews with five SUD community outpatient counselors to explore the following research question: How do the SUD community outpatient treatment counselors experience treating clients with co-occurring medical conditions?

The specific aims of the study are to:

- Describe SUD community outpatient counselors' experiences of treating clients with co-occurring medical conditions.
- Explore SUD community outpatient counselors' perceptions of the relationship between SUDs and co-occurring medical conditions.
- Identify what SUD community outpatient counselors perceive as challenges in providing treatment to clients with co-occurring medical conditions.
- Identify what SUD community outpatient counselors understand as strategies for implementing SUD treatment to clients with co-occurring medical conditions within SUD treatment.

### **Significance**

The study's significance is to gain a better understanding of SUD community outpatient counselors' experiences in treating clients with co-occurring medical conditions. IPA will assist in identifying key themes related to providing SUD treatment for clients with co-occurring medical conditions in community outpatient treatment settings. Rehabilitation counseling, with expertise in working with individuals with disabilities and chronic illness (including SUDs), can provide leadership by utilizing the study information to empower SUD community outpatient

counselors in the development of effective strategies and innovative approaches to treating clients with co-occurring medical conditions and adapting to new health care reform.

### **Delimitations**

The IPA study took place in a publically funded SUD community outpatient treatment center in Central Virginia. Virginia Commonwealth University Institutional Review Board (IRB) approval was obtained prior to study launch (See Appendix A: IRB Approval Letters). The research utilized a purposive sampling method to identify nine SUD community outpatient counselors within the site who held current licenses, had an active caseload, and provided counseling at the site for five or more years. The researcher contacted each potential participant via email and invited them to participate in the study. Of the nine eligible and contacted, five counselors agreed to participate. The researcher conducted all interviews at a county library utilizing private areas conducive to protecting their confidentiality and privacy.

Face-to-face interviews were conducted in Summer of 2013 using a semi-structured interview schedule. After the first interview, the researcher posted reflections and an assessment of the interview in a reflective journal. The researcher transcribed each interview within 24-72 hours after the interview. Interviews were coded separately, and then compared across interviews. A thematic summary of each interview was provided to participants for member checking. After analysis was complete, the researcher developed a written and graphic presentation for the dissertation committee to discuss.

Prior to participant data collection, a bracketing interview was conducted with the researcher. The bracketing interview identified professional and personal relationships the researcher had with the phenomenon. The interview also identified the researcher's presumptions and current thoughts on the phenomenon being studied and allowed for a more open view of

SUD community outpatient counselors' experiences. The bracketing interview was facilitated by Dr. Dace Svikis, Professor, VCU Department of Psychology and dissertation committee member. The researcher transcribed the bracketing interview. All materials including the bracketing interview, de-identified transcripts, reflective journal, analysis documents and additional literature, were provided to the dissertation committee for their review via VCU BlackBoard.

### **Assumptions**

The researcher has experience in the area of substance abuse treatment and chronic medical conditions on a personal level, but no direct clinical experience in working with clients with co-occurring medical conditions. In addition, the researcher has spent significant time reviewing the literature regarding substance abuse treatment and medical care utilization and the impact the relationship has on SUD treatment outcomes. The researcher acknowledges several assumptions in this project. First, there is heterogeneity among clients regarding the directionality of substance use and medical conditions. For some, the medical condition leads to misusing substances to control pain, anxiety, depression, etc. For others, substance use leads to chronic medical conditions in need of treatment. This diversity among clients regarding the relationship between substance abuse and co-occurring medical conditions require that counselor's take different approaches to working with clients.

Second, counselors are often trained in evidence based practices such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) to treat clients with substance use issues. However, substance abuse treatment counselor training is limited with regard to education on health conditions. This assumption is grounded in personal communications between the researcher and substance abuse treatment counselors who have requested further training and

education on this topic. Lastly, there is an assumption that current integration efforts have not included substance abuse treatment counselors' input into major issues related to integration of SUD treatment and medical care. This assumption is based on the lack of information in the literature regarding the experiences, challenges and successes SUD counselor's experience in treating clients with co-occurring medical conditions.

### **Definition of Terms**

- *Addiction Technology Transfer Centers (ATTC)*: Funded through SAMHSA, provides training and education on substance use disorders for the SUD workforce.
- *Clinical Trials Network (CTN)*: Funded by NIDA, provides clinical trial research on SUDs.
- *Cognitive Behavioral Therapy (CBT)*: Therapeutic approach addressing dysfunctional emotions and maladaptive cognitive processes and behaviors.
- *Dialectical Behavior Therapy (DBT)*: Therapeutic intervention combining cognitive behavioral techniques and emotion regulation strategies.
- *Emergency room/department (ER/ED)*: Facility for urgent care and trauma.
- *Eye Movement Desensitization and Reprocessing (EMDR)*: Psychotherapeutic intervention to assist clients with trauma and memories of trauma.
- *Health Maintenance Organizations*: Managed health care system.
- *Interpretative Phenomenological Analysis (IPA)*: A qualitative approach grounded in the interpretist paradigm.
- *Motivational Interviewing (MI)*: A client-centered interviewing approach to assist clients in identifying ambivalence and encourage behavior change

- *National Institute of Drug Abuse (NIDA)*: Federal agency and primary funder of substance use research within the National Institutes of Health.
- *PCP or Primary Care Physician*: Medical provider providing preventative and treatment of medical conditions.
- *Prescription Drug Use*: For the purpose of this paper, prescription drug use refers to the use of potentially habit forming medications such as opioid based pain killers and benzodiazepines.
- *Substance Abuse and Mental Health Services Administration (SAMHSA)*: Federal entity providing information, research and technical assistance for substance use and mental health.
- *Substance Use Disorders (SUDs)*: Substance use disorder includes the abuse/dependence of alcohol, illicit and prescription medications.
- *Traumatic Brain Injury (TBI)*: Injury to the brain resulting in cognitive, behavioral or other deficits.

## Chapter 2: Literature Review

### Introduction

The focus of this Interpretative Phenomenological Analysis (IPA) study is to describe SUD community outpatient treatment counselor experiences and perceptions of treating clients with co-occurring medical conditions. The current state of research supports the association between SUDs and acute and chronic medical problems (Chitwood, Sanchez, Comerford, & McCoy, 2001; McLellan et al., 2000), and medical care utilization (Cherpitel, 1999; Cherpitel & Ye, 2008a, 2008b). Research has also examined the affect substance abuse treatment has on changing medical care utilization patterns and any affect the association may have on substance abuse treatment outcomes such as abstinence (Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003).

The literature review was conducted prior to data collection. The relationship between SUDs, SUD treatment, and co-occurring medical conditions is an area of interest to the researcher and focus of current projects within her employment. Engagement in the literature immersed the researcher in the current state of the research and identified a critical gap in the scientific literature. Lacking is an in-depth understanding of what SUD community outpatient counselors experience in treating clients with co-occurring medical conditions. Although the literature seems to develop a logical flow of information regarding the association between substance use treatment and medical care, most is from a health administration viewpoint and quantitative in nature. An IPA study is needed to obtain the counselors' perspectives of being

engaged in the phenomenon of providing SUD counseling to clients with co-occurring medical conditions. The knowledge gained from the literature review and the thoughts, feelings and assumptions developed during the review were bracketed during the analysis phase (see Chapter 3: Methodology for further details).

The following literature review will cover: 1) Medical care utilization among people with SUDs; 2) The association of SUD treatment and medical care utilization; 3) Review of the association between SUD treatment, medical care utilization and substance use outcomes (e.g. abstinence); 4) Current state of research from the SUD community outpatient treatment counselor's perspective; 5) Conceptual model; and 6) Discussion of the current gaps and limitations in the literature.

The literature review identifies significant gaps in describing SUD community outpatient treatment counselors' experiences treating clients with co-occurring medical conditions. Although comprehensive in establishing the important relationship between SUD treatment, medical conditions and utilization, the research offers little, if any, information on what SUD community outpatient counselors are experiencing. By understanding their experiences, we can begin to understand the affect co-occurring medical conditions has on implementing evidence based practices (e.g. Motivational Interviewing, Cognitive Behavioral Therapy) and the challenges medical conditions pose in the client's ability to achieve successful substance abuse treatment outcomes.

The significance of the study is to gain a better understanding of the experiences of SUD community outpatient treatment counselors in treating clients with co-occurring medical conditions. The voices heard through this study can provide a perspective of what is occurring on a day to day basis that may lead to identifying and/or developing strategies for the enhancement



of SUD treatment and medical care integration. Rehabilitation counseling, in particular, with its expertise in working with individuals with disabilities and chronic illness, can take a leadership role in transforming the information gathered from such a study and aid SUD community outpatient treatment counselors in conducting evidence based practices and adapting to new health care reform.

### **Medical Care Utilization among People with SUDs**

According to the results of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (2011), 23.1 million people were identified as needing treatment for illicit drug or alcohol use problems (note: those identified in need of SUD specialty treatment do not necessarily need to meet diagnostic criteria of dependence or abuse). Of those, only 2.6 million who needed SUD specialty treatment reported receiving it. Of the remaining 20.5 million in need of treatment, but who had reported not receiving it, only one million said they felt they needed treatment. Interestingly, 341,000 respectively, stated they had made an effort to get treatment, while the other 683,000 were estimated to have made no effort (SAMHSA, 2011). These statistics demonstrate a significant amount of untreated SUDs within the US.

Untreated SUDs lead to increased medical/health conditions and health care utilization costs. For example, in 2011, 2.5 million drug misuse or abuse related emergency department (ED) visits occurred. Of those, 1.25 million were for illicit drugs, 1.24 million were for non-medical use of pharmaceuticals and 0.61 million were for drugs combined with alcohol (SAMHSA, 2013). Almost 40% of illicit drug use visits had follow-up including hospital admission (24%), transfer to another health care facility (10%) and referral to detox/dependency

program (6%). According to SAMHSA (2013), illicit drug related visits have increased 29% from 2009-2011.

Non-medical use of pharmaceutical ED visits included the use of prescriptions, over the counter medications and other types. Of those visits, pain relievers were most often seen (46%) with narcotic pain relievers involved in 29% of the visits. ED visits related to opiates/opioids rose 183% between 2004 and 2011 (SAMHSA, 2013). In examining ED visits related to drug and alcohol misuse/abuse, 58% included illicit drugs with a type of pharmaceutical with 30% also involving alcohol. These statistics demonstrate the various relationships between substance misuse and medical conditions, but also the prevalence of combining various pharmaceuticals with illicit drugs and/or alcohol. Interestingly, the Drug Abuse Warning Network data (DAWN) also found a quarter of million drug related visits was for patients seeking detox or SA treatment services. For individuals using heroin, this was a short-term increase from 2009-2011 in the number of patients seeking detox (SAMHSA, 2013).

Numerous studies have demonstrated important linkages between primary medical care, ED utilization and substance abuse treatment (Breton, Taira, Burns, O'Leary & Chung, 2007; Cherpitel & Ye, 2008a; Samet, Larson, Morton, Doyle, Winter & Saitz, 2003). The most notable population-based studies documenting the utilization patterns of people with SUDs, primarily alcoholics were conducted by Cherpitel and colleagues. Cherpitel (1999) examined data from the 1995 National Alcohol Survey representing people living in households in the 48 contiguous states. The author utilized univariate logistic regression followed by multivariate logistic regression with simultaneous entry of demographic characteristics, and drug and alcohol variables to examine their relationship to ED and primary care utilization. Hour long face-to-face interviews were conducted by trained interviewers after informed consent.

A multi-stage area probability sample of 100 primary sampling units of adults 18 and over with oversampling of Black/African American and Hispanics yielded a total 4,803 completed responses. Of those, 11% (n=517) had ED visits, 25% (n=1,186) had primary care visits and 84 respondents reported having both in the last 12 months (Cherpitel, 1999). Results found significance on several variables including race, gender, and alcohol and drug use as they related to primary care and ED use. ED utilization had more significant outcomes than primary care. For example, white and Hispanic males who reported high drinking were less likely to report an ED visit as compared to abstainers (OR=0.14, 95% CI=0.03, 0.73; OR=0.30, 95% CI=0.16, 0.58). Similar results were found with white females who reported more drunkenness episodes (OR=0.02, 95% CI=0.01, 0.03). However, black females who reported high drinking were five times more likely to report an ED visit (OR=5.59, 95% CI=1.72, 18.11) (Cherpitel, 1999).

Other notable differences by demographics were related to drug use. Hispanic males who reported attending drug treatment were five times more likely to have an ED visit in the past 12 months (OR=4.70, 95% CI=1.0, 21.54); while Hispanic females who reported attending drug treatment, were negatively associated with ED visits (OR=0.12, 95% CI=0.05, 0.31). Black males reporting drug use were 2.5 times more likely to have an ED visit (OR=2.63, 95% CI=1.22, 5.66), and three times more likely if they reported previous drug treatment (OR=3.24, 95% CI=1.25, 8.24) (Cherpitel, 1999).

However, only a few of the demographic and drug use variables were found to be significant for primary care. Examples include: a) Hispanic males reporting infrequent drinking; b) Hispanic females reporting light drinking; c) Black males reporting moderate drinking; and d) White males and Black females reporting alcohol treatment. Drug use was not associated with

primary care visits. Cherpitel's findings highlight the association between substance use and medical care by demonstrating the potential predictive influence of various factors, including drug and alcohol use, on medical care utilization.

Similarly, Cherpitel and Ye (2008a) analyzed data from the 2005 National Alcohol Survey to determine the prevalence and predicative value of alcohol misuse and drug use on ED and primary care. Of the 6,919 respondents in the Alcohol Research Group's 2005 Alcohol Survey, almost half were male (48.2%) and were White or Asian/Pacific Islander, Native American or Alaskan Native (76.5%). Three-fourths of the sample was between the ages of 30-49 (40.3%) and over 50 years old (39.2%). The majority reported having health insurance (85.5%) and non-risky drinking behavior (70.2%) (Cherpitel & Ye, 2008a). Only 3.5% reported greater than monthly illicit drug use.

Their results found problem drinking (OR=1.99, 95% CI=1.26, 3.17) and greater than monthly illicit drug use (OR=1.92, 95% CI=1.16, 3.16) were predictive of ED utilization. However, primary care use was only predicted by alcohol dependence (OR=1.63, 95% CI=1.00, 2.63). Demographics such as race and ethnicity were again found to have predictive influence. Significance was also found with those reporting health insurance 2.30 times more likely to use primary care (Cherpitel & Ye, 2008a). The author's concluded those with more frequent drug and alcohol use probably had more health problems often needing immediate attention. In similar fashion, findings of a trend analysis covering 2000-2005 found an upward trend of utilization for drug (not alcohol) related ED visits (Cherpitel & Ye, 2008b). Even after controlling for age, gender, and health insurance status in multivariate logistic regression, drug use was positively predictive of drug-related ED visits.

Recently, Cherpitel and Ye (2012) examined the trends of alcohol and drug related ED visits across four National Alcohol Surveys (1995, 2000, 2005 and 2010). Alcohol related visits nearly doubled between 1995 and 2010 (5.0% vs. 9.7%). Even after controlling for demographic variables, the year of the survey was predictive of alcohol related ED visits. Drug related ED visits were noted as going down between 2005 and 2010 (3.7% vs. 1.9% respectively) and primary care visits remained stable. One of the primary limitations of the study was the lack of data on the specific class of drugs and therefore, one cannot rule out that trends may have fluctuated depending on the type of drug consumed 6 hours prior to the ED visit (Cherpitel and Ye, 2012). Overall, their study demonstrates the continued relationship between alcohol and substance use and ED visits.

Taking a closer look at medical utilization among illicit drug users (excluding alcohol), Chitwood, McBride, French and Comerford (1999) examined epidemiology data from the Health Care Utilization Study from the Health Services Research Center at the University of Miami. Using a stratified two-stage network based sampling method during April 1996 through September 1997, outreach workers recruited three subsamples including : a) active injection drug users (IDUs) who had injected cocaine and/or opiates at least weekly for the past 12 months (verified by visible recent track marks and positive urine screen); b) other sustained or chronic drug users who never injected, but used cocaine and other opiates in the last 12 months (no visible track marks, positive urine screen); and c) individuals who have never used cocaine and/or opiates (no track marks and negative urine screen).

The study sought to determine if drug use was independently related to need and use of care. Logistic regression was utilized to analyze data from the three subgroups representing 160 IDUs, 271 other drug users and 105 non-drug users. The majority of respondents were male, had

an annual income of less than \$10,000 and a high school diploma or GED (Chitwood et al., 1999). Little more than half of the respondents had health insurance in the past 12 months. IDUs (89%) and other drug users (85%) stated a need for health care in the past 12 months compared to non-drug users (78.9%) (Chitwood et al.,1999).

The three logistic regressions conducted on the need, use and failure to use variables found significant results adding more information to the larger picture of medical care utilization by chronic drug users (in this case cocaine and opiate users) (Chitwood et al., 1999). Results of the logistic regression model for need for care in the past 12 months found individuals with health insurance reported needing health care 1.74 times more than those without (95% CI=1.32, 2.30). Respondents who reported a poor/fair health status needed care 2.3 more times than those with better perceived health (95% CI=1.50, 3.67). Injection drug users also reported needing care 1.64 times more than non-drug users (95% CI=1.08, 2.50). Interestingly, chronic drug use was not significant on the receipt of care. However, age, insurance status and poor/fair perceived health status was. Lastly, IDUs were 1.5 times more likely to have failed to receive care than non-drug using respondents on one or more occasions (CI not reported).

Chitwood, Sanchez, Comerford and McCoy (2001) took the same dataset and examined preventative health care among IDUs, other sustained drug users and non-users. In this analysis, the sample increased to 1,254 African American, Hispanic/Latin and non-Hispanic/Latino whites to determine the independent risk factors for utilization of primary preventative care. Demographically, the sample was over half males (59%), evenly distributed across race (approximately one-third White, Black and Hispanic), with most 30 years of age or older (80%). Two-thirds reported an income below \$10,000, and 49.6% reported having health insurance.

Univariate analysis showed that gender, ethnicity, health insurance status, drug use and alcohol use, and tobacco use were associated with primary preventative care (Chitwood et al., 2001).

Similar to Cherpitel and Ye's finding of low primary care utilization among drug users, IDUs and other drug users were less likely to have had an annual physical in the last twelve months (OR=0.54, 95% CI=0.37, 0.79 and OR=0.60, 95% CI=0.43, 0.83). Chitwood et al. (2001) results also showed heavy and moderate drinkers were less likely to have had an annual physical in the past 12 months (OR=0.50, 95% CI=0.36, 0.69 and OR=0.61, 95% CI=0.45, 0.83). It is interesting to note the Chitwood et al. (1999 and 2001) studies demonstrated more failure to receive care and less primary care utilization among drug users compared to previous studies such as Cherpitel. However, this could be due to the focus of Cherpitel's study on alcohol with only a small sample of other drug use and to different operational definitions for medical care utilization.

Two additional studies also support the predictive influence of drug use on ED utilization (Raven, Billings, Goldfrank, Manheimer, & Gourevitch, 2008; Rice, Conell, Weisner, Hunkeler, Fireman, & Hu, 2000). One of the most notable studies conducted by Raven et al. (2008) analyzed five years of Medicaid data (2001-2006) to develop a regression algorithm to find those at high-risk for hospitalization in the next 12 months. Information from the first four years was used to predict hospital admission at the fifth year. Risk scores ranged between 0 (no risk) to 100 (greatest risk) of re-admission. Of the 36,457 individuals who received care in the hospital, 2,618 (7.2%) were identified with a risk score greater than 50. Excluded were individuals younger than 18 or over 64, in prison or nursing home, HIV+ patients, or patients unable to communicate. The researchers checked daily admissions to match those identified in the algorithm to those admitted into the hospital (n=139). Of the 139 deemed high-risk and admitted, 60 met inclusion criteria

and 50 were interviewed. Demographically, the sample was mostly male (72%), ranged in age between 35-49 (42%) and 50-64 (38%), with over half Hispanic (54%), and having less than a high school education (60%) (Raven et al., 2008)

Of the 50 participants, 62% had a previous diagnosis of a chronic medical condition with 80% also having a co-occurring substance abuse and/or mental illness. Of 38% who did not have a previous chronic condition diagnosis, 89% had a substance use and/or mental illness issue. Just over half (56%) stated the ED was a usual source of care, and 42% were admitted for conditions related to substance use. The algorithm found high rates of substance abuse, social isolation and lack of medical home were associated with ED utilization (Raven et al., 2008). The findings reinforce the relationships between medical utilization and substance use. However, the study is weakened by the lack of information detailing drug/alcohol type and use, and whether or not patients had been or were currently engaged in substance abuse treatment.

Few studies have gone beyond the quantitative exploration of factors related to medical care utilization and substance abuse to address reasons why utilization occurs the way it does. Raven, Carrier, Lee, Billings, Mar and Gourevitch (2010) conducted a mixed method exploration of barriers to substance abuse treatment for patients presenting at the ED. Using the same algorithm by Billings, Dixon, Mijanovich and Wennberg (2006) and Billings and Mijanovic (2007) presented previously (in Raven et al., 2008) to predict people at risk for hospital admissions, the authors recruited a total sample of 50 people who were between 18-64, had a score of readmission of greater than or equal to 50, and spoke English for the study. The qualitative tool consisted of in-depth individual interviews of patients and treatment teams. The questions focused on patient experiences with hospital services, prior treatment, social support and health behaviors.



Their study provides a unique glimpse of the interaction of substance use treatment and medical care (Raven et al, 2010). Of the 50 patients, most were men with a mean age of 44 years. Participants identified as Hispanic (54%), African American (24%), and White (15%). The majority of the sample had less than a high school education (65% non-substance use involved and 52% substance use involved, respectively). Of the 50, 62% had a previous diagnosis of a chronic medical condition and 80% had a diagnosis of substance use and/or mental health issue. Almost three-fourths of participants had a substance abuse ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) risk score indicating moderate to high risk for substance use disorder (Raven et al., 2010).

One theme that emerged was the use of medical care, particularly the use of the ED, providing solutions to temporary housing or other social problems. When shelter was no longer available, participants would come to the hospital for detox. This notion of using the hospital as a respite was supported by physician views. The second major theme was utilizing the hospital for acute conditions and limited time to resolve other more complex social needs limiting the ability to provide follow-up care. The third theme was related to being unsuccessful in linking the patient from medical care to substance use treatment. Reasons for the lack of follow-up included patient distrust of rehabilitation and the inability to ensure successful linkage from hospital to treatment (Raven et al., 2010).

Overall, research on medical care utilization by people with alcohol and drug use is consistent with drug users' higher ED utilization and lower primary care utilization. However, as Raven et al. (2008) noted, there is still a high perceived need and failure to receive medical care among illicit drug users. The findings demonstrate a one-way direction of the association with drug and alcohol use contributing to higher medical utilization. A significant gap still remains

related to understanding the association of SUDs and medical care and its relationship to the delivery of SUD counseling.

### **The Association of SUD Treatment and Medical Care Utilization**

As more research on the health care utilization patterns of people with SUDs continues, researchers look at what affect SUD treatment has on medical care utilization patterns. People with SUDs are engaged in ED and primary care at some level for SUD related illnesses and injuries. The question remains how medical care and SUD treatment are interacting. Are some of the utilization patterns observed a result of people engaged in SUD treatment and working with their counselor to tend to health care issues, thereby increasing health care access to some degree? Or is engagement in medical care increasing awareness of people's SUD issues motivating individuals to seek SUD treatment? It is hoped people's engagement in SUD treatment and medical care occurs bi-directionally.

The impact of SUD treatment on medical care utilization is demonstrated in a variety of studies examining the longitudinal changes in utilization when individuals are already engaged in SUD treatment (Booth, Blow, Loveland-Cook, Bann, & Fortney, 1997; Stecker, Curran, Han, & Booth, 2007). Studies were often conducted in the Veterans Affairs Hospitals (VA) and Health Maintenance Organizations (HMOs) providing a more health administration perspective. Although these studies lack of generalizability and SUDs treatment view, they do provide insight to the potential impact of SUDs treatment on medical care utilization.

Booth et al. (1997) conducted a longitudinal study in health care utilization with alcoholics only who were engaged in VA inpatient alcohol treatment in 1987. The purpose of the research was to evaluate changes in health care utilization in a sample of in-treatment adult veteran alcoholics. The study compared five treatment groups representing a length of treatment

continuum: 1) formal inpatient treatment completion; 2) incomplete inpatient treatment; 3) extended detoxification and/or education program; 4) short detoxification; and 5) no specific direct alcoholism care. Related to Andersen and Aday's model for health care access, the study adjusted for predisposing (age, race and marital status), enabling (VA eligibility status) and need characteristics (severity of alcoholism and medical and psychiatric comorbidity). The sample consisted of 85,000 males from 172 Veteran Affairs medical centers (Booth et al., 1997).

Utilization data for the three years prior to alcoholism treatment and three years' post treatment were collected through medical record abstraction from the Patient Treatment File and Outpatient Clinic File. The index year for treatment was 1987 and patients had either primary or secondary diagnosis of alcohol dependence syndrome as defined by the ICD-9-CM. The sample consisted of three-fourths White, one third married and half were in higher disease stage categories (medical conditions related to alcohol). Overall, utilization was similar for all five groups.

Results demonstrated significant changes in the number of inpatient days did vary by treatment group with those completing treatment having an increase (average 7.9 days) compared to those in short detox (.7 days) (Booth et al., 1997). For the individuals engaged in short detox, very little change was observed. The author's explored the increase in inpatient days further and found the increase was primarily in substance abuse treatment service utilization and decreases were noted in medical/surgical utilization post index treatment. This held true for all groups except short detox (no change) and secondary diagnosis group where an increase in medical/surgical was noted. With regard to outpatient visits, again similar changes were noted in visits and inpatient days related to the utilization of more substance abuse and mental health services, with modest decreases being observed for medical services (Booth et al., 1997). These

observations could be due to the ability of SUD treatment successfully linking and engaging patients in aftercare; but variation exists between SUD treatment modalities.

Although this is one of the primary studies exploring the relationship of substance abuse treatment on medical care utilization, it is limited to a sample of alcoholics engaged in the VA health care system and may not generalize to all people with SUDs or those outside the VA system. Another limitation noted by the authors included the possibility of additional alcohol related services received outside of the VA system and its potential interactions with treatment and utilization. Again, the lack of SUD treatment provider view limits the conclusions that can be drawn from the association between SUD treatment and medical care utilization.

Similar in both study design and sample characteristics, a study by Stecker, Curran, Han and Booth (2007), examined service use and costs associated with intensive outpatient substance abuse treatment (IOP). Utilizing the VA National Health Services Database, the authors identified 9,933 veterans utilizing Intensive Outpatient Services in 1999. Veterans who were excluded from the study included: a) anyone under 18 and older than 95 years of age; b) who were engaged in centers not offering IOP; c) were engaged in programs with no program level data; d) or had no previous care. The final sample consisted of 8,329 veterans from 36 programs. Demographic variables were noted for their effect on utilization (e.g. age, gender, race, psychiatric comorbidity and medical severity). Patients were categorized into four treatment levels: a) 1-5 IOP visits (n=2,384); b) 6-14 IOP visits (n=2,940); c) equal to or greater than 15 IOP visits (n=3,005); and d) no treatment (matched group) (n=7,328). Changes in health care services were noted from two years prior to treatment and two years post index treatment episode (Stecker et al., 2007). Results found total outpatient visits within each treatment level category had increased prior and just after initial treatment, but then gradually began to decline.

The authors concluded patients engaged longer in treatment were more likely to access more services because staff had additional time to identify medical and other issues (Stecker et al., 2007). Although both studies add to the strength of the relationship between substance abuse treatment and medical care utilization, the studies are limited to VA samples whose services are often co-located and integrated. Therefore, they may not be representative of the population of people with SUDs engaged in other treatment settings and is limited in describing what is occurring within treatment that may be influencing utilization patterns.

Interestingly, research by Parthasarathy, Weisner, Hu, and Moore (2000) examining utilization patterns in a large managed care organization (Kaiser Permanente) challenged the hypothesis that substance abuse treatment can offset costs by reducing medical care expenses. The authors drew their sample from a larger study on the outpatient Chemical Dependency Recovery Program at Kaiser Permanente. Individuals in that study had to have continuous enrollment in the plan for at least six months prior, have met DSM-IV criteria for substance abuse or dependence, and be at least 18 years old at time of intake (no previous substance abuse care in previous six months). Utilization data was collected for pre- and post-treatment periods in six month windows extending 18 months pre and post treatment episode. The sample consisted of 1,011 study participants and 4,925 matched participants (Parthasarathy et al., 2000).

Overall, the sample was male (67%), White (75%) with a mean age of 38.4 years. Alcohol dependence made up almost half the sample (42%), followed by drug dependence (28%) and abuse (not dependence) (12%) (Parthasarathy et al., 2000). Results for pre-treatment utilization were similar to other studies and found that SUDs treatment had some impact on medical utilization. Utilization was higher pretreatment and declined post-treatment. However,

what was different than previous studies was the decrease in utilization (inpatient days in this case) was more drastic (Parthasarthy et al., 2000).

The above finding is different than previous studies because the decline experienced 18 months post-treatment was more sudden and sharp than previous studies where declines were more gradual post-treatment and observed across years. In addition, the study results again offer no explanation of what is actually occurring within SUD treatment that may be influencing utilization patterns. Another limitation was the lack of generalizability to people with SUDs outside of a large private health maintenance organization where services are often co-located and easily accessible for HMO members. Further exploration into the utilization patterns for individuals involved in community based and publicly funded health system programs who often face a segmented health care system is needed.

### **Association between SUD Treatment, Medical Care Utilization and SUD Outcomes**

Previous research examined the health care utilization patterns of people with SUDs and the association of SUD treatment on medical care utilization patterns. Research has demonstrated the association of SUDs with both physical and mental health issues; all needing treatment in order for a person to be successful in achieving SUD treatment outcomes (e.g. treatment completion, abstinence). In addition, other predictive factors have been noted including gender, race and age and motivation for change (Friedmann, Zhang, Hendrickson, Stein, & Gerstein, 2003; Green, Polen, Lynch, Dickinson, & Bennett, 2004). For example, when examining differences by gender, predictors of substance abuse treatment outcomes for men are different than women. Treatment outcomes for men were predicted by mental health and medical conditions, severity of substance abuse and treatment completion, while for women, outcomes were predicted by social, socio-demographic and life history characteristics (Green et al., 2004).

Based on previous research demonstrating better alcohol treatment outcomes among people with negative health effects (Brennan & Moos, 1996, Schutte, Brennan & Moos, 1994, Schutte, Byrne, Brennan & Moos, 2001), Mertens, Flisher, Satre and Weisner (2008) conducted a longitudinal study specifically focused on the medical predictors of substance abuse outcomes of people engaged in treatment over a five year period. This particular study, although limited to individuals engaged in a chemical dependency program in Kaiser Permanente Health plan, attempted to address a research gap of whether medical problems predicted better long term substance abuse outcomes. Participants were from a previous randomized controlled trial and were either in an integrated primary care and substance abuse treatment group or primary care separate from substance abuse treatment group. Participants had to be 18 or older, meet drug abuse or dependence criteria and be admitted to Kaiser Permanente California Chemical Dependency Recovery Program. The sample consisted of 747 individuals. During the five year period, 21 died and 598 were located and completed the five year interview.

The sample was mostly male (57%), White (74%), and between the ages of 35-50 (52%). Participants were classified as alcohol only dependent (40%), drug dependent only (31%), both drug and alcohol dependent (18%) and abuse only (11%). Most of the sample had remitted (n=338). Those that remitted were predominantly 50 years old or older and had higher medical problem severity than those who had not remitted ( $p=.023$ ). The authors found medical conditions did not predict substance use remission. They also reported that medical problem severity had higher odds for remittance (OR=2.0; 95% CI = 1.14, 3.54). Those who had been randomly assigned to integrated care also had higher odds of remittance at 5 years (OR=1.48; 95% CI=1.04, 2.13) (Mertens et al., 2008). The study is limited due to attrition of the sample and

reliance on self-reported remittance. The authors conclude individuals with SUDs could benefit from integrated care.

A notable study by Friedman et al. (2003) may shed some light on the availability of integrated care as it relates to addiction severity. The authors highlighted the association of chronic medical conditions and increased need for psycho-social services among substance users. They looked to see how providing supplemental medical and psychosocial services to addicted patients affected SUD treatment outcomes and overall well-being. The sample consisted of 7,782 patients enrolled in 72 treatment programs between July 1993 and November 1995 who met eligibility criteria for the National Treatment Improvement Evaluation Survey. Of those, 4,526 completed intake, treatment discharge and 12 month follow-up interviews. Twenty programs were excluded because they didn't provide information on availability of primary medical care (n=10) or were in correctional facilities (n=10). The final analysis included 2,878 patients in 52 non-correctional substance abuse treatment programs (Friedmann et al., 2008).

Primary medical care availability was divided into three categories: 1) on-site care (available to n=1,387 individuals); 2) only off-site care (available to n=493 individuals); 3) no primary medical care (available to n=998 individuals). Treatment types included methadone, short- and long-term residential, and outpatient non-methadone programs. Availability of on-site primary care by treatment modality included methadone (50%), short-term residential treatment facilities (100%), long term residential (47%) and non-methadone outpatient programs (16%).

The sample was over half Black (54.1%), between the ages of 31-40 (39.8%) and 21-30 (32.7%), and single (62.7%). Mean addiction severity scores were similar across all groups. Although the authors reported that statistical significance was not reached in bivariate analysis, stated that addiction severity scores appeared lower in the group who had onsite primary care



(Friedmann et al., 2008) Predictors of worse follow-up addiction scores included higher addiction severity score at intake, depressive symptoms, drug injection in the last 12 months and briefer treatment duration (Friedmann et al., 2008). Black race and younger age were also predictors. The authors suggested primary care may influence the person's motivational level in SUD treatment. This could be due to the patient provider interaction and not necessarily from the medical care itself. Several limitations were reported in the study including the validity threat posed by having different treatment modality's represented, limited generalizability and the limitations present in self-report data (Friedmann et al., 2008). In addition, SUD counselor potential influence and interaction was not measured to see if SUD counseling was related to engagement in medical care.

In addition to looking at predisposing factors associated with medical care utilization among people with SUDs, research has also been investigating medical condition and psychiatric co-morbidity and their effects on utilization and substance abuse outcomes. Mertens, Lu, Parthasarathy, Moore, and Weisner (2003) examined prevalence of medical and psychiatric conditions among 747 substance abuse patients and 3,690 demographically matched controls enrolled in a health maintenance organization (HMO). They found one third of the medical and psychiatric conditions were more common among substance abusers. In addition, other studies have found individuals with SUDs who have co-occurring medical and/or psychiatric issues have higher utilization and cost (Curran et al., 2003; Druss & Rosenheck, 1999; Hoff & Rosenheck, 1998). This suggests SUD treatment patients could be more successful in achieving positive substance use treatment outcomes if medical and psychiatric conditions were treated concurrently.

Previous literature has focused on HMO type facilities which may not generalize to community based and publicly funded treatment settings. Recently, Benjamin-Johnson et al. (2010) conducted a cross-sectional survey of individuals engaged in substance abuse treatment in publicly funded programs in a large behavioral health organization in Los Angeles County. This study provided descriptive information of the population accessing publically funded SUD treatment and their utilization patterns. The interview administered survey was conducted in June 2008. The focus was to address a gap in current research to describe the usual source of care, use of preventative care services and self-reported chronic conditions among this population. All clients attending one of 11 sites in the Behavioral Health Services network who were 18 and older, spoke English or Spanish, and engaged in treatment during the time period of the survey were able to participate. Of the 417 people enrolled in the programs, 254 completed the survey (Benjamin-Johnson et al., 2010).

The study sample had a mean age of 38.4 years and was mostly male (62%). People had been in treatment 89 days (plus or minus 80 days) (Benjamin-Johnson et al., 2010). Most participants were Latino (37%), followed by African American (27%), white (21%), mixed race/ethnicity (12%) and Native American (4%). Over half had no medical insurance (67%) and 33% reported their health as poor. Over half the sample (63%) reported a usual source of medical care with 14% reporting that care was the ED, or the ED and some other source (22%). Overall, 47% had stated they used the ED or doctor's office during this past treatment episode. Half the participants stated they had hypertension, asthma and/or arthritis. Almost half (41%) reported being obese (Benjamin-Johnson et al., 2010).

Bivariate analysis demonstrated no association between usual source of care and medical insurance. However having at least one chronic illness increased odds of ED utilization.

Multivariate analysis found utilization was associated with having one or more chronic illnesses and current homelessness (after adjustment for gender, age, insurance, race/ethnicity and alcohol use score). The information from this survey represents a snapshot of current health utilization among individuals with SUDs actively engaged in publically funded treatment centers. There were several limitations including the inability to determine differences between responders and non-responders, and the reliability of utilizing self-report for past ED use (Benjamin-Johnson et al., 2010).

The studies presented demonstrate the association between SUDs and medical care utilization, the association between SUD treatment and medical care utilization, and the potential impact of the association on SUD treatment outcomes. Although they provide a glimpse into the association of SUD treatment and medical care utilization, they are limited by their lack of generalizability and viewpoint of what it means to provide SUD treatment to someone with co-occurring medical conditions. Predictors including demographics, health insurance and type/quantity of substance use illustrate the associations between the two systems of care. Unfortunately, it is not enough information to determine what is actually being experienced within SUDs treatment and how medical conditions affect SUD treatment.

### **Current State of Research from the Community SUD Treatment Counselor's Perspective**

To date, no peer reviewed literature was found describing the experience of SUD community outpatient treatment of clients with co-occurring medical conditions. Most literature looks at the effect of integrated care on specific complex medical conditions from the client level or system level. Examples include integration of substance use treatment and prenatal care (Sweeney, Schwartz, Mattis, & Vohr, 2000); psychiatric conditions (review by Drake, Mueser, Brunette, & McHugo, 2004), HIV (Lombard, Proescholdbell, Coper, Musselwhite, & Quinlivan,

2009), physical disabilities (Ebener & Smedema, 2011) and chronic pain (Clark, Stoller, & Booner, 2008).

One particular study by Marsh, Cao and Shin (2009) examined gender differences in matching individual client needs in substance use treatment. From a SUD treatment perspective, the analysis of the CSAT National Treatment Improvement Evaluation Study (NTIES) study data of clients participating in CSAT funded SUDs programs is one of the few that looks at SUD treatment counselors identifying and matching services to individual client needs. The analytic sample for the study was a subset of 4,526 clients in the NTIES data set completed intake, treatment, discharge and follow-up. Clients in correctional facilities were excluded, leaving a final sample of 3,027 clients. The authors looked at services received including those related to access (e.g. transportation, child care), substance use counseling, family and life skills, health, mental health, vocational, housing and finance, and their impact on SUD treatment duration and post-treatment substance use (Marsh et al., 2009).

Results were geared towards gender differences. Women were significantly more likely to need services than men. Of most interest to this study was that women were 1.21 times more likely than men to need medical services (95% CI = 1.03, 1.41,  $p < .001$ ). Other service needs included mental health, family services, and vocation and financial services. When it came to examining gender differences on receipt of services, women were more likely to receive family, housing and financial services than men (Marsh et al., 2009). Although gender differences in need and receipt of comprehensive services is important, the overall message from the author's results adds another piece to the picture of the association between SUDs and medical care utilization.

Overall the authors found access and linkage to comprehensive services was associated with longer treatment duration and better outcomes. Some SUD treatment facilities are more limited in their resources than others when providing referrals and linkages to other resources (Marsh et al., 2009). Medical care is but one needed service within this larger comprehensive web of service delivery that may impact SUD treatment. Logically, this identification of a comprehensive service delivery adds another layer to the association between medical care utilization and SUD treatment. SUD counselors must work within the service delivery web to provide clients with the most needed services in order to reduce barriers related to or influencing SUD treatment engagement and retention. Yet the question remains, how does this fit in the actual experience of implementing SUD treatment?

Sterling, Chi and Hinman (2011) note SUD treatment is often more complicated for people with alcohol and other drug use disorders who also have co-occurring mental health and medical issues. In their review, integrated care for people with co-occurring substance use, medical and mental health conditions is still the exception to the rule. The systems remain separate and follow different treatment philosophies and approaches. Therefore, there needs to be exploration of each of the various service providers' perceptions of the associations between different services. This type of investigation would lead to a better understanding of the philosophical beliefs and other issues (e.g. education and training on integrated care) which may be barriers to developing a more integrated model of care.

To gain a glimpse of behavioral and primary care provider's perceptions on integrated care and potential barriers, Sanchez, Thompson and Alexander (2009) conducted a survey of publically funded behavioral and medical services in Texas. A total of 382 organizations were contacted to fill out a survey in June 2008. Of those, 170 were completed and returned.

Respondents were primarily health care and behavioral health care administrators. The Hogg Foundation developed the e-mail delivered survey. Measures included information about the range of integration, organizational information, strategies being utilized, and the status of integration efforts (Sanchez et al., 2009).

Although both medical and behavioral health organizations were surveyed, the results pointed more towards activities occurring within primary care and not within SUDs treatment or behavioral health. Of integration strategies being used, 69% endorsed co-treatment plans, 65% endorsed co-location of services, but only 39% endorsed having a single treatment plan. In addition, only 28% reported keeping a disease registry with identified behavioral health issues. Most barriers and training needs identified were related to the physician role. This included increasing physician knowledge of behavioral health issues (Sanchez et al., 2009). There was no discussion on the training needs of SUD or behavioral counselors regarding medical issues. Sanchez et al. (2009) provides the first insight into perceptions of the association of SUD treatment and medical care by surveying the status of care integration. Similar to other studies, it is limited to a health administration view. The question of what SUD community outpatient counselors experience when treating clients with co-occurring medical conditions remains.

### **Conceptual Model**

Not only does the current literature establish the relationships between SUDs, medical care, SUD treatment and SUD treatment outcomes, but it is important to note they also identify other predisposing, enabling and need factors influencing patterns of utilization of medical care and substance use treatment. The Behavioral Model of Access to Healthcare was developed in 1969 by R.M. Andersen. The model's primary goal was to serve as a framework for determining the population's ability to access care. Over the years, Andersen's model was revised and

refined, but maintained that numerous factors (e.g. predisposing, enabling, need and outcomes) all had various levels of influence on a person's ability to access and utilize care (Andersen, McCutcheon, Aday, Chiu & Bell, 1983; Gelberg, Andersen & Leak, 2000).

The Behavioral Model was translated for use with vulnerable populations such as the homeless, individuals with severe substance abuse and mental health issues, and other underserved populations (Gelberg, Andersen, & Leake, 2000). Gelberg et al., (2000) summarizes the model by saying, "the use (of health care) is a function of a predisposition by people to use health services, factors that enable or impeded such use and people's need for care (p. 1275)." The Behavioral Model for Vulnerable Populations illustrates how population characteristics and health behavior lead to outcomes. Each category is broken into sub-levels and then to specific variables. It is a framework by which a person's level of access can be determined based on influential factors including a person's willingness to seek care.

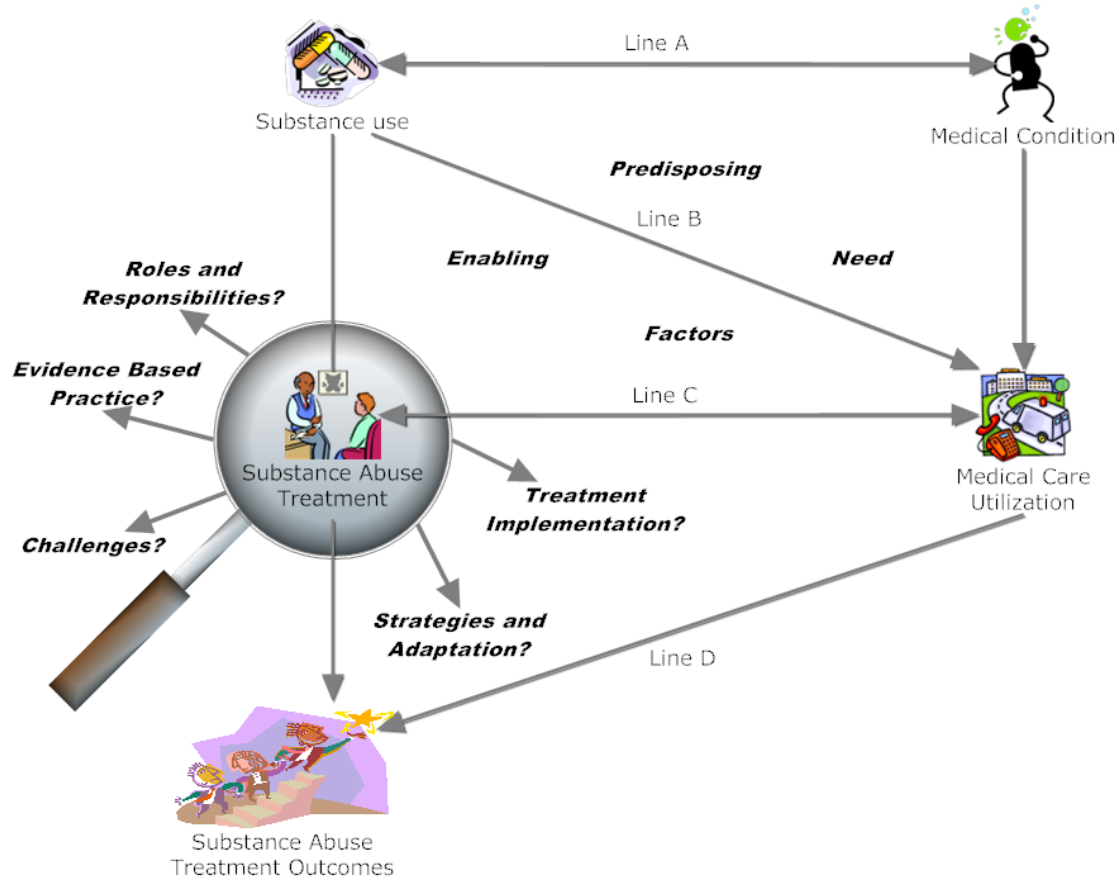
Predisposing, enabling and need categories fall under population characteristics. Predisposing factors include such items as demographics (age, gender), health beliefs (values, attitudes), social structure (education, employment, acculturation, literacy), sexual orientation and childhood characteristics (living conditions, criminal behavior, mental illness, substance use). Health behavior includes personal health practices including diet, exercise and risk behaviors. Use of health services is also captured under health behavior including utilization of ambulatory, inpatient, alternative and long-term care. Finally, health outcomes include a person's perceived health and evaluated health. Satisfaction is measured in both general and specific satisfaction with the health service (Gelberg et al., 2000).

Within this literature, although investigators often may not have reported using either the original Andersen and Aday model or Gelberg's model, their results of predictive factors to

medical care utilization mirror the model. Specifically, the literature review studies found demographics (age, gender, race, ethnicity) (Cherpitel, 1999; Cherpitel & Ye, 2008; Chitwood et al., 2001; Parthasarthy et al, 2000; Rice et al., 2000), substance use (Cherpitel & Yea, 2008b; Chitwood et al., 1999; Chitwood et al., 2001; Rice et al, 2000), health insurance status (Cherpitel & Ye, 2008a), perceived health status (Chitwood et al., 1999), substance abuse treatment (Stecker et al., 2006; Parthasarthy et al., 2000) and medical severity (Mertens et al., 2008) to be predictors of utilization. There is an understanding of the model that many factors contribute to a person's willingness and ability to seek medical care, as well as substance abuse treatment. For the current study, Gelberg's model is considered part of the researcher's preconceived knowledge and is bracketed and reflected upon during the analysis phase.

Between the literature and Gelberg's model, an illustration of the current environment around SUDs, SUD treatment and medical care can be discussed. Figure 1 illustrates the various relationships and influencing factors presented in the literature. It also identifies a significant gap in the knowledge. The first part of the conceptual model illustrates the bi-directional relationship between substance use and medical conditions (line A). Chronic substance use can lead to any number of medical conditions including acute and traumatic injury (McLellan et al., 2000). In addition, individuals with chronic conditions, such as chronic pain, may develop substance use issues. The literature also demonstrates a relationship between substance use and medical care utilization, especially an increase in emergency department utilization (line B) (Cherpitel, 1999; Cherpitel & Ye, 2008). Related to medical care utilization, individuals engaged in substance abuse treatment, especially when integrated with medical care (e.g. medical home model), will vary in their medical care utilization (line C) (e.g. increased utilization prior to treatment with gradual declines after substance abuse treatment) (Mertens et al., 2008;





*Figure 1.* Schematic representation of the relationships between substance use, medical conditions, medical outcomes, SUD treatment and SUD treatment outcomes based on current literature.

Friedmann et al., 2003). Substance abuse treatment and medical care utilization have also demonstrated effects on substance abuse treatment outcomes (line D). Where the illustration demonstrates a need for more knowledge is what is being experienced within substance abuse treatment from the SUD community outpatient counselor's perspective. What meaning does this phenomenon have to them in their practice?

### **Limitations of Previous Research**

As noted through the literature review, the primary limitations to the current studies are the restricted samples that may not generalize to the larger community and the lack of SUD community outpatient counselors' experiences in providing treatment to clients with co-

occurring medical conditions. Most studies utilize medical utilization data from large HMO and VA hospitals where services are often co-located or at least, systematically easier to link clients to services. This limitation leaves out information regarding the current environment of community based care. Although valuable in establishing the association between SUD treatment and medical care utilization, the viewpoint is from health administration view.

As health care reform moves towards more integrated care, it is important to expand from the health administration view to understanding SUD community outpatient counselor experiences. Integration seems to be focused on providing physician training in behavioral health to increase their ability to identify and provide brief intervention to their patients with SUDs. However, as some of the literature suggests, SUD counselors are focused on treatment involving a comprehensive web of services including medical care. Understanding the experiences of counselors is critical in understanding the influence of the association on successful substance use treatment outcomes. Sharing their experiences can provide information on where gaps, limitation of services, and barriers are present in the current structure and how best to resolve these issues. By implementing an IPA study, descriptions of SUD community outpatient counselors' experiences will aid in a better understanding of current SUD treatment for clients with co-occurring medical conditions.

## Chapter 3: Methodology

### Introduction

The purpose of the following Interpretative Phenomenological Analysis (IPA) is to gain an in-depth understanding of SUD community outpatient treatment counselors' experiences of the phenomenon of treating clients with co-occurring medical conditions. As noted in Chapter 1, it seeks to address the following research question: How do the SUD community outpatient treatment counselors experience treating clients with co-occurring medical conditions?

The methodology chapter will begin with a brief discussion of the following: 1) Overview and Rationale for IPA; 2) Research Sample; 3) Design and Method; 4) Ethical Considerations; 5) Issues of Trustworthiness (reliability and validity); and 6) Bracketing Interview

### History and Rationale of IPA

IPA was developed by Smith, Flowers and Larkin (1995). It was first utilized in health psychology and has since expanded to other human, health, and social sciences. It is a qualitative research method used to explore a person's experience with a phenomenon of interest using their own words and perceptions (Smith et al., 2009). As the authors describe it, IPA is a process by which the "researcher is trying to make sense of the participant trying to make sense of what is happening to them" (p. 3). Using descriptive accounts from participants, IPA provides an in-depth and rigorous analysis of the qualities of a phenomenon as it is experienced by the participants of interest. Each case is analyzed individually for major themes and then is analyzed

across participants to identify similarities and differences in experiences (Smith et al., 2009). Before describing IPA methods, it is important to understand its philosophical roots and influences.

IPA is considered one off shoot of phenomenology that also draws on hermeneutics (theory of interpretation) and idiography (attention to particulars) (Smith et al., 2009). Phenomenology was developed by Edmund Husserl (1859-1938) as a philosophical concept in psychology to understand people's experiences with phenomenon (Norlyk & Harder, 2010; Caelli, 2000; Smith et al., 2009). Positivist and epistemological in philosophical orientation, phenomenology sought to understand the structure, or essence, of a phenomenon through description (Dahlberg, 2006). It involved the researcher to "bracket" their preconceived knowledge, feelings and thoughts in order to experience the participant's view of the phenomenon (Dowling, 2007). Through a process of intentionality and imaginative reduction, essence (elements or structure) of the phenomenon would be described (Dowling, 2007).

As with any philosophical view, phenomenology has been debated and critiqued. For example, Martin Heidegger, who studied with Husserl, had conflicting views of how people experience phenomenon. Taking a more ontological view, Heidegger believed some level of interpretation occurs in the description of the phenomenon because of people's lived experience (Smith et al., 2009). Others still took phenomenology further and viewed it from post-positivist (Merleau-Ponty) and constructionists (Gadamer) paradigms (Dowling, 2007). What resulted was multiple ways by which a person could conduct a phenomenological inquiry. Therefore, as a research methodology, it is critical for the researcher to acknowledge their philosophical view (Norlyk & Harder, 2010).

As Phenomenology moved from Europe to America, a more Heideggerian approach of interpretative phenomenology took root emphasizing interpretation of the experience's meaning (Caelli, 2000). Firmly situated in the interpretist paradigm, the central tendency remains to describe and understand the person's experience with a phenomenon, but that such descriptions may also include thoughts and interpretations from both the participants and the researcher (Caelli, 2000). Analysis becomes a hermeneutic cycle of examining the whole experience, then examining the pieces of the experience all the while, recognizing bias and prior knowledge and utilizing them as analytic tools to delve into the meaning of the experience (Dowling, 2007). In other words, the interpretation begins when the researcher encounters the phenomenon through the text of participants and immerses in the data, listening and reading the participants' descriptions (Mackey, 2004). In the process, we continue to identify and utilize our prior awareness and knowledge of the phenomenon to make sense of the phenomenon's meaning. The findings are validated through the feedback and reflection of interpretation from the participants.

IPA embraces phenomenology, hermeneutics and idiography. According to Fade (2004), it seeks the inside perspective of the person's lived experience. It also embraces understanding and the acknowledgement that gaining the inside perspective requires interpretation (Fade, 2004). The depth and rigor of phenomenology allows us to identify the essential qualities of the phenomenon (Smith et al., 2007). IPA uses familiar phenomenological techniques such as bracketing, reduction and intention to insure rigor in the analysis. Hermeneutic influence provides a focus on the meaning of the text of the description (product of interviews). Smith et al. (2007) state "meaning will be strongly influenced by the moment at which the interpretation is made" and is therefore influenced by the timing of the phenomenon and the timing of analysis (p. 27). As a research process, analysis occurs shortly after the interviews, limiting the influence

of changing times and cultural contexts. It is a dynamic process by which we identify the relationship between the parts of a phenomenon and the whole.

Lastly, Smith et al. (2009) commented on the idiographic influence where there is a focus on the detail and depth of analysis. In order to understand the phenomenon, we must understand it “from the perspective of particular people in a particular context” (p. 29). Within the current study, the only individuals who can provide us with information on the experience of treating clients with SUDs and co-occurring medical conditions are the counselors. As researchers using IPA, we can then “see what it is like from the participant’s view, and stand in their shoes” (Smith et al., 2004, p.36). Once we understand an experience as a whole and through its structure, we can then enter into a discussion of its implications on substance abuse counseling.

Examination of the literature identified significant gaps related to what counselors were experiencing providing substance abuse counseling with clients presenting with acute and chronic medical conditions. The literature did not address what counselors experienced or what their perceptions were in how this may impact their counseling. Based on the researcher’s previous conversations and requests for technical assistance from the Virginia Commonwealth University, National Institute on Drug Abuse Clinical Trials Network (VCU NIDA CTN), component of the Mid-Atlantic node community treatment programs, it was mentioned especially in areas of chronic pain, counselors were looking for guidance and resources on assisting their clients to address other medical issues. The phenomenon has taken on meaning in their lives. In addition, with the changes forth coming in health care reform and push for integrated treatment, the research question of what SUDs community outpatient counselors were experiencing within their treatment sessions was critical if one is to be fully informed in their actions towards integrated treatment.

The research question stems from the interpretist paradigm. Of the various qualitative methods, IPA provides the structure and processes by which an in-depth analysis of SUD community outpatient counselor experiences can be conducted. The method allows for participants, in their own words, thoughts and feelings, to identify what is occurring within their practice. IPA also provides the rigor allowing for the identification of preconceived thoughts and knowledge and brings it forth into the interpretation. To have a thorough understanding of the phenomenon will provide critical information on the nature of the phenomenon, what meaning it has to the individuals involved in the experience, and provide insight on future directions in SUDs community outpatient counseling.

### **Sampling**

One aim of IPA is to provide in-depth and detailed analysis of each case and then examine across cases to identify convergence and divergence. To fulfill such an aim, each participant must be selected in a purposive way and have experienced the phenomenon of interest. In line with qualitative tradition, IPA uses purposive sampling. Although some may consider this lack of generalizability a weakness of the methodology, the intent here is to describe and analyze participants' experiences and perceptions of phenomenon. Analysis delves deeper with exploration on how their experiences then compares to the researcher's knowledge and preconceived thoughts and feelings, and the literature. The sample of participants must also be fairly homogenous having to experience the same phenomenon of treating SUDs clients with co-occurring medical conditions in community outpatient settings.

The sample size was determined by a number of factors. As Smith et al. (2009) state, sample size is determined by three criteria: 1) the degree of commitment to the depth of analysis; 2) the richness of individual cases; and 3) organizational constraints and access. IPA's primary

concern is the individual experience and the depth of meaning we can extract from that experience. Smith et al. (2009) state sample sizes may range from 1 (case study) to ten participants in a study. For a student project, the recommended sample size is 3-6 and should also reflect the requirements of the student's program (Smith et al., 2009). This allows for researchers new to IPA to focus on the in-depth individual case analysis with opportunity to explore for convergence and divergence without feeling overwhelmed by the amount of data. Other authors note that 1-10 are sufficient for IPA (Groenewald, 2004) and phenomenology in general (Creswell, 2007).

Participants were chosen from a publically funded substance abuse treatment outpatient provider in Central Virginia. The organization provides individual and group substance abuse counseling and case management. In 2012, the organization served approximately 1,402 clients in their substance abuse treatment program. The average length of treatment was 270 days. The site was selected because they practice a variety of evidence based practices and expressed interest in further education on various medical conditions (e.g. HIV, chronic pain).

Eligibility criteria included holding a current license (e.g. LPC, LCSW), having an active caseload at time of the interview, practicing at the site for five or more years, and providing substance abuse counseling (with or without case management responsibilities). The criterion was selected to identify a homogenous sample consisting of counselors providing substance abuse counseling among the general adult substance abuse population. In addition, the criterion identified counselors who had been practicing long enough at the site to establish their own personal style of counseling and have familiarity with the services available in the area.

At the time of the study, the site had 22 part-time and full-time adult substance abuse counselors serving men, women, individuals with co-occurring disorders and criminal justice



(probation/parole) clients. Of the 22 counselors, 16 held current licenses (e.g. LPC, LCSW). Of the 16, one counselor had practiced at the current site for less than five years and six counselors were identified as either working specifically in the Adult Drug Court or Dual Diagnosis programs, with the remaining nine counselors eligible to participate.

Inviting all eligible counselors (n=9) to participate allowed for a manageable exploration and analysis of the phenomenon. To obtain the study sample, the researcher met with the Adult Substance Abuse Outpatient Manager to discuss the study followed by a formal permission email to obtain access to counselor contact information (see Appendix B: Permission Letter). The Adult SA Manager forwarded the email to the Executive Director and permission was obtained. The Adult SA Manager provided a list of counselor names, current licenses, years of service, active case load (yes/no designation) and email addresses. From the list of names the Adult SA Manager provided, the researcher applied the eligibility criteria and identified nine potential participants.

The researcher sent each counselor an e-mail (See Appendix C: Sample Email) and invited them to participate in the research. It is the researcher's ethical responsibility to be sure each counselor who meets the selection criteria is offered an opportunity to participate. To space out the interviews, the researcher began by inviting the first three counselors. Of the three, two responded. Interviews were scheduled based on the counselor's availability. Two weeks later, the researcher sent out another two invitations with both counselors responding. Their interviews were conducted and the last four recruitment emails were sent. Of those, one responded they would participate giving the researcher a final sample of n=5 (55% response rate).

Since no follow-up emails were sent to those who had not responded, the researcher cannot state reasons for not participating. Further, it was impossible to determine if there were

any differences between those who responded and those who did not. No emails were returned to the researcher as undeliverable or with an out of office/vacation message. Each potential participant was given 10 business days to respond to the email; however, the researcher left the response window open for potential participants to respond to the email later than 10 days in case they were on vacation or out of the office. All counselors informed the researcher of their interest to participate by a response email. The researcher then either emailed or called the participant, depending on the participant's preference, to schedule the interview.

The sample consisted of five counselors, three females and two males, from the site. The counselors were all Caucasian, Non-Hispanic, and ranged in ages from 31-59 years of age (average = 50.4 years). Self-reported years of experience as substance use counselors ranged from 5-20 years with the majority having over 15 years of experience (n=4). In addition, counselors reported providing services at the current site for 5-25 years with just over half being at the site for 15+ years (n=3). All counselors self-reported they were Senior Clinicians. Counselor education varied, with three counselors reporting Masters of Social Work and two reporting a Master's of Science (from Rehabilitation Counseling) degrees. Counselor licenses included three Licensed Clinical Social Workers (LCSWs) and two Licensed Professional Counselors (LPCs).

Counselors described similar current responsibilities. They stated they provided individual and group counseling, case management, assessment, orientation, and consultation. Self-reported caseloads ranged from 14-37 clients with an average of 23.6 clients per counselor. Each counselor treated either men only (n=4) or women only (n=1). Although this added a level of heterogeneity to the sample, it provided an opportunity to examine similarities and differences between their experiences in a community outpatient treatment setting where gender differences

in treatment are well documented (Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, 2004).

### **Design and Method**

IPA requires the researcher to obtain an in-depth description of the participants' experiences with a phenomenon. One way of doing so is to conduct face-to-face individual interviews (Smith et al., 2009). The face-to-face interview allows the researcher and participant to develop rapport and engage in a conversation allowing the participant to describe and reflect on their experience through telling of their stories, thoughts and feelings. The IPA interview schedule can be semi-structured or unstructured. Smith et al. (2009) recommends new IPA researchers use a semi-structured interview schedule with 6-10 open ended questions with prompts and probes. More experienced IPA researchers may often use an unstructured interview schedule.

Being new to IPA, the researcher utilized a demographic form (See Appendix D: Demographic Form) and a semi-structured interview schedule (See Appendix E: Interview Schedule). Although experienced in interviewing from both her experiences in journalism and research, this is the first time engaging in analysis from an IPA framework. The researcher insured the aims of the research question were covered, while still allowing for the flexibility and freedom for the participants to share and describe their experiences. Interviewing for IPA is very similar to Brief Motivational Interviewing sharing techniques such as active listening, utilizing open-ended questions, reflective listening and summarizing. The main goal of the interview was to give the participant an opportunity to talk about their experiences, while the researcher participated as an active listener (Smith et al., 2009).

The semi-structured interview schedule was based on the research question and specific aims. The dissertation committee reviewed the schedule prior to IRB submission. The researcher made recommended edits to the demographic form and interview schedule. To verify the phenomenon was being captured in the depth necessary for IPA analysis and to insure the interview was done using an active listening stance; the researcher assessed the interview immediately following the interview and transcription, noting strengths and weaknesses. In addition, Dr. Lori Keyser-Marcus, Assistant Professor in Psychiatry and dissertation committee member, reviewed two transcripts and provided feedback.

**Method.**

Figure 2 provides an overview of the study from IRB approval through analysis and summary.

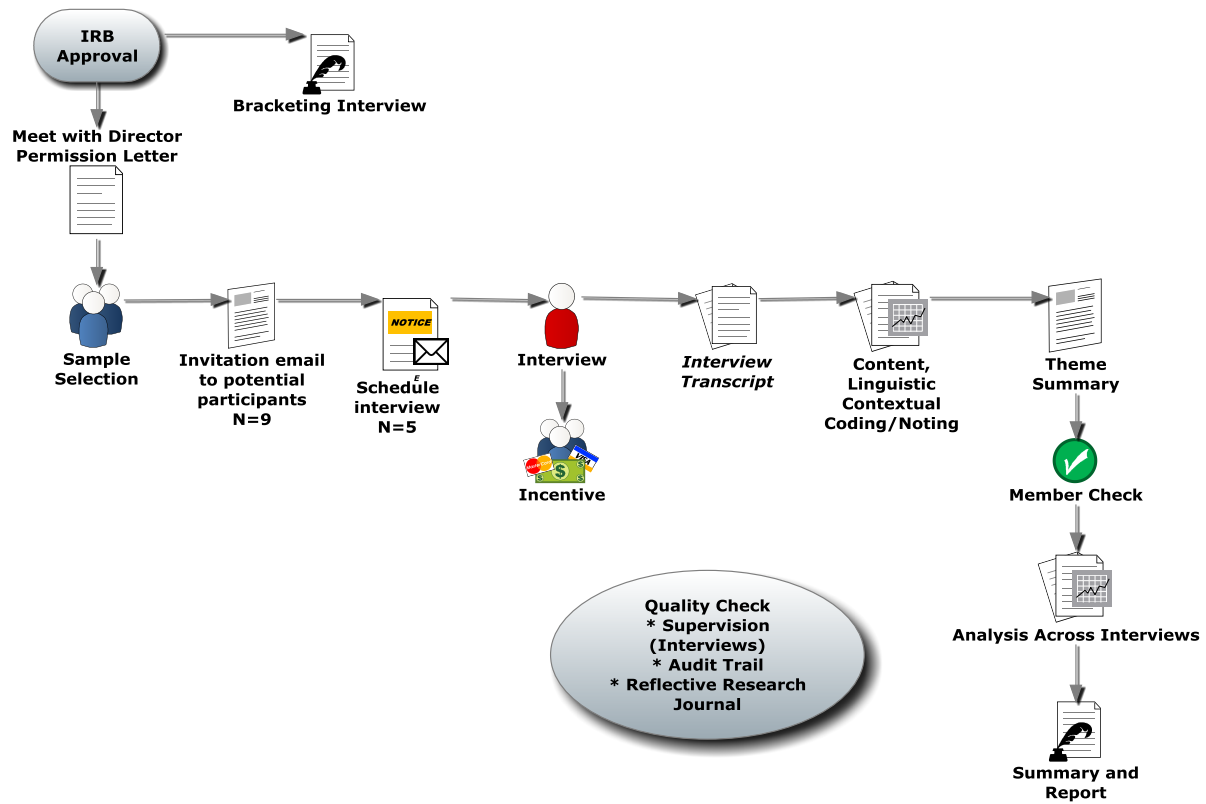


Figure 2. Step by step illustration of the study methods.

The researcher submitted the research protocol to the Virginia Commonwealth University Institutional Review Board (IRB) for expedited review in November 2012. The study was approved, after revision, on February 1, 2013. A modification to the IRB approved protocol was made to add a committee member and to increase initial estimated sample size from 7 to 10 in April 2013. IRB approval was granted in June 2013 (approval letters are available in Appendix A).

Once IRB approval was obtained, the researcher followed the sampling procedure described earlier. For counselors who responded to the invitation email (n=5), the researcher worked to schedule an interview day and time convenient for the participant. All interviews were conducted in a private area at a public library. The researcher conducted informed consent; including consent to digital audio recording (Appendix F). During this process, participants were informed of the purpose of the study, their rights as a study participant, risks and benefits, and compensation. Participants were also asked to identify a pseudonym for use in the conversation. The pseudonym was used in the transcript and final written report to protect their confidentiality.

After informed consent, the researcher began audio taping and administered the brief demographic form (Appendix D). Upon completing the demographic form, the researcher conducted the interview using the semi-structured interview schedule (Appendix E). Interviews lasted between 45 minutes to 1 hour and 10 minutes, with 4 of the 5 interviews lasting more than an hour. All participants agreed to audio taping. The researcher utilized prompt and follow-up questions during each interview either to explore the participant's experience further or to get clarification. The researcher took written notes of important points, body language or other observations during the interview. After the interview, the participant was reminded they could withdrawal from the study at any time up to the dissertation defense. In addition, the researcher

informed the participant they would be receiving a summary of their interview within 1-3 weeks for their review and feedback. Each participant was given \$50 Target gift card for their time.

Within one hour of completing the interview, the researcher moved the digital audio recording to an encrypted, password protected file for data security and deleted it from the digital recorder. Although the goal was to transcribe interviews within 24 hours of the interview, the transcription process was much more intense than originally planned with one hour of audio taking 5-6 hours to transcribe. Interviews were typically transcribed within 1-3 days of the interview.

### **Data Analysis.**

Data analysis involved several steps to transform the interviews to final thematic analysis. The researcher uploaded the digital audio recordings into Atlas-ti and transcribed. Atlas-ti is a qualitative data management and analysis program designed to aid researchers in handling large amounts of text data. It provided an interface allowing the researcher to document notes, comments, thoughts and themes. Atlas-ti served mainly as an auditing tool for this project, documenting the various stages of analysis from initial coding through to the final emerging themes. The researcher, in preparation for this project, also completed both Atlas-ti Basic and Atlas-ti Advanced Webinar trainings (12 contact hours) provided by the software company.

“In reality, analysis is an iterative process of fluid description and engagement with the transcript. It involves flexible thinking, processes of reduction, expansion, revision, creativity and innovation” (Smith et al., 2009, p.81). Smith et al., (2009) offer an analysis structure that is flexible and seeks to gleam the participant’s meaning of their experience. The authors describe a series of steps to conduct an IPA study. The first step was to immerse oneself into the transcript of a participant. The researcher immersed herself in the interviews in several ways. First, the

researcher personally transcribed each interview. Second, the researcher reviewed the transcription while listening to the audio for verification. Lastly, the researcher reviewed each written transcript several times prior to initial coding.

The second step is to begin initial noting. Smith et al. (2009) describe three types of noting: 1) descriptive comments; 2) linguistic comments; and 3) conceptual comments. Descriptive comments are noting text that describes the content of the interview. Linguistic comments focus more on how the participant utilizes language including pauses and repetition. Lastly, conceptual noting is more interrogative and incorporates a reflective and interpretative stance (Smith et al., 2009). Often, conceptual coding could take the forms of questions. Each note is done in its own style (different color, underlined or bolded) to distinguish between codes.

To complete the second step, the researcher worked from a printed copy of the transcript. The transcript was prepared with a two inch margin to the right for notes. The researcher underlined important statements and noted descriptive, linguistic and contextual comments in the right hand margin. The researcher then took the hard copy notes and began in vivo coding in Atlas-ti. In vivo coding is when the quote or highlighted statement serves as the code. The researcher entered a comment for each in vivo code (date and time stamped) describing the statement. In addition, contextual and linguistic thoughts and reflections were entered as memos attached to the text (date and time stamped). Once the in vivo coding process was completed, the researcher outputted the in vivo codes with comments and reviewed them generating a list of simple codes. Once coding was complete, the researcher returned to the transcript and renamed in vivo codes and merged similar codes together. Atlas-ti, through this process, obtained all comments and merged comments together when in vivo codes were merged. This provided an

audit trail of the process and documentation which could be referred back to when a definition of a code was questioned.

The researcher reviewed all the memos and codes with comments, re-read the transcript and developed a participant summary (Appendix G). The summary consisted of a description of the counselor and the clients they serve. In addition, themes from the analysis were identified and included with potential participant quotes. Smith et al. (2009) describe this stage as one that reduces the volume of the detail while still capturing the participant's description, "It is the attempt to produce a concise and pithy statement of what is important in the various comments attached to the transcript" (p. 92). The goal of the summary was to identify what was important in the text and to the participant. Themes were listed in chronological order (as they appeared in the text). Interviews had anywhere from 7-9 themes with supporting quotes. Smith et al. (2009) states, "this process represents one manifestation of the hermeneutic circle. The original whole of the interview becomes a set of parts as you conduct your analysis, but these then come together in another new whole at the end of the analysis and write up" (p. 91).

The summary was sent to the participant for member checking. This was to insure the researcher's interpretation of their experience was accurate and for them to give final approval on the quotes to be used in the published report. The researcher sent a follow-up email informing the participants of the timeline to dissertation defense. If participants did not respond to member checking email or the follow-up, it was assumed they had no disagreements with the summary. Of the five participants, four provided feedback on their summary sheets. One participant did ask that a quote be removed because of possible identification. The researcher removed the quote from both the summary and the dissertation analysis section. The researcher also slightly modified quotations. The modifications included taking out the "ums" and "uhs." Each interview



was individually analyzed in this manner and analysis of one interview did not begin until the interview prior had been summarized.

Once all interviews were summarized, the researcher printed out the existing code list with quotations and reviewed it for codes that were duplicative, similar or not well defined. In addition, code families were identified to assist with analysis. The nine code families included Barriers, Counselor Characteristics, Client Characteristics, Chronic Pain and Prescription Drug Use, Education, Strategies, Outcomes, Health Condition and Roles and Responsibilities. By grouping codes by family, specific research questions could be queried within the software. A total of 137 codes currently exist within the data management system.

The researcher then developed a table of themes for each interview. Based on Smith et al's. (2009) recommendations for looking for patterns, the researcher reviewed each interview's emerging themes. Their suggestions include: a) abstraction (looking for like themes and clustering them); b) polarization (oppositional relationships); c) subsumption (bring together a series of related themes); d) contextualization (looking for events at temporal moments); and e) numeration (how often the theme appears). Identified patterns were developed into super-ordinate themes. Next, the researcher laid out each interview's thematic table and examined themes across the five interviews. The researcher identified connections, most potent themes, similar and differences between interviewees. Themes were also matched to the research question's specific aims. According to Smith et al. (2009) IPA is flexible and analysis write up can take on many forms. For projects with a small number of interviews, the researcher can conduct a theme within case presentation where each interviewee is presented separately, or for a larger number of interviews, a case within theme presentation which looks at themes across

participants. The analysis section presents a case within theme presentation of the results of this process.

It was important during this analysis phase the researcher continued to engage the reflective journal to identify personal reflections and questions, especially as each individual interview is analyzed. The resulting documentation demonstrated how analysis of one interview may have affected the interviewing and analysis of another interview, especially as similarities and differences in experiences emerged. This bracketing technique was used both as an audit of what the researcher brought into the analysis, but also as sounding board for interpretation and further analysis.

As an additional quality check, the researcher worked with the VCU School of Allied Health technology services director to create a BlackBoard course. This course allowed the researcher to upload the reflective journal, de-identified transcripts, analysis documents and other documents to make available to committee members in real time. BlackBoard provided the space for committee members to review and engage in the analytical process at their leisure. It was maintained on a VCU secure server and provided more flexibility and engagement between the researcher and committee members during data analysis.

### **Ethical Considerations**

There were several ethical considerations to be mindful of during the course of the study. First and foremost, this study focused on the participants' experiences and perceptions, and the meaning they gave to their experience. As in any study, it was important to avoid harm to the participants, protect confidentiality and practice proper data security measures. The study involved discussing the phenomenon of treating substance abuse clients with co-occurring medical conditions. During the interviews, it was not uncommon for participants to share client

stories. It was the duty of the researcher to be sure no names of clients or other identifying information was collected. The researcher reminded participants not to share names or other identifying information of themselves and their clients during the informed consent process. If a name was mentioned, it was deleted from the audio tape and transcript.

Participants may have also felt uncomfortable discussing any system or administrative barriers to treating clients with co-occurring medical conditions. The study sample was small and contained within one organization. Based on the limited demographic information collected, it may still be possible for participants to be identified. During the consent process, the researcher reminded participants of this possibility and every opportunity to protect their confidentiality was taken. This included immediately assigning a pseudonym to each transcript and not releasing a list of counselors who agreed to participate to their supervisor or any other individual within or outside the agency. The researcher also reminded the participant to speak only to what they were comfortable discussing.

Each participant had the opportunity to review the summary written by the researcher and all quotations which may be included in the dissertation or other publication. This provided the participant an opportunity to correct any misinterpretations in the analysis of their interview, as well as approving quotes that would be in the public domain. Participants were reminded that they could withdraw from the study anytime up to the dissertation defense.

Once an audio coding was transcribed, it was assigned a pseudonym and a study number. The researcher is the only one who can link a particular transcript to an individual. Access to the raw data (transcripts) was limited to the researcher and the dissertation committee. Transcripts were kept on a password protected computer. Each file was encrypted using TruEncrypt software and password protected. Any hardcopies of the transcripts used during the analysis were stored

in a locked filing cabinet in the researcher's office located at Virginia Commonwealth University.

### **Trustworthiness and Credibility (Reliability and Validity)**

A research study is assessed by its reliability and validity. Applied readily to quantitative studies, most of the criteria for assessing reliability and validity are difficult to apply to qualitative research. For example, according to Cho and Trent (2006), validity in qualitative research is about how well the researcher's interpretation of the participant's experience correlates with the participant's reality. As qualitative research has evolved, there has been greater emphasis on how to assess qualitative research. The most notable criteria come from Lincoln and Guba (1985). The criteria include four domains:

- Credibility – confidence that the results are “true” to what the participants reported;
- Transferability – the ability for the findings to fit into other contexts;
- Dependability – the results are consistent and can be repeated; and
- Confirmability – the results are based on the participants' words and not influenced by researcher bias.

Lincoln and Guba (1985) offer various strategies for researchers to engage in to increase the trustworthiness and credibility of their studies. For this research project, the researcher utilized three strategies to increase credibility of the study. First, the researcher engaged in prolonged engagement with the phenomenon of interest. The researcher has conducted an extensive literature review and coordinated multiple discussion luncheons with counselors and physicians related to SUDs and medical care. In addition, the researcher is known by the counselors at the research location. The researcher has had opportunity to work with counselors and has established rapport.

Another way of increasing credibility was through the phenomenological technique known as “bracketing.” This included a dissertation committee member interviewing the researcher on the subject matter and assisting in identifying the researcher’s biases and assumptions. Lincoln and Guba refer to this as peer debriefing. In addition to the initial interview, the researcher maintained a reflective research journal open to the committee to read, question and challenge. Lastly, each participant was offered an opportunity to member check. This included reviewing the summary of their experience and quotations selected for the dissertation. Although there was a risk of participants disagreeing with the interpretations or wanting to change a quotation they felt projected them in a negative light, the benefit of having their check outweighed the risk. If any disagreement was noted, it was documented, discussed and changed accordingly.

Transferability is often handled through providing thick descriptions of the experiences of participants. Also, in an IPA study, thick descriptions of each participants experience are provided in the analysis prior to discussion of emerging themes within and across participant cases. Such a thick description can then be compared to other similar settings. It is beyond the scope of this research project to compare two separate settings, therefore it was critical that the descriptions of the participant experiences were detailed and in-depth.

To also add to transferability and achieving thick description, a dissertation committee member provided feedback on the first interview. The following is the dissertation committee’s verbatim assessment.

The researcher had a very smooth, easy dialogue with Wayne; very conversational. He was a good respondent, and had no trouble providing the researcher with detailed information. The research also made good use of open-

ended questions to keep him talking. At times, the participant would potentially start to lose focus, but the researcher was able to bring him “back” to the topic at hand with phrases like, “now I want to go back.” (Dr. Keyser-Marcus)

In addition the formal assessment provided by the dissertation committee member, the researcher and the committee member would engage in informal discussions after interviews. The researcher noted where she missed opportunities for follow-up questioning and times when an interview may not have been as conversational and the questioning was less fluid. The verbal exchange between dissertation committee member and the researcher during the process assisted the researcher in self-reflection and increased awareness.

Dependability and confirmability utilize the same technique of auditing. The researcher organized all raw data, audio and transcript, all analysis files, notes and journals. Such organization allows for any researcher to perform an external audit. In addition, all research material was available to the dissertation committee providing opportunity for audit. Also to enhance confirmability, the researcher maintained a reflective journal to write reactions and thoughts. This was a way to consistently check in on researcher biases and assumptions throughout the study. The journal was available to the dissertation committee in a timely basis for them to review and engage in discussion.

### **Bracketing Interview**

The bracketing interview was completed on February 13, 2013 by a dissertation committee member. The bracketing interview explored the reasons the researcher chose this particular topic, as well as her own personal experiences with medical conditions and substance use issues. The researcher’s interest in the topic sprang from a series of events including working on existing projects related to medical conditions and health care utilization among clients

engaged in community substance use treatment, and a retrospective medical record abstraction examining health care utilization and referral to specialty care. As the researcher engaged the literature around the projects, she noticed a gap related to exploring medical conditions from the SUD counselor perspective. This gap in knowledge was re-enforced with various technical assistance requests on chronic pain and HIV and through her own observation of how clients with medical conditions had to alter their SUD treatment.

Community based outpatient counseling centers were the primary focus because of their implementation of evidence based practices. Methadone clinics and residential clinics were excluded due to an existing level of medical care available on site. Therefore, they were excluded because their experiences may be different than outpatient centers. The counselor acknowledged her previous relationship with the study site and discussed the impact the relationship might have on the interviews. She felt one of the positives was that many of the counselors already knew her, which may have increased the comfort level of participants. Another influence was that participants may have assumed the researcher already had a certain level of knowledge or experience with the phenomenon.

The researcher also acknowledged personal firsthand experience with medical conditions and substance use. First, was being witness to a terminally ill friend's level of substance use and the afterthought of how his substance use may have hastened his death. The second was her personal experience in working through a pain condition, use of potentially habit forming medications and alcohol use. She reflected how depression, pain and use of alcohol interacted with one another to create a complex situation and the personal struggle to achieve her well-being goals. These reflections provided a level of empathy and understanding of the stories counselor's shared.

## **Chapter 4: Analysis**

### **Introduction**

The following chapter presents the results of the Interpretative Phenomenological Analysis (IPA) study exploring substance use disorders (SUD) community outpatient treatment counselors' experiences treating clients with co-occurring medical conditions within a publically funded treatment setting. Smith et al. (2009) state there is a discrete division between presenting the participant's experiences and the additional analysis examining the findings within the context of the current literature. The following chapter will follow this guideline and present the participants' experiences with further analysis presented in Chapter 5. The analysis chapter includes: 1) Super-ordinate Themes and Themes Overview; 2) Description of Client Population Served by the Counselors; 3) Theme 1 Analysis: Experience, Relationship and Challenges; 4) Theme 2 Analysis: Challenging Medical Conditions to Address in SUDs Treatment; 5) Theme 3 Analysis: Roles, Responsibilities and Strategies; 6) Theme 4 Analysis: Preparing Future SUDs Counselors; and 7) Summary.

### **Super-ordinate Themes and Themes Overview**

Often when we think about the term "co-occurring" in substance abuse treatment, we think of the impact of mental health issues as they co-occur with substance abuse and dependence. The following study provides an opportunity to explore SUD community outpatient counselors' experiences in treating clients with co-occurring medical conditions. The participants appreciated the opportunity to share their experiences as medical conditions among their



population are prominent and affect their counseling strategies, as well as client outcomes. Several participants commented how this research project got them thinking a bit differently about the role of co-occurring medical conditions within their treatment setting. Counselor interviews brought to light the various affects medical conditions had on the treatment process and client outcomes.

Individual interviews were analyzed, coded and presented in a summary form which included the interview's themes and referenced quotations (Individual interview summaries can be found in Appendix G). Each individual interview was then broken apart according to their themes and analyzed across interviews. Themes were organized based on abstraction (similar themes), polarizations (opposite views), subsumption (themes merged together), contextualization (temporal events) and numeration (frequency) to identify super-ordinate themes. Four super-ordinate themes emerged across the five interviews. As super-ordinate and sub-themes emerged, the degree to which they were woven together became apparent. Although different parts could be highlighted, there was still significant overlap.

Table 1 illustrates the prominent themes that emerged from the interviews. The super-ordinate theme is presented with sub-themes for prominent concepts linked to the main themes located within each interview. A more detailed table linking specific interview quotes with each theme and their association to interview themes is located in Appendix H. As we see in Table 1, Specific Aim 1 is labeled in all four themes. This represents the wholeness of the counselors' experiences.

Overall, similar themes reappeared across the interviews and focused around key areas such as access and reduction of resources, chronic pain and other health conditions utilizing

Table 1

*Super-ordinate Themes and Sub-themes from the Project*

<p><b>Super-Ordinate Theme #1 (Specific Aims 1, 2, 3):</b></p> <p><b><i>Substance abuse clients with co-occurring medical conditions experience multiple layers of factors interacting with one another affecting client motivation and outcomes.</i></b></p>
<p>Sub-Theme 1a: There is a multi-faceted relationship between substance abuse, medical conditions, mental health and other factors affecting motivation and outcomes. (Specific Aims 1 and 2)</p>
<p>Sub-Theme 1b: Clients and counselors face a host of challenges needing to be managed concurrently (Specific Aims 1 and 3)</p>
<p><b>Super-Ordinate Theme #2 (Specific Aims 1 and 3)</b></p> <p><b><i>Medical conditions including those utilizing potentially habit forming medications and traumatic brain injuries, present unique challenges to substance abuse treatment.</i></b></p>
<p>Sub-Theme 2a: Prescription drug use is prevalent among SUD treatment clients and includes unique challenges to treatment.</p>
<p>Sub-Theme 2b: Traumatic brain injury and other cognitive disorders are challenging to work with due to the lack of information.</p>
<p><b>Super-Ordinate Theme #3 (Specific Aims 1 and 4)</b></p> <p><b><i>Counselor roles and responsibilities have expanded and adapted to incorporate a host of strategies building a more holistic view of treatment.</i></b></p>
<p>Sub-Theme 3a: Counselor roles and responsibilities have expanded over the years as counselors take on more responsibility for client well-being.</p>
<p>Sub-Theme 3b: The key to providing SUD treatment counseling is the development of a healthy relationship between the counselor and client.</p>
<p>Sub-Theme 3c: Counselors utilize a mix of holistic and evidence based strategies to treat the client holistically.</p>
<p><b>Super-Ordinate Theme #4 (Specific Aims 1 and 4)</b></p> <p><b><i>The SUD treatment counselors' experiences shed light on where additional education and experience can increase the readiness of future SA counselors.</i></b></p>
<p>Sub-Theme 4a: Counselors need to remain hopeful and take care of themselves to avoid burnout.</p>
<p>Sub-Theme 4b: The assessment as a living document changing over time.</p>
<p>Sub-Theme 4c: There are multiple topics counselors would appreciate more education and training in, including trauma, pain, and grief and loss.</p>

potentially habit forming medications as part of treatment, the impact of multiple factors interacting with one another, and the idea of rethinking what is meant by “recovery” and “abstinence.” The counselors also shared their experience of adapting their roles and responsibilities in treating clients with co-occurring medical conditions, which included their utilization of various strategies to help clients achieve a better quality of life.

Examination of the super-ordinate themes illustrates community outpatient counselors’ experiences of treating clients with co-occurring medical conditions is more than just one factor that may or may not have a relationship with the client’s substance use. Instead, medical conditions present a complex web of influential factors impacting the continuum of substance abuse treatment beginning from the client’s ability to function, to how treatment is delivered, to the ability of the client to reach recovery goals. Co-occurring medical conditions are just as important as any other factor related to SUD treatment requiring substance abuse treatment systems to collaborate and engage with complicated health care systems. To understand the depth the role of co-occurring medical conditions has on substance abuse treatment clients, the following analysis examines each super-ordinate theme in detail from the counselors’ perspectives and experiences.

### **Description of Client Population Served by the Counselors**

In order to understand counselor experiences working with clients with co-occurring medical conditions, it’s important to describe how counselors view their client demographics and characteristics. In general, the counselors all described their clients to range in age from 18 years of age and older. Clients are predominantly Caucasian (estimates around 80%) with some African Americans (estimates around 20%) and few Hispanics and Asians. As one counselor noted, the clients are representative of the geographical region’s demographics. To protect

counselor and site location confidentiality and privacy, geographic census data will not be presented. The researcher did cross examine census data with counselor descriptions and found the information to be similar.

To introduce each counselor and their perceptions of client characteristics, each counselor's summary description is presented. Some of the counselors described the clients within their unit, while a few described based on their case load. This is noted where relevant. "Wayne" (1001), "Nicole" (1003), "Don" (1004) and "Laura" (1005) work primarily with men while "Lee" (1002) works primarily with women. The descriptions are based on counselor interviews. Any use of statistics is to be viewed as estimations the counselors made regarding proportions of clients with particular traits.

#### **Wayne, Interview 1001.**

Wayne describes approximately a third of the unit's male clients are currently involved with the legal system for a substance use related charge such as underage possession of alcohol, possession of marijuana, or possession of paraphernalia. The clients in this segment of the population vary in levels of motivation from pre-contemplative to contemplative, with a small minority in the preparation phase.

Co-occurring mental health disorders are common. Mental health disorders are severe and include depression, anxiety, bi-polar and some episodes of psychosis. Previous suicide ideation and/or attempts are also common. Although severe, clients do not meet the classification of severely mentally ill which would result in being assigned to a different department (Mental Health). Wayne describes a subpopulation of men known as the "good ole straight substance abuse client" (1001:070). They usually come in highly motivated (action phase) and are committed to complete abstinence. Among the men's unit, Wayne has observed the primary

drugs of abuse as alcohol and marijuana, followed by cocaine and heroin. He states a lot of clients have trauma exposure.

Clients struggle with multiple layers of issues. Wayne describes the majority of male clients have some health, dental, housing, and/or economic problems, and a small minority have access to resources for health care and dental care.

Obviously, they have some health problems. They have dental problems. They have housing problems. They have economic problems. But for the most part they tend to be... have much better access to resources for health care, dental care, eye care. Many are employed. So they are not representative of the other 70% of people we see. (1001:092)

However, the other 70% of the people they see struggle financially which impacts their ability to access healthcare.

Because we are a community based program, we work on a sliding scale. Many of the people that come to us have no other place to go. So they've, and they've lost a great deal along their way with their struggle with mental health and substance abuse problems. (1001:092)

Health problems include rotten teeth, poor vision, hypertension, pain issues, gastro-intestinal problems (GI), and chronic obstructive pulmonary disease (COPD). Health conditions prevalent in the population are either caused by their substance use or because of injury/wear and tear from laborious employment. Wayne said clients may not share their health conditions with their counselors or may be unaware of the extent of their health conditions.

**Lee, Interview 1002.**

Lee states the women they serve often have substance abuse issues co-occurring with trauma and mental health disorders. She states that probably 80-90% of the women in her unit have trauma or a co-occurring mental health disorder. Many of the women are parents with or without custody of their children. Domestic violence is a common issue. Women enter their site through a variety of referral sources including family members, social services, courts, corrections and self-referral, to name a few. The challenges women face getting into services include poverty, unemployment, lack of support, lack of transportation and child care. The site attempts to address some of these issues (e.g. transportation and child care). Lee describes the women are “reluctant to engage, let their children get involved in services with us. That’s a real scary one for most women, though we’ve tried to do some of that.” (1002:032)

Lee states over the years, the women have discussed a number of different medical conditions. Chronic pain, including fibromyalgia, is probably one of the most common medical issues. Other health conditions include diabetes, head injuries (especially from domestic violence), high blood pressure, cancer, a few HIV positive clients, and working with clients who are living with the lifestyle change that occurs after gastric bypass surgery. Gastric bypass surgery appears in both Lee and Don’s interviews. Lee describes a women’s group conversation,

They said, they were talking about nutrition. It was the first class and five women out of the ten had, had gastric bypass surgery and I was blown away, and they all lifted up their shirts to show their scars and I’m going, “you got to be kidding me.” Five women, because one woman had brought it up, she wanted, a sixth, wanted to get some kind of gastric bypass surgery and they were talking about the pros and cons and how it changed their life and I’m thinking, “WOW!” What

does this say about some of the women that we treat? How many have had that kind of issue, gotten surgery and now they have to deal with the after effects of it?  
(1002:088)

**Nicole, Interview 1003.**

Nicole states the male clients the site serves are “fairly resource limited,” unemployed and looking for work. The substances most often used by the clients are (in order from highest prevalence): alcohol, marijuana followed by heroin and other opiates, and cocaine. She states the clients are usually involved in some sort of labor type of employment (e.g. construction type jobs). This type of employment puts them at risk for work-related accidents and wear and tear on the body leading to chronic pain conditions. In addition, alcohol and substance use puts them at high risk for injury.

She describes some individuals referred after hospitalization have insurance and possibly more access to resources. However, as Nicole notes,

That doesn't describe all the folks who are hospital..some folks who are hospitalized are people without resources and they end up being TDO'd (*Temporary Detention Order*) or some use of the hospital if they are in an emergency situation; especially if they are not hooked up with services yet. They just present, you know, they present at the ER and they may or may not have resources. (1003:048)

Individuals who enter treatment at the site after hospitalization are there for follow-up treatment for either a mental health or substance abuse issue. Mental health issues include being suicidal or homicidal, and severe depression. Substance abuse issues usually involve alcohol either related

to accidents or other health conditions, or being referred after detox. Other referral sources include self-referral or referral by employer.

Nicole describes the medical conditions she has observed among clients including chronic pain conditions, pancreatitis, diabetes, cancer and other conditions that have somehow limited a client's ability to function (e.g. remain employed, mobility). Some clients are on disability. She states some clients have considered applying for disability because of their inability to find to work.

Lately, we've also had a lot of people who have not found work; that have thought about applying for disability, not really understanding that disability is not because you can't find work, it's more because you are unable to work.

(1003:064)

**Don, Interview 1004.**

Don describes the clients he primarily works with at the publically funded agency as male, uninsured and from lower socio-economic backgrounds. He states most clients often have a high school education, GED or less. A lot of his clients work blue collar jobs and trades. Don states he works with people who have both mental health and substance abuse problems, and co-occurring health issues.

Don has observed the following health conditions including: diabetes, injuries such as serious back injury, high blood pressure, neuropathy, serious head injury, HIV/AIDS, clients with gastric bypass surgeries, and liver damage. Don says sometimes clients are unaware if their substance use contributed to their illness. Don states,

That's a little bit of challenge because, you know, some of the clients we see are older and so it's kind of hard to say exactly what's causing their problem, you



know their health problem. And we get some younger people who have had accidents and so the accidents may have been substance related. I had a client who dove off of a rock into shallow water and broke his neck and had a head injury, but also had a pretty significant neck injury too. Had to learn to walk again and all those things. And I suspect he was probably drinking at the time of that. With the accidents, it's always, sometimes, even the clients don't know themselves. They might not remember parts of what happened or...but so yea, sometimes drinking related, sometimes not. It's a little hard to determine that sometimes. (1004:043)

**Laura, Interview 1005.**

Laura states about 90% of the men she sees have a history of trauma, with a lot having complex trauma (exposure to multiple traumatic events). Most of the men also have co-occurring mental health disorders such as depression, anxiety, and Post Traumatic Stress Disorder (PTSD). She states, "Rarely do I see someone who kind of just presents with substance abuse" (1005:213). Laura describes the younger clients (18-22 years old) are often there for some legal charge and to fulfill a probation requirement. Older clients often are there more voluntarily. Laura describes the health conditions she's observed on her case load to include: hepatitis C, pancreatitis, high blood pressure, diabetes, traumatic brain injuries, HIV/AIDS (1), gout, and diverticulitis. Health conditions are usually identified during the assessment process.

Counselor descriptions were similar to one another. Although counselors discussed different characteristics, there were no contradictory descriptions. Similarities in the counselors' descriptions include recurrent identification of co-occurring mental health disorders, medical conditions, and exposure to trauma. These similarities did not differ between the counselor's

working with men and the counselor working with women. Table 2 summarizes the client characteristics as described by the participants.

Table 2

*Summary of Client Characteristics*

<b>Gender</b> Male Female	<b>Race</b> Caucasian (est. 80%) African American (est. 20%) Very few Hispanic, Asian	<b>Age</b> 18 years and older
<b>Education</b> Less than High School Graduate High School Diploma GED	<b>Employment</b> Skill/trade Laborious Unemployed Disability	<b>Legal</b> Possession Probation or Court Mostly younger in age
<b>Drugs</b> Alcohol Marijuana Opiates/Heroin Cocaine Some reports of synthetics	<b>Referral Sources</b> Self Family/Friends Hospital Social Services Court/Legal Employers	<b>Trauma</b> High prevalence in both men and women with estimates over 80%
<b>Mental Health</b> Depression Anxiety PTSD Bipolar Some Psychosis Suicide/homicide ideation	<b>Challenges</b> Poverty/Economics Unemployment Lack of Support Co-occurring MH/Trauma Child care Transportation	<b>Challenges</b> Multiple issues Medical Conditions Housing Domestic Violence Insurance

The counselors identified a variety of health conditions. This is not representative of all counselor experiences and is not a comprehensive list of health issues among clients at the site.

Table 3: Observed Health Conditions illustrates many of the medical conditions are chronic in

nature and can impact a client’s function and quality of life. Left untreated, these conditions may severely impair a client or result in death.

Table 3

*Observed Health Conditions*

<b>Health Condition</b>	
Injuries/Accidents	Diabetes
Dental/Rotten teeth	Traumatic head injuries
Poor vision	Cancer
Hypertension	Liver problems include hepatitis C
Pain conditions	Gout
GI problems/gastric bypass/pancreatitis	COPD
Vision	

The counselors’ descriptions of client characteristics assists us in identifying the prominent predisposing, enabling and need factors clients present with. As the following analysis will present, counselors’ experiences begin to illustrate the relationships between many of these factors, substance use and medical conditions. Some relationships were first mentioned in their client characteristic descriptions. For example, Lee noted a link between trauma and health condition as it relates to domestic violence among women. Often not only is a woman having to work through the trauma of domestic violence, but may have also incurred a head injury as a result of the domestic violence. Another example is how several counselors described male clients as having predominantly labor type of employment which may lead to various health conditions.

## Super-Ordinate Theme 1: Experience, Relationship and Challenges

*Super-Ordinate Theme 1: SUD clients with co-occurring medical conditions experience multiple layers of factors interacting with one another affecting client motivation and outcomes.*

Table 4 provides an overview of the most prominent issues identified during cross-interview analysis with the interviews quotations and reference to the individual interview themes. Each super-ordinate theme will begin with a similar table. Key words in text are italicized and underlined and sub-themes are noted as bolded subheadings for easy reference.

### **Relationship.**

When speaking with counselors about how they experience treating clients with co-occurring medical conditions, similar descriptions emerged related around the multiple issues clients present with. These factors interact creating a complex view of the client. Through their experience, the counselor's identified how they viewed the relationship between substance use and medical conditions, and the challenges that face both them and their clients. The multi-faceted relationship between substance use, medical conditions, mental health and other predisposing, enabling and need factors affect client motivation and outcomes.

One important factor in exploring the experience of treating clients with co-occurring medical conditions is to define what is meant by co-occurring medical conditions. Nicole describes different aspects of co-occurring medical conditions. Nicole states,

Again, I feel like you have to kind of eye between the medical conditions that are treated with habit forming medications and the medical conditions that are not. If somebody has a medical condition that doesn't involve, you know, habit forming

Table 4

*Super-Ordinate Theme #1 Sub-Themes and Key Words*

Keywords	Quotes	Referenced Theme
<b>Sub-Theme 1a: There is a multi-faceted relationship between substance use, medical conditions, mental health and other factors affecting motivation and outcomes.</b>		
Defining co-occurring medical conditions	1003:112; 1003:116; 1003:136; 1003:140; 1003:144; 1004:047	1003 - #5 1004 - #2
Counselors experiences	1001:092; 1003:080; 1003:084; 1004:087	1001 - #1 1003 - #1 1004 - #2
Awareness	1005:071; 1005:173;	1005 - #2
Motivators	1005:135; 1005:139; 1005:143 1003:154; 1003:154	1003 - #1 1005 - #5
<b>Sub-Theme 1b: Clients and counselors face a host of challenges needing to be managed concurrently</b>		
Complex Relationship	1001:156; 1001:156; 1001:140	1001 - #3
Accessing Services	1004:047; 1004:091; 1003:088; 1003:088; 1002:084; 1002:088; 1001:148; 1005:095; 1005:099	1001 - #3 1002 - #4 1003 - #2 1004 - #3 1005 - #4
Fear and Apathy	1002:092; 1002:092; 1001:180; 1001:168; 1001:168; 1001:176	1001 - #1, #5 1002 - #1, #3, #5
Client Strengths	1001:148; 1002:040; 1002:044; 1002:048; 1002:48; 1002: 048; 1002:052; 1004:123; 1004:139	1001 - #3 1002 - #1 1004 - #2, #6

somebody has a medical condition that doesn't involve, you know, habit forming medications, I think it's a lot easier for them to achieve abstinence and it really also kind of boils down to what definition do you use for abstinence? (1003:112)

In addition, a difference lies between clients who present with chronic conditions versus those who present with acute conditions. As Nicole states,

I think the other thing is, you know, for chronic conditions that aren't likely to improve, which most chronic conditions don't, there's, there's a certain level of acceptance that it's helpful for people to reach and so that might be, that might be an issue that, that we might work on. If it's, it's someone that you know, isn't quite in a place where they realize that, you know, the goal is really going to be adaptation as opposed to something suddenly getting better. And on the other hand if it, it's a medical condition that they can do something to improve, then just helping to, you know, to support them and help keep them motivated to do whatever; whatever next small thing they can do to improve their conditions.

(1003:116)

However, one aspect of co-occurring medical conditions that was not considered was the role of caregiver. In essence, because the SUD treatment client may not have the financial means to provide their own shelter or other basic needs, the client may find themselves living with a family member (e.g. parent or extended relative) or friend who has a medical condition. The situation may place the client into the role of caregiver for that person. As Nicole describes

I mean, sometimes what, on an individual basis what seems to be happening a lot is that we have clients in that age range who are often, as a result of their substance use, are living at home and are starting to take care of aging parents. So

that's, that's, that's kind of brought up some, you know, some different issues as far as how, you know, they manage their time, as far as whether they seek employment. Some of have had parents that have passed away, so then you get into grief issues. (1003:136)

What Nicole describes are two phenomena occurring affecting current substance abuse treatment clients. First, is the phenomenon of the baby boomers aging and their children being their primary sources of care. The second phenomenon is of the client who has lost everything while engaging in their substance use and is financially reliant upon their parents. These two events merge to create a new perspective on what it means for a client to be dealing with a co-occurring medical condition. Not only must a client work through issues related to their substance use, but now hold the primary responsibility of caring for an aging parent or family member. Nicole states she has observed times when clients shared stories about their role in their family member's medical diagnosis and treatment. Their stories are filled with emotions as they process what their family member's diagnosis means to them.

Don elaborates on this as he discusses how a lot of clients lack various supports including health insurance and employment, thus being supported by someone else. Although Don doesn't discuss the role of caregiver, his experience with treating clients with co-occurring medical conditions confirms the process by which clients become supported by other individuals, and may include caregiving.

Well, a lot of them don't have health insurance. Many of them are unemployed and because a lot of them do physical labor type of jobs, you know, if they got a serious health problem, then they become unable to work and they may not have

any means of supporting themselves, often being supported by someone else.  
(1004:047)

Taking care of a parent or other family member may complicate the situation by adding more emotional stress and ultimately affecting a client's ability to achieve their goals. Nicole states,

So maybe it's a function of the demographics that with the older population increasing that it's coming up more often. But it very much affects them and often can affect their ability to work towards abstinence because if it's a parent they are connected with they often feel pretty depressed when they see the parent going downhill. (1003:144)

Nicole brings a new light into the experiences and interpretations of those experiences by adding the idea of caregiver. As we continue to explore the relationship and challenges of co-occurring medical conditions, we should keep in mind just because a client may not have a physical ailment themselves, they could potentially be a caregiver to someone who is close to them.

In thinking about how co-occurring medical conditions can present themselves, the counselors discuss their *experiences* with substance use, medical conditions and mental health. As Wayne describes,

I would say the majority of those 70% have issues related to health care or have physical, dental, hygiene, housing, economic problems that pile up on top of them. (1001:92)

Nicole further describes the layers of issues affecting clients and the relationship between those factors and medical conditions.



Especially if it is something that prevents their ability to work; those, those kind of medical situations can create or can worsen situations that are already going on with depression or anxiety or that, or that type of thing. So I think, I think just being sensitive to the fact that, you know, in the unit where I work you are also going to be dealing not only with the problems created by their substance use, but also problems that are created from the physical issue or the mental health issue. (1003:84)

The situation is further complicated if the client has a medical condition where they are using potentially habit forming medication. As Nicole states,

I'd start by saying it's, it's fairly rare for us to have somebody, in the particular unit that I'm in, who has substance abuse issues without other either mental health or medical conditions. And, one that is particularly difficult is when people have a legitimate pain situation and are taking prescribed pain killers. It's, it's very hard for them if they have been addicted; it's very hard for them to kind of hold the line with taking things that are prescribed as prescribed. (1003:80)

Their experiences lead one to think about a spiral of events. SUD clients use may create or exacerbate a medical condition or a substance use problem may have begun with medical condition. Don states,

Sometimes they're connected, sometimes they're not, and they interact or interplay in that, you know, you know substance use can cause accidents and health problems; and the health problems can cause people to drink because they're unable to do things that they were before. They become isolated, depressed or whatever. They're limited in, in their abilities. They might become

dependent on someone else because now their health isn't good enough for them to manage on their own financially. (1004:087)

Having a client situation that is multi-layered with factors interacting creates a difficult environment directly impacting the client's ability to achieve treatment goals. If one aspect of the client's life is treated, but the others are not; the stress from the other factors makes maintaining new changes difficult.

In addition to having to work with multiple issues interacting with one another, the client's level of awareness of the relationship between a medical condition and substance use also adds another layer complication to the situation. As Laura describes,

One of the biggest things, I think, that still kind of surprises me is that people don't see the, the clients don't see the connection between, for example, treating their diabetes and their addiction. So people will, you know, I've had a client who would, would stop drinking, but would stop, you know, would start eating a lot of sweets after they stopped drinking. Obviously, you know, affects their diabetes and, and really kind of just those simply things as far as educating the connection between how all of that is really important. And, and that really still surprises me sometimes to hear people not be aware of that. (1005:071)

Clients may not be aware of the relationship between their medical condition, substance abuse and other factors such as a trauma. As Laura provides an example below of how trauma and pain are connected and when one factor is addressed, it may impact the severity of another factor.

That a lot of, a lot of people with, with histories of trauma and complex trauma have a lot of sort of pain issues and it sort of manifests itself a lot of times in different parts of their bodies. So like I know people say fibromyalgia, you know,

has a lot to do with or some people that's, I guess a hypothesis, that fibromyalgia is really kind of untreated trauma and stuff like that. But I see a lot of people who have health issues that are connected to their trauma and once kind of their trauma gets resolved or they work on those emotional issues, the pain kind of lessens. (1005:173)

By increasing the awareness of the relationship and medical condition, the information can act as either a *motivator* for clients to reach their goals, or create further stress complicating their life and making reaching their goals difficult. Laura states,

But once again they don't see the connection between, you know, my stress level was high this week or you know, I didn't take good care myself this week and so I had this flare up; so it's, it's about sort of educating and it's a lot of sort of back and forth. So yea, it could, it could delay people meeting their goals. It could sometimes, you know, it pushes people to get sober if they have a scary experience and they get hepatitis or something like that, it can push them forward. (1005:135)

The relationship between a client's awareness of their medical condition and their substance use and its effect on motivation can generate a range of emotions for a client. For some, it generates fear that can push clients either in the direction of abstinence or further into addiction.

But now that I'm kind of thinking about it, it's usually, you know, it kind of scares them. Doesn't mean they are going to maintain sobriety. It just kind of, you know, it adds to their motivation but sometimes, sometimes it doesn't. Sometimes

it just scares them to the point where they end up drinking more because it's so scary. (1005:139)

The relationship of medical conditions with substance use and other factors has a direct impact on the client's outcomes. Laura provides a client example,

A couple of them, I'm thinking their confidence in being able to stay sober. I have one client I'm thinking about in particular has had a really difficult time staying completely sober. He's you know, he's moderated and he's definitely cut down, but then he found out, he got some test results with his blood. He had some test results come back and it was, he really needs to stop or he'll, you know, he'll die. And it scared him to the point where he was able to stay sober for a few weeks. But now he's back to drinking and it's sort of like, he gets discouraged. It's another reason why he knows he needs to stop, but doesn't necessarily mean that he is going to do it long term. (1005:143)

Not only does this complex relationship of factors affect the ability to achieve substance abuse treatment outcomes, but may also impede a person's decision making process. As we saw in Laura's example of the client who has liver issues and continues to drink, Nicole also experienced treating a client who was in need of a dialysis.

I think especially for clients who have depression going on, that, that makes taking care of any medical condition or pain condition more difficult; and what brought that to mind is a client I saw quite, quite a while ago whose divorced, who sort of felt like he had lost his family and had kidney disease and was approaching a point where he needed to make a decision pretty quickly about whether to start undergoing dialysis. And I think in part because, I think that it

was hard for him to make a good clear headed decision because he was depressed, he was sort of like, “What’s the point? Who needs me? It’s going to be difficult.” And so that was a real clear connection for me between the depression and his, his interest in doing something to help, to help the medical condition. (1003:154)

Fortunately the client had support from both Nicole and an attending psychiatrist who assisted him through this process and the client eventually made the decision to proceed with treatment. However, if not for the support of clinicians and the integration with mental health services, it would be difficult to determine if the client would have come to the same decision. Nicole summarizes the relationship stating,

I mean if someone is, if someone is depressed and has a medical condition, they are just less likely to take care of it. I mean, either lacking the energy or lacking the hopefulness that if they do something to take care of it, it can improve. And then in terms of the anxiety end of things, having a medical condition usually just jacks that up especially if it’s something that, you know, that is not likely to shift, you know, or improve very much. (1003:154)

### **Challenges.**

It’s like trying to change a flat tire when you got a blown engine. It’s just, you know, it’s not going to fix the problem. (1001:156)

Wayne’s metaphor captures the complex relationship between substance use, medical conditions and other factors both client and counselor face. The flat tire represents substance abuse and the engine represents the basic needs of the client including medical care. You can work to fix the tire, inflate the tire with motivation, skills and commitment to recovery.

However, if the engine is blown, if the car is unable to move and go places, then the repaired tire

will sit there. Eventually holes appear in the tire and the air begins to leak out; symbolic of relapse. The challenge then, is if other parts of the car are not worked on, the ability to focus and put in practice the skills learned in therapy are difficult. Wayne states,

Regular attendance in counseling. If we are talking about all the socio-economic factors that come into it, the housing is an issue. Financial is an issue. Health is an issue. Transportation is an issue. They are all tied together. So their ability to regularly attend counseling is impacted. Their ability to focus on the things that we focus on in that 50 minute counseling session or that hour and half counseling session, to be able to go out and practice them because talking to me for an hour a week don't do a whole lot of good unless you go out and put it to use. But when you're trying not to hurt; to worry about floaters in your eye from your high blood pressure and not being able to breathe well with COPD or all the gamut of the other, it's, it's very difficult. (1001:156)

Wayne further explains there are competing needs the client must work through in order to reach their treatment goals. We understand from Maslow's theory that if basic needs such as food, housing and medical care are not met, the client will not be able to focus on other needs.

When you look at Maslow's hierarchy of needs, if they don't have housing, if they're in poor health, if they're struggling to have enough to eat, then obviously mental health therapy is going to be difficult because they are not getting their basic needs met. (1001:140)

Each counselor discussed the challenges they experience when assisting clients to meet basic needs, especially medical care. One of the most prominent areas discussed among the counselors was around the notion of *accessing services*. Don stated resources were limited due to

the geographic location, but have also shrunk over time. Both Nicole and Don attributed the decline in resources to the economy and new policies. Don states,

I think not having the health insurance, not having consistent health care, preventative health care and those sorts of things, or ongoing PCP kind of care is a problem. And some of the resources around here have dried up for that...The options have shrunk a little bit in the area. (*name omitted*) is still a good option. But that takes some time for them to go through the financial process, have the, have the testing or anything, particularly if they have to go downtown, transportation is always an issue. (1004:047)

Nicole elaborated on shrinking resources stating,

The biggest, the biggest one really is, is helping them to find medical care. There are not, I think that, I think that the few resources that are available for people who are uninsured are just really flooded right now. But things, resources like that, I think are just so flooded because there are so many people, due to the economy, who are applying for those things that it's taking a very, very long time; much longer than some of our clients really have the patience for. (1003:88)

In addition to resources being overwhelmed, new policies are creating additional service gaps that put yet another layer of complexity in the mix. Nicole states,

Some co-workers and I were talking recently about just the difficulty finding Medicaid providers who are, who are taking, who are taking new clients. And if their medical issue isn't being treated, then obviously their medical condition isn't going to improve; their mental health condition isn't going to improve and they're

likely to keep using as a way to manage pain or just kind of, you know, forget about it. (1003:88)

Nicole's description links how changes in the overall economy and new policies can contribute to a person's continued substance use. Because they are not able to access needed services, clients will continue to use as a form of self-medication both for physical issues and mental health issues. Lack of needed health care resources also impacts the counselor's ability to line up substance abuse services for the clients. Don discussed how it's important to address a medical condition, but challenging since medical services are not connected to the substance abuse treatment center. There are no medical professionals on-site to treat or provide consultation when needed. This impacts the ability to assist clients who have a medical condition already, provide any type of preventative care or provide medical services needed for detox. Don describes,

And it becomes an issue for us sometimes when we are assessing for detox or referring people for detox. You know, I mean I can take a client blood pressure. I can probably get their pulse reading. I used to have to do it (*name omitted*) when I used to work there. But, you know, it's not easy for me to assess, you know, exactly how serious their withdrawal might be. If they have a history of DTs (*Delirium Tremors*) or something, those sorts of things; but we have to refer people, it takes us some time and some of the facilities won't, they won't touch them, the kind of places we refer, until they've been detoxed. So you have this thing of you got to arrange the detox. You got to arrange residential treatment. You got to coordinate all that and get the timing set up. And in the meantime the



client might or might not be drinking or, might end up in the hospital anyway. It's always kind of, it's a real challenge. (1004:091)

The difference onsite medical care can make is a stark contrast to when onsite care is not available. Lee describes a time when the substance abuse treatment facility provided some *integrated medical services* through a nurse practitioner.

We got five hours of a nurse practitioner once a week and they took the funding last year. That was so wonderful because they came there. There, we could provide transportation. They met her (*nurse practitioner*), she got them hooked up with everybody and anybody. Really, we had a woman diagnosed with cancer that she helped. I mean we had so many serious physical problems that got caught, because it was right there and accessible. (1002:084)

However, when funding was pulled and the service ended, counselors were back to having to locate offsite medical care without the assistance of a medical professional. This posed several challenges for the counselors. Lee discussed that follow-up on the referral was very difficult for clients as most don't have transportation to get to the site and/or the clients lack adequate phone service to follow-up with service providers. Wayne describes the challenge of accessing health care,

Do the best you can. You encourage them. You, you, you, you make health care access available to them; which we are very fortunate in this area through (*name omitted*) and have (*name omitted*) insurance. But anybody that's ever gone through that process usually comes back a tad traumatized because it is a lot of call and wait, call and wait. A lot of these people might have three different

telephone numbers in two months and you know, it's leave messages and get back. (1001:148)

The complexity of interacting with the health care system was noted by several counselors. As Laura describes,

And even when they do have health care, such as Medicaid or Medicare, it's such a process that it's, it takes a lot of effort and a lot of energy and for someone who is already struggling with health issues, you know, it's quite a feat to sit at a doctor's office for the entire day to see someone. (1005:095)

Laura further states, for the client who is motivated to start taking better care of themselves, to work to access services and tend to health issues, is a process requiring a lot of effort. Things may not happen or be very slow in happening. Laura and Wayne stated that clients reach a point where they cannot stand how they are feeling anymore and receive care through the emergency room.

Most of the clients that I see want to take care of this stuff. They want to be able to take care of their health, but they don't because they don't have the access to health care. And so they, they sort of, what a lot of them end up doing is going on an emergency basis only when things get bad enough. (1005:095)

The frustration of engaging a complex system is also felt by the counselor. Laura describes the discouragement.

There are times where I want to pull my hair out and, or someone else's hair. I mean, it's, it's yea, I mean you end up sort of just being a witness to their pain and that's, and that's one of the most difficult things is when you just have to

witness it and, and sit with it and there's, you know, nothing you can do.  
(1005:099)

Similar to Laura, Lee also notes her feelings about obtaining access to medical care.

I just think we make it so hard, I mean, sometimes, I just want to cry at how we make it so hard. Some of it is location, some of its (the area name) can be pretty isolated in terms of, but if people need it, there needs to be an easier way to access it. You know what I'm saying, and then again their willingness to use it even if it was easier to access. I don't know if they would use it. (1002:88)

Clients are faced with the challenge of limited resources, the ability to physically get to the resources and the complexity of engaging the system. If services were accessible, Lee notes they may not be a willing to use it. Client *fear and apathy* may be part of the explanation as to why clients may not want to utilize resources. Lee describes,

I think not really wanting to believe you might have a serious problem. Maybe you didn't grow up taking the family, that wasn't a value, that good physical health care. Fear is always a big one. Then what am I going to do if you tell me I have something. I think those kinds of things are just, you know, apathy. I mean it's just easier not to. It takes less energy not to mess with something. Often it's the things we wait and become urgent that we mess with, as opposed to preventative, not getting the, a lot of this stuff could be prevented if we did some things early. It's the crises that get our attention. (1002:92)

Wayne discussed how clients are fearful of the outside world. Client systems tend to be closed for a variety of reasons. Often the clients are isolated and disconnected with the world. If

a client is motivated, they have to open up their system for the world to see. That is frightening for clients. As Wayne describes,

They can't allow information in to see the level of dysfunction that goes on. Well in a closed system, going outside of that system and telling people about anything is a taboo. It's a dying, atrophying system, but it's holding on to its last breath because it can't let the world see what is going on inside; the horrors that are going on inside. (1001:180)

Wayne states clients also have problems interacting with people in service agencies. Because client systems tend to be closed, they may lack the interpersonal skills necessary to navigate the system. He states,

So sometimes it's, it's working with people about how do you deal with the front line people at social services, at (name omitted) when things are getting in your way of accessing these services. Things that you and I would figure just basic human skills, they don't have them. (1001:168)

Interestingly, gender differences were noted in this area. Lee discusses the difference in men and women accessing health care. Much of the difference was focused on the internal feelings about healthcare.

I think men historically probably have more difficult accessing. They don't want to. I mean, even stronger than with women. Often at (site name) we still have a high unemployment rate with men too. Because maybe, the kinds of things; I don't see, I don't think it's real different other than I think men have traditionally just kind of not wanted to admit there might be a problem and women maybe more apt to talk about it or do, you know. But as you are doing something about,

that can be the obstacle. So that becomes part of our job, hopefully to motivate them, help them find some motivation to take better care of themselves. So I don't see those as real different with men either whether it's to stop smoking or the getting a checkup or...(pause) (1002:92)

In contrast, Wayne describes men may have a more difficult time accessing things like health insurance. However, he confirms the internal emotions men may have towards dealing with health conditions.

As men, they put on a bravado and "arrrr, I don't want to mess with that stuff." But it has a whole lot to do with fear, about their educational level, how they feel like they can interact, past experiences where they turned anxiety and feelings of helplessness into anger and they ended up making a ruckus and going to jail or being disconnected for services. (1001:168).

Wayne also describes client fear and the impact of culture.

And you talked a little while ago about fear, even though they're sick, there's also this fear how sick they are. So to them it seems less scary to say "oh" and it also supports the addiction, "Well maybe I got cancer. Maybe I got heart disease. So why should I even quit drinking? The doctor is just going to tell me to quit drinking or something." So there's a lot of factors, even if they had access to health care, easy access to health care, whether they connect with it or not, related to the addiction, to the mental health symptoms. And just cultural fears around doctors, medicine and even these good ole Caucasian guys, the culture they grow up in, you just don't go to doctors. They don't trust doctors. You hear a common story about some uncle or some parent or somebody that went to the doctor and

that experience somehow caused the illness that the person has. They were either misdiagnosed or in the process of diagnosis, that exacerbated the situation. You know, it's all these urban legends they brought into around health care, especially preventative health care. (1001:176)

Fear to engage health care systems as described by the counselors seem to appear across the client population.

Lee and Don provide two examples of clients who, although they faced many of the challenges described above, utilized their *client strengths* to achieve healthy outcomes. Lee describes an African American female who was pregnant, was on methadone and was HIV+. Her fear was the baby would be born HIV+ and she had to manage being on methadone. The client also had other children. Her partner was not a steady source of support. "And just dealing with the feelings about that (HIV) and the possibility of her life span being shortened and she's got (*number omitted to limit identification*) children now and how to deal with that. Not wanting to tell anybody" (1002:40).

Lee's client exemplifies the closed system of a client. She did not want her family to know about her substance use or her HIV. Lee understood this was a cultural factor, "that she was now the matriarch and she could not let them see that she had any of these weaknesses. She was African American and that was just not in her culture. You just kept that to yourself to her" (1002:048). Lee utilized various strategies to assist the client.

The impact of keeping secrets in that, the MI (*Motivational Interviewing*) to keep her engaged, skill building, education, CBT (*Cognitive Behavioral Therapy*) stuff..but again she was very good at taking care of herself. She didn't, in terms of case management, she was a very good advocate for herself. So I just offered a lot

of support and education. Again she was just more supportive therapy with her.

Because she knew what she was going to do and not do. (1002:048).

As Lee describes, the focus was on how secrets impacted her family, dealing with the losses in her life, including the loss of her employment due to her HIV diagnosis and how HIV had changed her life. The client engaged multiple services to support her pregnancy and delivered a healthy HIV negative baby.

The client had a number of obstacles the counselor assisted her with walking around in order to meet her goal of delivering a healthy baby. The client was stigmatized because she was a substance user with children and struggling financially to make ends meet. To meet her goals, she had to manage multiple systems and advocate for herself. She is an example of a client who successfully managed her health condition and substance use. Lee continues on to note that this was a successful case and “not often are the women, they’re not as knowledgeable about resources or what their rights are” (1002:052) and many of the obstacles the HIV+ client had are the same as most women. For example, Lee describes the role of methadone in her client’s case and the common issue most of the women on methadone face.

Weighing the pros and cons of being on methadone. How was she going to get off it because she really couldn’t afford it. That’s a big issue for most of our women on methadone. You know the cost of it is prohibitive. She was constantly, I mean financially she didn’t have any money. They couldn’t cut her off of methadone because she was pregnant. (1002:048)

Counselors discussed treatment outcomes are difficult to achieve when health conditions are present, but as Lee exemplified above, some clients are successful. Wayne states,

When you see the difference in the people that do (*get access to health care*), they start getting better right away even without therapeutic intervention, without medications for depression, anxiety or bipolar disorder. Just start feeling better and having some health care, just that, achieving that goal and starting to treat these medical problems, they start getting better and then of course, they start responding better to treatment. (1001:148)

Don described a client who had a hip issue who because of the type of work he did, was unable to stay employed and unable to maintain his social activities. He too, became isolated from various supports which impacted his depression.

It caused him to be very socially isolated and then that spirals into the depression, which could have let him to relapse, but didn't in his case. (1004:123)

The client maintained his recovery. Don is not sure what resiliency factor is within some clients who are successful versus those who are not as successful. Life experience, he thinks, may have something to do with it. He states,

The one's that seem to be the most resilient are the ones that have had some serious struggles in their lives and older. Trying to think of some younger ones that have had some chronic health issues that (pause). The clients I'm thinking about are older and it may just be that I have more older clients with chronic health conditions. Yea, I think life experience.” (1004:139)

### **Super-Ordinate Theme 2: Challenging Medical Conditions to Address in SA Treatment.**

*Medical conditions including those utilizing potentially habit forming medications, and traumatic brain injuries, present unique challenges to substance abuse treatment.*



Table 5 provides an overview of the most prominent issues identified during cross-interview analysis with the interviews quotations and reference to the individual interview themes.

Table 5

*Super-Ordinate Theme #2 Sub-Themes and Key Words*

Keywords	Quotes	Referenced Theme
<b>Sub-Theme 2a: Prescription drug use is prevalent among SUD treatment clients and includes unique challenges to treatment.</b>		
Prevalence	1001:124; 1001:120; 1001:124; 1002:104; 1004:059; 1004:063; 1005:055	1001 - #2 1002 - #5 1004 - #5 1005 - #1
Legitimacy	1001:132; 1002:112; 1002:104; 1004:107	1001 - #2 1002 - #5 1004 - #5
Lack of Resources	1002:104; 1004:071	1002 - #5 1004 - #5
Stigma	1003:096; 1002:104; 1002:112	1002 - #5 1003 - #4
Limited Treatment Options	1003:096; 1004:071; 1004:099;	1003 - #4 1004 - #5
Defining Recovery and Abstinence	1003:112; 1002:072; 1002:076; 1002:076	1002 - #2 1003 - #5
Outcomes	1002:132; 1002:136; 1002:132; 1004:111; 1004:119; 1004:119	1002 - #5 1003 - #6
Strategies	1001:116; 1001:132; 1001:136; 1002:104; 1002:116; 1002:136; 1003:108; 1003:108; 1003:104; 1005:055; 1005:067	1001 - #2 1002 - #5, #6 1003 - #4 1005 - #1
<b>Sub-Theme 2b: Traumatic brain injury and other cognitive disorders are challenging to work with due to the lack of information.</b>		
Challenges	1004:035; 1004:208; 1004:208; 1005:087; 1005:091	1004 - #1 1005 - #3

As Nicole mentioned earlier, when we think of co-occurring medical conditions, there are several notable differences among the population. Clients can present with acute conditions that will resolve over time; while other clients must learn to adapt to living with chronic conditions. Breaking this down further, there is a difference between clients whose medical conditions are treated with potentially habit forming medications versus those that are not. These include both physical conditions such as chronic pain and mental health conditions such as anxiety. In addition, some chronic health conditions like traumatic brain injury or other cognitive issues present a complex situation for counselors to address during substance use treatment.

### **Prescription Drug Use.**

All five counselors discussed the challenges chronic pain, and more broadly prescription drug use, has in counseling. Prescription drug use is *prevalent* in their treatment center. Wayne noted he has seen more individuals coming in for treatment of prescription drug misuse.

I'm seeing more people coming into treatment now that have been caught for prescription fraud and that is why they are being referred for treatment. Well, they've gone to their probation officer and they've said, "Look I did this because I have an addiction." So the probation officer refers them to us. Many times they are motivated. But anyway, I think it is becoming harder to do so maybe that's why we are bringing, we're seeing more people coming into treatment talking about this. But it's still, it just seems epidemic. (1001:124)

Don described another group of individuals coming into treatment who have significant pain problems and are on medications which they are now addicted to.

But we have a lot of folks who, you know, have significant pain problems and so they have to sometimes be on medication and it's always a challenge knowing

how to address that with someone who has a substance use history. And then we see a lot of clients who have had pain problems ended up addicted and then they come in for treatment and, because of pain pill addiction, maybe now they are on methadone. Those folks are really, that's a real challenge. (1004:059)

Most of the time counselors rely on self-report of prescription drug use and what role the medications play in the client's life. Laura shares the complexity of prescription drug use as it relates to chronic pain in a client's life.

It's, it's definitely a lot more complex because what I found, and as far as people coming in, typically they will have an issue with one, one substance and then they'll have some legitimate pain issues and they'll be using, you know, opiates to treat that condition. (1005:055)

To add to the complexity, both Don and Lee noted some folks are moving from prescription opiates to heroin. Don states,

So you see people who, you know, may have gone in for a medical condition and they start taking pain pills, they end up addicted to them. Now they're doing heroin because now they can't get the pain pills. (1004:063)

It could be that as prescription monitoring programs and other surveillance activities have identified more and more users, the availability of the drugs has diminished and individuals turn to street opiates to get their drugs. Lee describes a recent story she saw,

I just think they're a real challenge. I just saw an article this weekend about how heroin is coming back too, because we've gotten so good at monitoring prescription drug abuse, that the supply, it's easier to get heroin, than it is drugs; which is interesting. (1002:104)

However, as Wayne noted, there is still a high prevalence within the community.

It is just amazing. It's, it's, we'll sit around and talk about shared clients we have and certain areas like, there's certain parts of (*street name omitted*), where it seems like everybody in that community has a valid prescription for opiates. How in the world does this happen? Because most of us when we go to the doctor and we have legitimate pain, are very cautious about prescribing opiates and monitor that pretty closely. But these people, they even talk about it in group, "oh yea everybody in my trailer court has a prescription." So it's, it's something we see a lot of now in what I do whether your question was has it increased over time, I can't say. (1001:120)

In addition, counselors describe how clients are finding ways to obtain prescriptions. Wayne states,

And, and some people talk about getting opiates over the internet! That they can just go pass the whole going to my doctor or forging prescriptions and all that, go on the internet if you got enough money and get a prescription mailed to your house. You see some younger people coming in with that kind of stuff. It seems more prevalent now than in the past that people have access to prescription opiates over...typically in the past it was heroin either being snorted or injected was primarily where you saw the addiction there. (1001:124)

Treating clients who are using prescription medications comes with a unique set of challenges. The first is trying to identify what is *legitimate* use and what is not. As Wayne describes,

...It's a different animal because people feel that it's legitimate and they are taking it many times as the doctor indicates. So maybe one of the things to answer your question is if you start to hear people say, you start to hear change talk, you start to hear some ambivalence, then you can talk to them about "Well how would you know if this was a problem for you?" What is...and give them an example, you know with permission, "is it ok if I make some suggestions?" And they say sure. "Well do you ever find yourself taking your medication even when you don't have pain?" And that seems to be the one most commonly that they will respond to, "Well, yea." "Well what's that all about? Well I really like how they make me feel." So then you have something to talk about. (1001:132)

Don's experience reflects Wayne's statement. He talked about how it is difficult to determine what is legitimate because they are not physicians or pain management specialists. They do not have access to x-rays or other medical diagnostic tools to determine what impact the physical injury has on a client. Counselors often have to rely on client self-report. These factors make determining legitimacy difficult.

Yea, and it's hard for us to know what's legitimate and what's not. I mean that's probably true for the pain specialists too to some degree. But I'm sure that they are much more adept at it than I am and they probably have some medical training. They can look at their x-ray's or their, you know, and understand how they are being impacted by whatever their physical injury is in terms of pain. (1004:107)

It leaves the counselor attempting to identify what legitimate use is. Lee states,

I think that's a tough question. I wouldn't want to be a doctor prescribing for them. But I also don't want to see them hurting. I go back to my, I like to encourage people to take as much control as they can and again that's a tough sell when the pill makes it go away a lot quicker. (1002:112)

Lee touches on an important aspect of prescription medication use, our desire for the quick fix. As a society, we have ingrained this notion of the quick fix into our culture. The counselor is left to not only figure out what is legitimate, but now must work to find a balance between using alternative methods to help regulate pain and the quick relief a pill would provide; while also being mindful they are not in the role of a medical professional. Lee states,

I think that the lack of alternatives, instead of going to immediately a pill, which we all want; what about working with them to learn mindfulness and yoga. Because when I'm with my clients I try and do is teach them mindfulness skills to work with the pain. The value of exercise in working with the pain because I think we've gotten so used to give me a pill and make it go away. And again I understand the clinic needs to keep things safe and the doctor's license in place and the clients just want to feel better and trying to work a balance of it's not just a pill. (1002:104)

Although counselors can provide some alternative therapies within their treatment center like yoga and mindfulness, the *lack of resources* is a constant challenge. Lee states,

Which is what we see with a lot of things, just give me that pill and I'm not going to be depressed. That's the big challenge and finding, there are very far and few between and they're hard to access. Again that's another access. They're just not

out there. Again, the ones doing alternative stuff, I don't even know of. So that, I mean, that in hearing from the clients what that's like and how painful it is and again how do you tease out what's "I'm just hurtin' cause I need to use" and "I'm really in a lot of pain?" (1002:104)

Don also reflects the challenges Lee describes,

You know, these are some, actually some of the hardest issues we deal with because we don't have a lot of resources for health. I don't know if that is the right way to say it. But, you know, we don't work directly with a doctor in our agency and we're not medical professionals. So we don't have a complete understanding and training, what's appropriate, what's not appropriate and what their health conditions are and what's...I mean, you know, you got to work with their motivation, so you start there. And you try and encourage them to take their medication as prescribed first, and to discuss with their doctor any addiction issues they might have or might have had in the past so their doctors are informed. If they have, you know, kind of, what might be an addiction concern and we might refer them to methadone. Or some patients we've talked to them about seeing a pain management specialist. (1004:071)

Nicole also confirms much of what Lee, Don and Wayne talked about with prescription medication and highlights the increasing challenge of accessing health care because of the associated *stigma* and discrimination client's face when they are seeking services. Nicole states,

So it's, I think, clients with the pain conditions who are taking pain killers for example, often feel they're either, either with or without justification, often feel very sort of discriminated against. If they've had a pain condition for a long time

and they've, you know, gone around to several hospitals or doctors in the course of their condition. If they truly get in pain and they go to a hospital, we've had clients say they were, that they were sort of labeled as med seeking, and so I think there's more, I think there's more stigma attached sometimes to people who have pain conditions if they are in a substance abuse sort of setting especially. (1003:96)

Nicole's thoughts on discrimination and stigma tie directly back into what is legitimate.

Lee also noted the first thing that came to her mind was the stigma associated with being a substance user and having a chronic pain condition.

Well I think the first thing that comes to my mind is the stigma associated with being a substance user and having chronic pain because immediately they just think you are med seeking. And it, it's, that's certainly could be some of that, but we also have folks who legitimately have chronic pain and how do you work around that? (1002:104)

The counselors recognize med seeking could be part of what is happening, but conversely, there are legitimate pain issues with clients. Lee describes a client referred to treatment for potential medication misuse, but who also had significant pain issues.

But when you have somebody that, I mean we get folks who've got, the woman I was talking about who was sent for acupuncture, she walks with a walker. She's got horrible muscle-skeletal. She's had major back surgeries. I mean what do you do when somebody has an addiction and they truly do have need? (1002:112)

As Don and Nicole describe, *treatment options* are limited when working with a client taking potentially habit forming medications. Nicole describes the situation.



And, another big issue if they're in need of residential treatment, often what they're taking rules them out in terms of eligibility for residential programs. And that holds true for, you know, other potentially habit forming medications that they might be taking for anxiety....So it makes it, it kind of rules out a whole avenue of treatment for those clients who might really benefit from 28 day treatment. So we've talked before how it would be great if there was a 28 day program for treating substance abuse and people who had those kind of chronic medical issues, but at this point we don't. (1003:96)

Don confirmed the limited treatment availability for clients who take prescriptions that could be habit forming. It creates a challenge for the counselor to get wrap around services for a client and limits other treatment options. "And so they're different in that they have less services maybe available to them, less options" (1004:099), stated Don.

Medicinal marijuana was also included in the discussion of limited treatment options. Don talked about clients who stated they are using marijuana to help with a variety of conditions including pain and ADHD. Although marijuana is not legal in the Commonwealth of Virginia, people are still using it to self-medicate. Unfortunately, this too creates an access to services issue. Here, Don describes a client who had come from a state that allowed medicinal marijuana and the challenges he faced.

And apparently he had some pretty significant injuries to his back; lots of health problems over the course of his life and he smoked pot for a long time before he was willing to address it. So now he's not on pot and he's actually, his pain doesn't seem to be as great as he imagined it was. For what that's worth. So, but he wasn't willing to give up pot immediately, but I encouraged him to get

evaluated, you know and see. Catch-22. Someone's on pain meds and they're automatically ruled out for residential treatment. This client wanted some services that his marijuana use ruled him out for and so, the question was, could he go to residential treatment? Could he function without pain meds? I can't answer, I can't answer that question because I'm not a pain management specialist. So if you've taken him off the marijuana and you send him to residential treatment, is he going to be in dire pain and not going to be able to be maintained? And some of the treatment facilities are better than others about managing those health conditions and stuff. (1004:071)

The use of potentially habit forming medications, and also medicinal marijuana use, makes *defining recovery and abstinence* difficult. Several counselors brought this issue up in discussing the successes of their clients. Nicole talked about the meaning of recovery and abstinence.

I mean, we have recovery groups and people in those recovery groups who are taking prescribed pain killers and yet they are in a recovery group. So for me a lot of what you have to start with is what is considered abstinence? Are you talking about not taking anything that is habit forming or taking it as prescribed? How do you know if it's being taken as prescribed? (1003:112)

In a client example provided by Lee, she describes a woman who was in recovery who was diagnosed with breast cancer.

The recovery and her trying to work that with her program because she had to be on pain pills, you know, and she's alcoholic and balancing that with what she needed and staying in recovery and being so...the lack of, nobody prepared her

for how physically ill she'd get from chemotherapy. And so she was just knocked off her feet for as long as that went on. So for years, a couple of years of recovery, it was devastating and she also has a mental illness and she had children and balancing all of that and she, well she really didn't, her husband took care of everything mostly and her children did. She was just debilitated. (1002:72)

Fortunately, the client had a lot of family support and was connected to services. The physicians had prescribed some potentially habit forming medication and to Lee's knowledge, she took the medications as prescribed.

In matter of her husband supporting her and monitoring her. To my knowledge, she took the meds as prescribed. There was never a question and she continued to attend AA and really, there were, and her experience in AA was some folks were understanding about her need to be on pain meds and others were, from her perspective, pretty shaming about that. (1002:76).

The client faced stigma within the context of defining what is meant by recovery and abstinence. Some in the group felt the client should not be taking anything, while others were more understanding of the situation and supported her. She continued to work her program and remained sober.

Oh yea, that was a big one for her. Again some folks were pretty accepting, others were you don't need anything. And in her case she needed to be on everything she was on. Then, again she dealt with it by just sticking with folks, staying in therapy, talking about it. (1002:76)

Later on, the client did test positive for marijuana. It is unclear to Lee why the woman tested positive for marijuana; something the woman was not using prior to this moment.

The majority of the counselors also agreed clients using habit forming medications are less likely to have successful *outcomes*. As Lee states, “Well I think for the ones that have to use some kind of medicine that may be addictive, they’re not always as successful as some of the other ones” (1002:132). She continues to explain her rationale.

Well it puts them at higher risk because they are still continuing to use something. They’re not able to be abstinent and learning how to manage that and whatever cravings that may or may not create or problems that creates with them or when their tolerance goes up and they’ve got to take...I think just maintaining that line, if they’re in recovery. Now you got to realize a lot of folks we work with don’t ever reach, you know, they continue to use actively. (1002:136)

Lee also states maintaining a sense of control over one’s health and working the balance of taking medications and recovery can promote success.

I mean it varies, I mean, if the folks who are taking medication and have some sense of control over their health conditions, I think that helps in their recovery; and again vice and versa, you got some sense of recovery, and the principles of recovery and focus on what you can do and what you can’t, what you need to work on, those folks are better all-around too. (1002:132)

However, as Don’s example below describes, the opposite is true for clients too.

Prescription drugs can also lead to relapse if the client is unable to maintain that balance.

I’m thinking of one specific person who had some health issues, injured his back, his mother was doling it (*prescription meds*) out to him. He ended up relapsing, taking pain medicine, getting worse and ended up incarcerated (*information omitted because it was potentially identifying*). So this guy was doing real well,

really stable for a period of time and had a really ugly relapse which was kind of sad. It seemed to be tied in with some combination of pain, chaotic lifestyle, and you know, so I don't know. (1004:111)

Each client and their responses is different depending on the health condition, the medical treatment, and the internal motivation of the client. As Don reflected,

I hate to say it, but it kind of depends. It seems like every individual is a little bit different. So you know, I've had clients I've worked with for a long time who've complained about pain and struggled with, with an on-going basis and have had to take med, pain medication, at least as far as I know; and struggled to achieve abstinence or achieve consistent abstinence. And I think maybe to some degree they're related because I think chronic pain is an issue that if I had an ongoing, I'd probably, you know, "fuck it I want to drink, too much pain today." (1004:119)

As Don demonstrates above, the counselors seem to personally empathize with the struggle of managing a health condition, especially chronic pain. Their ability to empathize helps them identify *strategies* to support, educate and encourage their clients. As Nicole describes,

The most frequent thing that I use is just, is just, just reflective listening...sometimes having people do some kind of rating is helpful as far as how important a goal is or the difference between how important it is and how ready they feel to take the next step. As far as the mindfulness piece, I think, I think sometimes to help people learn that for many people, even pain can pass if you don't latch on to it quite so much. And not having a chronic pain situation, I don't have any way to know how easy or difficult that is to actually put into practice. (1003:108)

Lee could also identify with her clients. Lee states,

But I'm a big advocate of finding, I myself have (*health condition omitted*) and when I started doing yoga, you know I suddenly was able to walk better and my hips improved, so I can say it really does, when you start applying some of these other things, whether it's the mindfulness, these are things I know work, mindfulness, yoga, gentle exercise, what you're eating, what you're putting in your body impacts it. So again, all that holistic stuff. (1002:104)

She approaches her strategies in a holistic manner incorporating exercise and nutrition.

Practice. The thing I do with them, is practice in the office. Maybe not the yoga, we do have the class, but even showing them some of those kinds of moves, talking about it, but certainly the mindfulness. And educating about kind of riding through some of the pain, distracting from the pain, teaching some specific skills for, you know, dealing with it, how rest can make a difference, your diet can make a difference. Those are some things they have control over. (1002:116)

Nicole also states clients find the physical activities and mindfulness strategies provide some relief for clients.

But the physical relaxation kinds of things we do, sometimes people who have pain situations will say, you know, they felt a little bit more comfortable while we were doing some kind of mindfulness kind of meditation activity. So, you know, it might just be a little glimmer of hope that there might be some things that can just provide some respite. I mean for people that, I guess some people's pain is constant and some people kind of have episodes, but especially for people who have that constant pain to just, to know that there's anything that they can do to

just have a little break from it, I think can be something that provides a little bit, a little glimmer of hope. (1003:108)

Alternative strategies are part of providing more intensive outpatient treatment. Nicole states mindfulness kind of activities, relaxation and things of that sort can be helpful for the clients.

Well, I think we, we can step things up in terms of providing a, you know, providing more intensive outpatient treatment. We do a group that's more, that has more of a mental health focus (*name omitted*). And in that group, we do some mindfulness kind of activities and, so sometimes just teaching them some relaxation techniques, sometimes that sort of thing can be helpful. It's difficult. It's really, you know, we would, we would love to have our own designated psychiatrist who treated only substance abuse clients or, you know, have a doctor that we had some sort of contract with. But it's really, it's really, it's really difficult, it's really limiting to, you know, to have certain avenues of treatment kind of blocked off, and then, you know, it's not always easy to know whether, whether someone is taking whatever is prescribed as prescribed. (1003:104)

Educating clients on the dangers of mixing prescription medications with their drugs of abuse is another strategy mentioned by several of the counselors. Laura states,

So it's, it's really about having a good doctor which has been an issue for a lot of clients, sort of having someone who, who understands their addiction, but also educating the client about, about being extremely, you know, extremely, just careful about treating their pain condition. (1005:055)

Part of that education is also to collaborate with physicians. Both Laura and Lee talk about the importance of having a good doctor who understands addictions. Although collaboration and communication with physicians would be ideal, the counselors struggle with getting clients to sign medical releases. When counselors get a release, the next challenge is attempting to connect with the physician. Laura states,

Just framing it in terms of wanting to collaborate and you know, really needing, needing for all of us to collaborate for the best treatment to occur. And I mean usually there's a reason if a client doesn't want a release signed. Usually, there may be some hesitation about not getting their medication anymore because they are abusing it or, or just not seeing it to be helpful. And the other piece is actually when you do get a release signed is trying to get in touch with the doctor. That's, that's, once kind of that hurdle gets, gets crossed, it's usually pretty difficult to get the doctor on the phone. (1005:067)

Lee also works with the client to motivate and encourage them to open the discussion with the physician themselves instead of the counselors having to tell a doctor about a client's substance use.

And how one it could, if you are taking this medication for your depression and you're drinking, they are going to counteract each other or they may, or if you are taking this for anxiety and your drinking it's going to make it, it's more dangerous. Or if you're taking methadone and taking benzos for this, it's more danger...you could kill yourself. Or you're on narcotics but you are continuing to mix it with alcohol. You know, again making sure they understand. And we have no control over that, if I don't have a release communicating that with their doctor, my



preference is the client communicate it and I facilitate that. Not me tattling to their doctor, but trying to emphasize safety. You are mixing some powerful drugs and the folks we're working with, and that's a tough sell sometimes. Cause again, they don't want to let go of their drug. Their getting it, they don't want to lose that and if they are not ready to give up the alcohol, often times most of them do not share that with the physician. (1002:136)

Wayne discussed his strategies working with clients who are using prescription medications. For him, motivational interviewing is a way to open up the discussion about prescription medications and helping clients weigh the benefits and consequences.

I look for opportunities for us to discuss that and pull from the client his perception of cost/benefits, that kind of stuff. But it's not a requirement in our program that you be sober and if that is something that a doctor's prescribing for them, #1: we are not doctors so we can't give them medical advice and #2: you know if a person is not ready, they're not ready. (1001:116)

His strategies are based on the client's motivation and awareness level. As illustrated in the following two passages from Wayne,

But do I use the old model of beating down denial and say, "look you got a problem and I don't give a crap what you say, I know you got a problem." No I don't do that. (1001:132)

And there's times when people are in the action phase when you move out of that and you confront, but that's a different population, like you are saying "Yea, well, I've been sober for six months, but the doctor's prescribed these pills and I do find myself craving them and sometimes taking them when I don't need them."

Then you don't sit around and tease out the ambivalence. You say, "Well that's your addiction, clearly." So it depends on where people are and how you, how I, interact with them as a therapist. (1001:136)

For the counselors, prescription drug use, especially related to chronic pain, was a significant experience in their counseling. The phenomenon adds a whole new level of complexity filled with unique challenges requiring the counselors to be flexible in their utilization of strategies and approaches.

### **Traumatic Brain Injury.**

In addition to health conditions treated with potentially habit forming medications, several of the counselors, in particular Laura and Don, noted treating clients with traumatic brain injuries and other cognitive disorders is also a *challenge*. Lee first mentioned traumatic brain injuries as a result of the domestic violence her clients experienced. Others mentioned traumatic brain injuries as a result of either a work related or substance use related injury (such as motor vehicle collision or other accident).

The primary challenge noted by counselors is the lack of information related to the injury. For example, counselors often do not know what parts of the brain have been damaged or what impact that has on the client's life. As Don describes,

I've had many clients with, well many; I've had a number of clients with head injuries in the past. Those are a bit challenging for us because we don't get a lot of information about how the head injury is impacting them. So we never get neurological studies or anything like that typically. So, even if we request them, it's hard to get that information for some reason. (1004:035)

It was difficult to tease out what was from injury or what cognitive deficits a person had prior to an injury or event, such as an overdose. Regardless of the cause, neuropsych testing or availability of a physician to consult with are things that Don wishes were available.

And sometimes we're wondering what's going on with this client; why can't we seem to be impacting them. It would be nice to have some neuropsych testing for those kind of clients. And then maybe integration of, it would be nice if we had a PCP (*Primary Care Physician*) down the hallway who could see our clients or consult with or whatever. (1004:208)

Laura also brought up how the lack of information is part of the challenge of working with clients who have some sort of brain injury. For her, she approaches a client with a head injury a little differently than other clients. She states,

Well, with traumatic brain injuries, I certainly don't know as much as I would like to know. And it's just so complex because we don't know what part of the brain was affected when it was injured and exactly how it's manifesting itself. It's really hard to tell whether someone had a deficit to begin with or is it the brain injury that's causing some deficit. So I feel like traumatic brain injuries I approach a little bit differently in that they seem a lot more complicated and you're sort of always have to, you always have to kind of pose that question, you know, can this be something related to the traumatic brain injury? Was this present before? Is it something new? (1005:087)

Part of her strategy is to pace therapy differently than maybe the pace she would use for another client. Here she reflects on one particular client.

I find, I'm thinking of one particular client, I find that you sort of end up kind of going over the same things sometimes. You know, you sort of you, you, pace things differently. Always kind of keeping in mind that, I mean and that's with anyone, you would pace things for sure. But you kind of pace things according to how much the person can absorb. (1005:091)

The presence of traumatic brain injury is something not considered when the project first started. Both prescription drug use and traumatic head injury support the need for integrated care and greater collaboration between medical providers and substance abuse treatment facilities. Information from neuropsych testing and physician consultation could provide additional resources to counselors to aid in treatment planning.

### **Super-Ordinate Theme 3: Roles, Responsibilities and Strategies (Research Question 4)**

*Counselor roles and responsibilities have expanded and adapted to incorporate a host of strategies building a more holistic view of treatment.*

Table 6 provides an overview of the most prominent issues identified during cross-interview analysis with the interviews quotations and reference to the individual interview themes.

#### **Roles and Responsibility.**

As super-ordinate themes 1 and 2 demonstrate, substance abuse clients with co-occurring medical conditions face a lot of various challenges in their quest for recovery. Within the journey of substance abuse treatment, the counselor plays a key role in identifying issues, figuring out how they relate to one another and then deciding the best course of treatment, all while keeping the client's needs and goals in mind. In speaking with the counselors, they expressed how their

Table 6

*Super-Ordinate Theme #3 Sub-Themes and Key Words*

Keywords	Quotes	Referenced Theme
<b>Sub-Theme 3a: Counselor roles and responsibilities have expanded over the years as counselors take on more responsibility for client well-being.</b>		
Roles and Responsibilities	1005:195; 1005:195; 1003:166, 1003:166 1002:152; 1001:160; 1001:194: 1002:140; 1002:140; 1002:144: 1002:140; 1002:144: 1002:144: 1002:152	1001 - #4 1002 - #3, #6, #7 1003 - #6 1005 - #6
<b>Sub-Theme 3b: The key to providing SUD treatment counseling is the development of a healthy relationship between the counselor and client.</b>		
Relationship Building	1001:168; 1001:188; 1001:194; 1001:206; 1002:140	1001 - #5 1002 - #6
Goal Setting	1003:092; 1003:092: 1003:116; 1004:167	1003 - #3 1004 - #4
Empathy	1003:162; 1003:162; 1003:124; 1003:174; 1003:178; 1004:163; 1004:171; 1005:115; 1005:107	1003 - #1 1004 - #4 1005 - #2
Lifestyle Changes	1002:056; 1002:056; 1002:072; 1002:076; 1002:076; 1003:116; 1005: 123; 1005:083	1002 - #2 1003 - 116 1005 - #2
<b>Sub-Theme 3c: Counselors utilize a mix of holistic and evidence based strategies to treat the client holistically.</b>		
Strategies	1002:056; 1002:064; 1002:124; 1002:064; 1004:147; 1005:177	1002 - #3 1004 - #4 1005 - #2

*roles and responsibilities* expanded to adapt to the needs of the population. Laura describes how she views her responsibilities and the honor she feels working with her clients.

I take my responsibilities pretty, pretty seriously. You know, it's, it takes a lot of courage to be in counseling and address some of these things, and so I don't take things lightly. And, you know, if someone's working on their issues, it, it's an honor for me to be there for them. And so definitely, and when I say I don't take

things lightly, I recognize my own limitations and I recognize where I still need training and I recognize my strengths. And so, you know, knowing when to, when to ask for, when to consult with someone else, knowing sort of, knowing my strengths and limitations is really important. (1005:195)

Laura talks about how important being able to identify her strengths and weakness are.

Compared to the counselors who have been in the profession longer, they acknowledge how their role and responsibilities expanded to include more of people's welfare. Nicole explains,

I feel like it has changed. I think in my agency, as time goes on, I feel responsible for a larger portion of people's welfare. Anything that I'm not able to provide, I feel like there's an expectation that I know where to direct them and especially when there aren't many resources to direct them to, that, that's stressful. And I'm thinking of things like medical care. I'm thinking of things like shelters in the particular county (*omitted*). I'm thinking of transportation. So, I think when I first started, you know, the substance use was sort of, it was a specific target and I think as time goes on, it feels like the target is much more, is much more far reaching. It's not only treating the substance use, it's also helping them to access resources at a time that it feels like there are fewer resources than when I first started the work. (1003:166)

In this context, Nicole talks about how her substance abuse counselor role changed. As she describes, it is more than just providing therapy, but also case management "because I think that the, the therapist and the setting that I'm in is really expecting to be looking out for a whole lot of things besides just, you know, the substance abuse piece" (1003:166). The other counselors agreed case management has become a significant responsibility in their field. As Lee states,

That the job is going to entail a heck of a lot more case management than you think it will. Most of us signed up to be therapists, but because of the nature of the work now a days (*site identifying information removed*), its case management. Helping people access services and linking with this, that and the other because again, nobody comes in most of the time with a simple little thing. (1002:152)

It is important to note the expansion into case management is an adaptation. Most individuals who go to school to be substance abuse counselors are trained to provide therapy. However, given the complexity of client's lives and understanding there are other competing needs, some level of case management is necessary. Wayne states,

I guess my expectations of the gains that we make in therapy are different from when it was 5, 10 years ago. I, you know, my primary role I see as a therapist is to provide therapy. What I've had to adapt to is doing more case management stuff to try and get people access to these things that will support them so they can focus on what we need to try to accomplish in that therapeutic relationship. (1001:156)

Wayne further clarifies how case management has been incorporated into substance abuse counseling and how even the therapy has changed to meet the clients where they are.

You jump out of school thinking you have a great deal of power and the older you get you realize the best thing you can do is just have a healthy relationship that encourages, supports, and builds on a healthier lifestyle. (1001:194)

Wayne further discusses how roles have changed.

But the question is, how has it changed? The changes have come to adapt to the populations. With the individuals that I work with now, my approach, as we

talked about earlier, has moved more from, moved away from the sophisticated, the more ego psych type of skills that you focus on to help people grow emotionally, psychologically to a more basic, developing the relationship. And once you have that, encouraging, supporting, pointing towards the areas of their life that will help stabilize the goals that they want to accomplish. Cause it just doesn't do any good to get somebody to quit drinking when they got nothing else to fall back on. (1001:194)

Wayne illustrates the client needs something to fall back on to continue to be successful in recovery. This could include employment, social support, getting medical conditions treated, etc. In addition, there is a level of hope the counselors try to give their clients. However, the people they work with don't necessarily have a lot of hope. Lee states,

You know the people we work with don't have a whole lot of (*referring to hope*), not all them, but they, but my guess is, my knowledge is they've tried and tried and tried. You know, in some way or another, they know what's going on for the most part. They know their life's not working, but believing they can make a change. Then our problem is access, getting in quick enough. (1002:140)

Again, their role to help clients find hope, to encourage and motivate them to make changes can be impeded by the ability to get clients into the services they need. Just as clients get frustrated and discouraged due to access issues, the counselors too get discouraged. Therefore it is important staff also remain hopeful.

Catching them while they're in that mode to look at that and it's our job I think, as clinicians, to motivate them, help them to find the motivation and the willingness and to believe that it **can** (*emphasis added by participant*) get better. That's the



tough part. It doesn't have to be like this. That just brings me, when I say about clients, that's a piece where you also got to have staff believe that too. Because we get so mired down in so few successes, whatever you want to define as, stories where somebody actually does move on. We have them, but compared to the number who just come in because probation made me and I got to do this and I don't want to change anything, it's real different and so keeping staff immersed in the idea that really people do get better and they can and there are some things they have some control over and it's our job to help them identify it and work on it. (1002:140)

This leads to another part of the counselor role which is to build client self-efficacy. Lee talked about how important it is for clients to do the work, "to find the power within them to do the things they need to do to feel better" (1002:144) and to recognize they do have some control over their lives. Lee talked about a study she read recently discussing how quality of life improved for people who maintained recovery.

I just read a study, I tried to send it to somebody at work, it's too big, that looked at the benefits of recovery versus the cost of addiction which we are well versed in. This showed, it was really neat, the stuff we know, but that when somebody's been in recovery, in active recovery for three years, you see more paying taxes, they got a job, their doing this and they're connected and they're, they're, and this many years, they go do this and it's like WOW! I mean that, we really, that's the kind of data I want to be giving clients versus here's, you know, showing them honestly, if you can rather than, well you're drinking all these years has done this, this, this, you know, it just like there is hope. (1002:140)

Once the client has identified what they need to do to reach their goals, the role of the counselor then is to support them and encourage the healthy things the client does. Lee states,

That being respectful, asking permission, trusting. They truly do know what they need to be doing; and my role is to help them, if they want, bring that out. And I do trust that and honestly people aren't going to do anything they don't want to do anyway. (1002:144)

Counselors recognize clients have a responsibility to themselves to do what needs to be done. Ultimately it's the client's decision whether or not to follow-up with medical care or access services, or change their environment or behavior. But success does happen and it is about honoring the work clients do along their journey. Lee says in her interview,

I don't have any control over what my clients decide, unless it's a crisis situation. And if you are working in this field, be prepared for not a lot of big, big successes. That it's a success when so and so comes in and tells me, "hey I've been sober for a week" or "I've been sober for two months" or "I've been..." and then the next day they might go out, but you don't take that two months away from them. You know, honoring the work they do and how difficult it is. (1002:144)

Lee describes how the counselor needs to see the whole picture and how changes in one area impact another for the client. Lee states,

Again, I have the deepest respect for somebody who can come in there and I don't care if its two days sober, but can come in there and try that. And again and look at all aspects of their life that have to change if I'm going to give up drinking because that might mean, I'm going to have a problem with my boyfriend or my

husband or; so it's not as simple as thinking I'm just stopping. You got to the look at the whole picture and the impacts. (1002:144)

### **Relationship Building.**

A large part of helping clients develop hope and self-efficacy is in *relationship building*. As Wayne describes below, sometimes clients come in thinking a counselor has something that will suddenly make them better.

I have to develop a relationship with a human being that has never met me before; that may not have a whole lot of hope that things can be much different, and may think I have some magic pill or phrase that I'm going to say that's all of the sudden going to make them feel better. (1001:168)

However, as Lee states, the process to recovery is slow whether you are working with substance use, medical conditions, or both. It is a process needing to be treated holistically and with patience.

It would be nice to be able to improve the access, remove whatever obstacles are there and if they still don't want to go, then that's on them. But us making that a little bit easier and maybe health care reform will do that. I don't know. Just to remember to treat it, like I said, it's a holistic approach, it's not a one this will do it. And helping folks stay patient with, that it's not a short, this is not a short two, three session. We are talking about asking folks to make lifestyle changes. Whether it's their addiction or chronic illness and that is a slow process. (1002:140)

It is also a process by which counselors look to build upon smaller successes. Smaller successes build the relationship. Wayne gives us a perspective on the process and how it is connected with the role of the substance use counselor.

You develop a relationship with people and they begin to trust you and they're willing to step outside of their comfort zone because they trust what you are telling them are true. They start feeling a little better when some of this stuff happens and that builds on it; it's almost a contingency management kind of thing. You get some positive out of the advice, I'm willing to do some more. And it's always best when it's their idea even if it wasn't. (1001:188)

The counselor is flexible during this process and stays client-centered. This results in gaining a better understanding of the client, their definition of recovery and their strengths.

Wayne describes this process in his interview.

So you kind of have to throw away some of the stuff you typically would say, ok these are some basic one, two, three of what recovery is. And as we love to say in social work, meet the people where they are to really develop the relationship, understand what strengths they have, what...where they want to start and what they have to start with. And then have simpler basic goals as compared to the big goal. (1001:194)

Wayne emphasizes the counselor expectation also must be one that matches with the client. "So if my expectation is that they want to get sober and I want to help them get sober; I'm never going to have a good relationship with them" (1001:206).

Nicole discussed how she uses smaller goals (*goal setting*) to help clients reach larger goals. She describes often clients will come in with some pretty big goals in mind. Her approach is then to break those down into smaller steps.

My, my newest catch phrase is “think small.” Which is, a kind of against the grain for, I don’t know, for our culture in general. You know, we are kind of taught to think big, think big. But getting them to focus on something very small and manageable is sometimes helpful because if you make it small enough and if they carry it out and accomplish it, then it helps to build some feeling of confidence that they can, you know do something a little bit bigger. (1003:92)

She continues to describe the difficulty in getting clients to think about smaller steps and complete those steps.

But a lot of times they, their version of thinking small is still something pretty big. So getting them to kind of think about just the next thing they can do in terms of a phone call, you know, asking, asking friends if they have a physician they can recommend or that type of thing. It’s, it’s hard for people to think small apparently when they are so used to thinking, you know, in much bigger terms. (1003:92)

Nicole talks about using this strategy with medical care issues and how sometimes it is about figuring out what they want to get out of the next appointment or making another call. Here we see the balance again between the role of substance abuse counselor and medical provider.

Well I know one thing that I do is to help them think about what it is that they want to get out of maybe the next appointment, for those that have a doctor. You

know, writing down questions that they might have. Having somebody go with them if there is somebody whose, available to accompany them to an appointment. So I'm not really providing the medical information, but I'm helping them to come up with strategies for how they can get information that's needed. (1003:116)

Don also uses a similar strategy. As he discusses below, client motivation is an issue, especially when the system is complicated and it takes time to get the services.

Well motivation is always an issue. You know, I mean, the client has to want to get, you know, you can encourage and encourage, but if they aren't willing to address it, it's not, if they don't see it as an issue, then that's going to interfere with their ability to follow-thru. And the harder you make it, you know, the more their motivation comes into play. Like if I have to call (hospital name), get down there, fill out a financial paperwork form, you know, to qualify financially and then wait months for my PCP to be assigned, so I can get a card so that I can go see the doctor on a regular basis and then I can access testing and health care that I need through the whole system. That takes a sustained level of motivation to do that. So it sometimes requires repeated encouragement at each step and lots of praise and affirmation when they do things that, you know, might benefit them. (1004:167)

Part of the relationship building and developing trust relies on a counselor's ability to *empathize* with the client and what they are going through. Some counselors noted that they have personal experiences with medical conditions and others have gained a better understanding as they have matured. Don reflects on his personal experience,

Well I try to be empathetic and understanding about health problems. I'm, just from an individual perspective, I'm a person who had a lot of serious health problems at a young age; so can identify with what it's like to be, you know, how valuable your health is and how difficult it is when you're not able to do things you want to do or not capable at that moment to do the things you want to do and stuff. So I think I bring a level of understanding and empathy. (1004:163)

In addition, Don recognizes his educational background has also helped him gain a better understanding of the impact medical conditions have on a person's life.

You know my training is in rehab counseling, so I'm kind of glad about that in some ways. Because one of the things we had to take is a lot of medical information and to understand the impact of chronic health problems in someone's life. So I think I may have gotten more of that than some of, maybe someone who went through the MSW program or something or any other kind of counseling program. So in a way, I, I, I am maybe sensitized I guess to that. And so I mean, you know, I think from my perspective that again I'm a whole health kind of person that, you know, you've got to address all the issues in order for someone to have the best quality of life that they can have. And so, if people aren't seeing the doctor regularly, if their diet is shit, if they are chronically obese or whatever the problem is, if they are not at least seeing the doctor on a regular basis, you know, for an evaluation, checkup or whatever, then they may not be as healthy as they could be and that might affect them down the road. (1004:171)

For other counselors, their understanding comes from maturity in the field and their dedication to providing a holistic treatment plan. Nicole reflects,

I think just in terms of, in terms of kind of the whole person concept that recognizing how important somebody's health is to their general well-being. And maybe, and maybe, because I've obviously been there 25 years, so I've aged as a I've been there, and so maybe that's something that's a little more, that I'm tuned into a little bit more than when I first started and was very young and didn't, and really didn't have any, not many ways to relate to physical problems that people were having. The aging process helps you to kind of get a little more in touch. (1003:162)

This sense of empathy helps counselors understand how health conditions impact their client's life. Nicole states,

So I think just being aware of how important people's health is for their, for their general well-being and I mean that gets, when that gets messed with, when that gets disrupted, it just, to recognize how, how far reaching it is in terms of how they function in terms of how they interact with other people, in terms of how they see themselves. (1003:162)

For substance abuse counselors this means understanding how it impacts a client's ability to participate in treatment and not being afraid to ask questions.

I guess I've just developed a better understanding of how the physical condition kind of interacts with other problems that people are having. I think about chronic pain, when people are in chronic pain they are often irritable. They often don't sleep well, and I think as I've, you know, as I've been a counselor longer and longer, I start hearing from them a little more about how a physical condition



affects a lot of aspects of their lives that I wouldn't have really known about and I probably ask more questions about things I'm not familiar with. (1003:124)

As Nicole and Don described, it is important to be aware of the client needs and provide environmental accommodation.

The other thing, I just thought of that we do when people, when we know that somebody is in pain, although people don't often feel free to do this, we, I always tell them, please stand up if you feel like you need to stand up. Feel free to walk around. We've had a few people in groups that we've said, that if you need to, if you need to leave and walk up and down the hall or do you need a different chair or just doing whatever you can to accommodate them just in the little, just in the amount of time they are with you. And also to communicate that, you know, that you respect the fact that they may have a different need during the course of the hour than people who are just sitting there comfortably, relatively comfortable. You know, having something as simple as a having a decent chair for them to sit in. So some of that is more of an environmental accommodation I guess, than it is really related to your counseling, but it's kind of important too. (1003:174, 178)

Making accommodations demonstrates counselor awareness and understanding of what the client may be experiencing. This may mean a client is unable to complete a treatment session. As Laura discusses, the clients are motivated and want to work on their issues.

I mean there's, and that's kind of the sad part is people, people really do try and they'll come in sometimes sneezing and really sick and it's like, no it's really better to go home. So, you know, you just have to kind of gauge it. But sort of when I'm sitting there thinking about it, just, I mean this has got me thinking a

little about the fact that a lot of times I think my clients are not feeling good physically anyway and so, I don't know, the work we ask them to do (sigh), it's just amazing that they even do it. (1005:115)

Here we see Laura's awareness increase regarding the level of impact health conditions have on her client's ability to engage treatment. She continues to reflect,

The clients we see are not, generally are not healthy. And so when you're struggling with a health condition, you can't be fully present to, to address emotional issues. And so even though there's times where people will come in and say "I'm just not up for it, you know, I didn't sleep well" and so we'll have short session. But even in a more subtle way, it's difficult to address emotional wounds when physically you're not, you're not feeling good, or you're not healthy. So even on the days where it's not so over, when someone comes in and says "I'm sick and I can't do this today." I think it does affect it even probably more than, even more than we think. (1005:107)

The level of counselor awareness and understanding contributes to their ability to assist clients in adjusting to the *lifestyle changes* a medical condition may require. As Lee describes, part of her work is to help clients adjust and accept a diagnosis.

I think part of it is the adjustment and kind of working with accepting the diagnosis. What does that mean? Lots of education and support around that, looking at the impact on the family, their job, the resources that, you know, I think a lot of our women don't have access to transportation; so they don't have some kind of Medicaid or somebody who can drive them, getting to the resources. (1002:56)

Acceptance often involves working through the shame and guilt of how their substance use may have contributed to their medical condition and grieving of the loss of life as they once knew it.

And with the substance use, and I think some of it comes to grieving, is that how they ended up contracting the disease? Is that part of it? Reminding folks about just the risky behaviors that some women are, the prostitution they have to go through, and again, helping them not beat themselves up. Because, you know, their addiction led them to a lifestyle that put them in some danger. And some of that stuff, our women feel powerless to ask a man to use a condom, to really push that. I mean, they don't have, when you are in the midst of that, sometimes you don't have that choice. (1002:56)

This particular aspect of working to help the client accept the diagnosis and make lifestyle changes involves helping the client move beyond shame and guilt and start focusing on what they can do now. Lee states,

Well, maybe some shame and guilt. I mean, they could, they can get stuck in blaming themselves. I mean, what did I do with my life? I, really again, not entering that, helping them to grieve that's; it's a workable issue; that the treatment again, that it's a process of grieving. Yes, it's the consequences of your addiction and what are you going to do about it. You know, you can't, you can sit here and wallow in it and kick yourself and go "oh my God," and you can decide you need to do something about it. So it's a balance of both helping them grieve, let go of that guilt, stop beating themselves up and then also what are we going to do about it so you can live as a quality of life as possible at this point. (1002:72)

Nicole mirrored Lee's description by stating in many ways their role is to help the client figure out what was in their control to do and then support them through the process.

It's, it's not, it's not totally unlike the substance abuse work in a lot of ways because you're just helping them figure out what, what's within their control to do and helping to support them, taking a step and kind of checking in with them and providing feedback, if that's appropriate about, you know, that they did a great job. That, you know, there might be something else that they might want to keep in mind whenever they kind of take the next step. (1003:116)

Returning to Lee's client who had breast cancer, the medical condition took a large toll on the client. As Lee described,

She was just debilitated. Doing much better now, but that's still an issue in terms of how cancer changed my life. That's still a theme and it's been, she's maybe at the five year mark, I'm not sure of where she's at. And a shift her total life went when she got that diagnosis of breast cancer. (1002:076)

To work through the changes that occurred in the client's life, Lee utilized art and writing to help her gain power back over her health.

The cancer, she started writing, encouraged her to just kind of draw, do mandalas and kind of communicate and to begin writing a book of her story in terms of what nobody prepared her for with cancer; and kind of gaining some power over that and what, how it took, changing my life and then what I wish I knew then that I know now. And so trying to get some power back. (1002:76)

## Strategies.

Table 7 illustrates the vast tool kit counselors mentioned they utilized to assist in their counseling.

Table 7:

### Strategies

Strategies		
<b>*Note: Some strategies may be components of other strategies</b>		
Music	Art Therapy	Acupuncture
Cognitive Behavioral Therapy	Contingency Management	Collaborative documentation
Coping Skills	Dialectical Behavior therapy (DBT)	Eye Movement Desensitization and Reprocessing (EMDR)
Education	Exercise	Grief and Loss
Motivational Interviewing	Mindfulness	Relational Model
Skills Building	Self-Care	Guided Imagery

As the counselors have mentioned throughout their experiences, they utilize a holistic approach to address the different aspects of a client's life. For some clients, they are successful in their journey to recovery and are able to manage the challenges medical conditions present. As Laura notes,

I think we look at things in this society sort of in a Band-Aid way. You know, something's wrong and we put a Band-Aid on it as opposed to prevention. And in that, you know, when you talk about substance use, even though we, I think we've done some great strides forward as far as how we treat substance abuse. I still think we have a long way to go in that, there's still isn't a focus on, you know, how our physical, mental, emotional, spiritual health kind of is all connected.

(1005:123)

The mind, body and spirit connection provides the foundation for counselor's to build and integrate strategies into the client's treatment plan.

Well I'm a big believer in sort of the mind, body, and spirit connection. And, so you know, I think once again, everything is connected, and for whatever it is that we are putting in our body is going to affect how we are feeling. And so, I try to approach, and health conditions kind of, manifest themselves when there's an imbalance in any of those things. And so, that's kind of how I approach it is really looking at all those different pieces. (1005:083)

As Lee describes,

So the work is getting them engaged in services, staying in services so that again hopefully addressing the SA where they are taking better care of themselves. The other challenges have to do with the, you know, your nutrition, your health, your exercise, just your whole body. Learning that lesson of taking care of yourself is not often an easy one or getting somebody in the habit of improved self-care. And what a difference that makes in whatever disease, or whatever you got going on with it whether it's the substance use or HIV or hepatitis or whatever. (1002:56)

Self-care also extends beyond their nutrition and exercise, but also learning to be assertive and setting boundaries. Lee states,

Some of it again is good self-care, is learning to be assertive, set some boundaries and sometimes that might be one that they can take a little steps in. Watching your smoking. How much are you smoking? You know, hooking them up with smoking cessation stuff. So yes, very much that the treatment, at least I try to do it, the team too, is it's a holistic thing, you look at the whole person and their body

and everything. Hopefully, if they can't do it right now, introduce them to some different concepts and I think we do a pretty good job of bringing stuff there to them. (1002:64)

Counselors are able to provide tools clients can use through their recovery process. Often they will combine tools and skills to assist a client in both their recovery and managing a medical condition.

I'm trained in guided imagery and music. I'm trained in EMDR (*Eye Movement Desensitization and Reprocessing*). The one though, I probably use the most is DBT (*Dialectical Behavior Therapy*) skills. The way that particular, Linehan laid out those use of skills. I talk about distract skills, emotion regulation, emotion, I mean just interpersonal effectiveness, mindfulness, that whole...I use that a lot with clients, the tools of using a diary card, that kind of take a snapshot of your day. What is going on emotionally, physically, your meds, any alcohol use, stressful situations and those, I find those tools very helpful because they are concrete and if the person is willing to use them, they work. (1002:124)

Laura states when she is working with a client, if emotions come to the surface or something else comes up, they work on the issue at that time. She states,

Well, I do a lot of sort of body work, and so the mindfulness and the music and the art, and the EMDR and all that stuff you know, when we're working on something and someone has something come up for them physically that's what we do, we, we work on it right there. (1005:177)

Having alternative strategies available to clients such as acupuncture and ability to offer walking groups and yoga, empowers the counselors too. It gives the counselor's options to mix and match therapies to fit the client needs. As Don describes,

My favorite approach is the CBT approach. I think about things in terms of, you know, not awfulizing, creating, you know, the worst out of situations. Trying to see things in perspective, I guess. Maybe thinking about a time when things were better and what their strengths were like then and how those might apply to the future. I mean I've done a lot of, you know, I mean, some clients I do, sleep problems and stuff, done meditation, progressive relaxation training. (1004:147)

Again, the counselors can offer these opportunities and introduce clients to new concepts, but it is up to the client to act on them. Lee described a women's group who were very responsive to being introduced to things like how to eat healthy on a very tight budget or to do yoga. However, as Lee notes below, being responsive is different than action.

I think being responsive to it and actually making some changes are two different things and that's where the MI might come in; working with them or adding some incentives to do some, like we added a yoga group and we're encouraging the ladies to do yoga. We've done walking groups. We've done, you know, I mean, it is, that's the piece that yes, it sounds wonderful, but, "I don't have the money to eat healthy" and so again, that's part of what the new group that we educate about how to do that on a tight, tight budget. Like I said the response is often positive, being able to do it are two different things. (1002:064).



## Super-Ordinate Theme 4: Preparing Future SUD Counselors

*The SUD treatment counselor's experiences shed light on where additional education and experience can increase the readiness of future SUD counselors.*

Table 8 provides an overview of the most prominent issues identified during cross-interview analysis with the interviews quotations and reference to the individual interview themes.

Table 8

### *Super-Ordinate Theme #4 Sub-Themes and Key Words*

Keywords	Quotes	Referenced Theme
<b>Sub-Theme 4a: Counselors need to remain hopeful and take care of themselves to avoid burnout (self-care).</b>		
Counselor Self Care	1001:224; 1001:206; 1002:152; 1004:183; 1004:179; 1004:179; 1005:203	1001 - #6, #7 1002 - #7 1004 - #7 1005 - #7
<b>Sub-Theme 4b: The assessment is a living document changing over time.</b>		
Assessment	1001:220; 1002:231; 1002:152; 1003:170	1001 - #7 1002 - #7 1003 - #7
<b>Sub-Theme 4c: There are multiple topics counselors would appreciate more education and training in, including trauma, pain, and grief and loss.</b>		
Other Education	1002:156; 1003:194; 1003:170; 1003:186; 1004:200; 1004:192; 1004:199	1002 - #7 1003 - #7 1004 - #7

### **Counselor Self Care.**

“And you know clinicians are human beings. They have good days. They have bad days.” states Wayne (1001:224). Through the three themes we have gotten a glimpse of substance abuse

counselors' experiences working with clients with co-occurring medical conditions. There are numerous challenges they face with their clients. There is also a great amount of honor and respect counselors have for their clients and the work clients do. Based on their experiences in the field, they offer insight on how education can help prepare future SUD counselors. As Wayne points out, substance abuse counselors are human like everyone else. In addition, because of the complexity of client's lives and the challenges they face, counselors are also prone to burnout. Several of the counselors offered advice on how to limit burnout.

As Don states below, it is important to remember the successes clients have during the course of treatment, even if that success is not the ultimate goal.

Then, I mean, I think if you see everything in terms of whether they're completely sober and clean or not, that would make, could make for a pretty depressing career because the majority of people that I see are not going to stay sober forever and ever and ever from the day they walk in my door for the first time they've had substance abuse treatment. And you know if they can get off the heroin, but they're still smoking some pot, well I'm glad that they are off the heroin, you know. Ideally, I want them off the pot too, but I'm glad they're off the heroin. You know what I'm saying. (1004:183)

This idea of redefining what recovery and abstinence mean has resonated throughout the analysis. Wayne captures this in his statement regarding ethics. We are so fearful sometimes that we may negatively impact a client, that we need to let go of some of the fears and focus on what the client wants.

But if you are working within your ethics, the ability to do harm is, many young counselors spend many nights worrying about, "Oh my God, did I do the right

thing? Did I destroy this person?" It just doesn't happen. So let go of some of those fears and the other is you got to figure out what the client wants before you start trying to help them change; because we make a lot of assumptions when people come into therapy, that since they are coming to a male substance abuse unit, clearly they want to get sober, right? Nah...it may have nothing to do with why they came in. (1001:206)

As Don stated in his interview, sometimes you plan your interventions towards building skills for clients to use further down the road. He illustrates this through a story he told during the interview.

I was telling someone I was providing some supervision to today that sometimes when I'm counseling, I'm not thinking about how this intervention is impacting the person today, I'm thinking about how this is going to impact them 3 years from now, 5 years from now. That a lot of times, you know, you can only work with where the person is; but you're hoping that, you know, this intervention is a stepping stone to the next intervention, to the next intervention, to the next intervention. That if you think about substance abuse as a chronic on-going problem with, there are going to be many interventions. Then you know, if I think about myself preparing someone for the next one and the next one, not that I'm trying to cop out of this intervention, but just that I'm trying to raise people's awareness so when they come back the next time they have more tools, more skills, more understanding to take more advantage of maybe more intensive or more disease focused, more action oriented level of treatment. That's a good way to look at it, because I don't feel like I'm failing as much. (1004:179)

Don continues by saying,

So to think about it, you know, what you're doing is part of a larger continuum and that success isn't measured in whether people are sober today necessarily, but if they're quality of life is improving. If they're doing some things better, if they are doing less harm to themselves, that's a successful intervention as well. (1004:179)

Lee also reinforces the notion of how it is important to stay hopeful and take care of yourself regardless of whether or not clients make their recovery goals.

To take care of yourself. Know, teach about burn out long before they ever start because you are dealing with folks that don't often, at least in substance abuse, where you may not see a lot of folks get sober and stay sober. It's cyclical to people, they come in and out of that. And don't do it if they (*the counselor*) can't stay hopeful. (1002:152)

For Laura, that includes recommending people engage in their own counseling process. First, it gives the person the experience of what it is like to sit on the other side of the counseling session, but also to work through one's own issues.

Do your own work. Do your own personal work. There's no way that I could be a good counselor or I believe that no one can be a good counselor until they've done their own work. It's so, it's so emotional and it's so heavy at times that it takes work to stay, you know, grounded; to stay clear; to know your own issues and having moved past them. I think it should be a requirement for people going into this profession to be in their own counseling process. To be doing whether it's counseling or something else, you know, to do your own work. (1005:203)

## **Assessment.**

Another aspect the counselors emphasized for education and training is the assessment process. The majority of counselors stress the assessment is a living document changing and evolving from the first visit to the last visit. Wayne states,

It (*the assessment*) is a task that you complete before you can get to therapy and want, I would want people to learn from what I'm saying now, encourage people, to see that as a living document that begins the first day and continues to grow and is constantly referred back to with both the therapist and the client; because it changes and as people grow in that relationship. They say, "You know I really wasn't honest with you there, this is something" and it needs to be an ongoing thing instead of this task we complete and then move on. (1001:220)

As Wayne notes, the assessment can build the relationship and holds a very powerful tool to recognize an underlying issue or feeling.

You are seeing twenty some people and you are not referring back to it, you know, you just say, "Ok, what's going on with you today? Are you taking your medications? Are you still sober?" Instead of, "Remember when you said it was really hard, I noticed you are having some trouble with sadness and about a year ago you said you lost your mom and you never really grieved that. I wonder if that's still affecting you in any way?" Number one, that is one of the most powerful tools in the world when people say, "Oh, you remember that about me?" All of the sudden they become important to somebody and, "hmmm I hadn't thought about that for a while, but I, you know, I saw somebody the other day that reminded me of my mother and really had this big urge to drink." Then you got a

chance to talk about how emotions relate to this need to want to change the way you feel. (1001:231)

Although the assessment process is taught, Wayne stresses understanding why we ask the questions we do and how it builds to getting a larger view of the factors impacting a client's life. Nicole, although not mentioning the assessment specifically, provides an example of this.

I think paying attention to things beyond your own little area of focus. So it's sort of like being the, the, in a mental health sense, a substance abuse sense, being more like the general practitioner than the specialist. So asking about things like do you have any medical conditions? Are you in pain very often? Do you sleep? So maybe broadening what you ask people instead of just the, what do you use and how often? How long has it been going on? I think it's important to find out how, how people's bodies are cooperating or not. (1003:170)

The other important piece is for counselors to get experience in the community. By doing so, new counselor's gain more knowledge of what people are dealing with. As Lee states below, one does not need to be an addict to understand some of the things that addicts face.

The more you can get out there and actually work with folks, get exposed to some good placements and go out especially if you are going to do SA. Don't try and go out into SA without some exposure. You don't have to be an addict or an alcoholic, but you know, go to some AA meetings, get out there and immerse yourself in some of the things. (1002:152)

### **Other Education.**

Along the same lines of immersing oneself in the community and extending your knowledge beyond just substance use, the counselors advocated for education across disciplines

to increase information sharing and building a larger base by which to draw understanding. Don states,

So I'm thinking that sometimes taking classes across departments is kind of a cool thing...overlap those resources and may get people to think how in rehab counseling, you know, you might benefit from some information from pharmacology and vice versa and sharing information back and forth. (1004:200)

In addition, several counselors advocated for education related to topics that are becoming more prominent issues in substance abuse treatment like trauma. Lee states,

Knowing, I think more teaching about trauma and trauma informed services and how many people, that's a real gap in terms of not recognizing the effect that has not only in a woman, but in the rest of the life, if that's not addressed. (1002:156)

Another topic is grief and loss. Clients face a number of losses in their life and go through a grieving process similar to how people lose a loved one. Nicole states,

I think providing some information about grief and loss. I think, I think that ties in because I think medical conditions are, a lot of them represent a type of loss to clients. Yea, when people think of grief and loss, they think of people usually passing away, but for someone who's worked for 20, 30 years and has become disabled or has had an injury or something who can't work, that sort of sets in motion a whole series of losses. The loss of the job. The loss of their identity as working person. Maybe the loss of their ability to do certain things, you know, as leisure activities because they may not have the money to do that. (1003:194)

Lastly, some counselors emphasized the need for more education on chronic pain. As Nicole describes, it is not about becoming an expert in pain or pain specialist, but to have more information about the effect of pain in a person's life.

I think to have some, to have some information or during your educational process to, to, to, learn some things about pain, in terms of how it affects people. Not to become a pain specialist, but to, but to just appreciate how, how that shifts a lot of things for people from like the time they wake up to the time they go to bed. And maybe, maybe at the time they go, you know is when it's actually when it's worse for them so. You see them at 9 in the morning, they may not be very cheerful. (1003:170)

It is important to note the education suggestions from counselors go beyond just graduate school education, but continuing education as well. Continuing education is utilized by the counselors not only to keep their licenses up to date, but to keep them up to date on new interventions and changes in the field. Don commented on the recent loss of the Mid-Atlantic Addiction Technology Transfer Center (ATTC) located in their area.

I'm really sad that the ATTC isn't located here in (*area omitted*) anymore. I just feel like something has slipped a little bit as a result of that. But, I think that the trainings that they offer and some of the resources that are available, like those CSAT TIPS and stuff are a pretty cool idea. (1004:192)

Counselors are now provided education and training by Central East ATTC located in Maryland. The utility of having centers dedicated to providing continuing education and tools needed to implement evidence based interventions is a primary way for counselors already in the field to stay up to date. Don states,



I mean, I think one of the challenges I have, I've been doing this for a while, is maybe keeping current about what is going on. So I think the ATTC is pretty good about doing that. (1004:192)

As the counselors have discussed their experiences, Nicole reminds us as educators and counselors we are in a position to educate policy makers. The clinical experience each has can assist policy makers in decision making regarding funding for treatment services.

Maybe something even like educating policy makers about the need for additional, you know, medical resources, additional dental. I didn't even get into the dental thing, additional dental resources. I mean I think educators are probably in a pretty good position to do that, especially if they are in the field themselves. If they are teaching students who are, who are in the field because you are hearing about that and so I think that puts them in a good position to, to try to impact policy making. (1003:186)

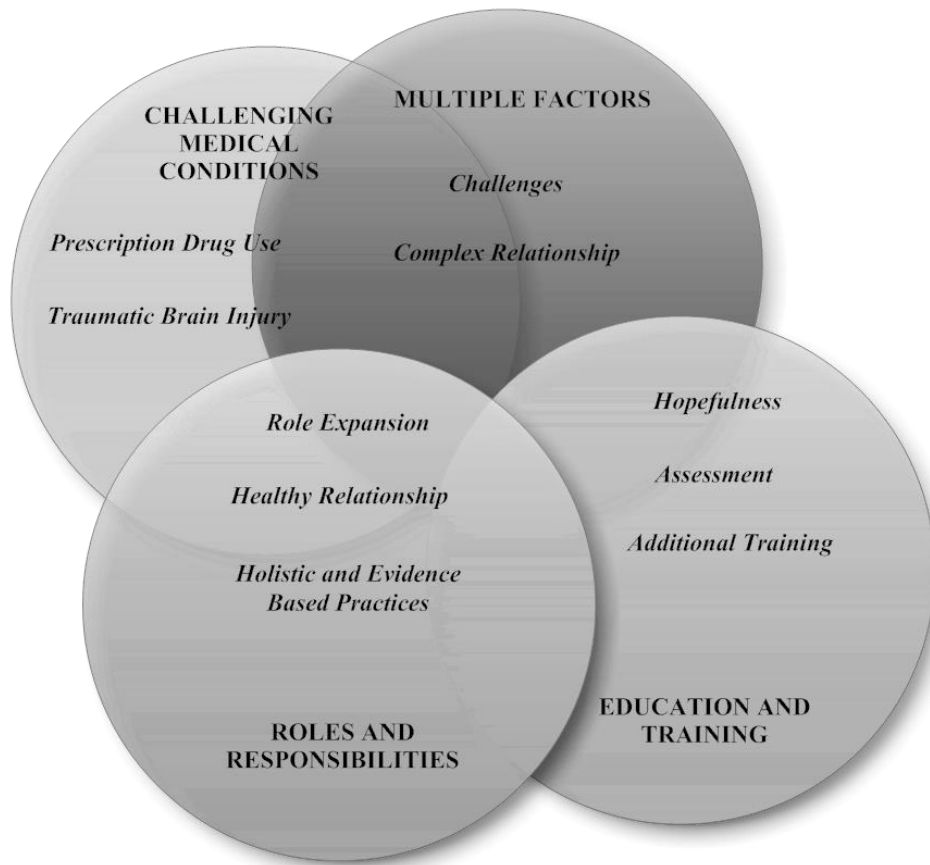
## **Summary**

Through the SUD community outpatient treatment counselors' descriptions of their experiences treating clients with co-occurring medical conditions, we are able to gain an understanding of the complexity of client's lives and the creativity counselors exhibit in providing SUD treatment. Four super-ordinate themes emerged corresponding with the four research aims presented in the research project including:

- Substance abuse clients with co-occurring medical conditions experience multiple layers of factors interacting with one another affecting client motivation and outcomes;
- Medical conditions including those utilizing potentially habit forming medications and traumatic brain injuries, present unique challenges to substance abuse treatment;

- Counselor roles and responsibilities have expanded and adapted to incorporate a host of strategies building a more holistic view of treatment; and
- SUD treatment counselors' experiences shed light on where additional education and experience can increase the readiness of future SUD counselors.

Figure 3 demonstrates as the first theme emerged exploring the complex relationship of factors associated with the phenomenon, another theme began to emerge related to specific challenging conditions; medical conditions utilizing potentially habit forming prescription medications, and traumatic brain injury and other cognitive impairments. The prominence of these two challenging medical conditions in the interviews warranted a separate emerging theme. However, they shared many of the challenges and complexities as clients who had other medical conditions (e.g. lack of resources, interaction with other factors). In addition, counselors described their roles and responsibilities expanding due to the complex relationship of factors, and in some cases related to the specific challenging medical condition. Lastly, interviewees expressed their desire for additional education and training related to complex medical conditions, their roles and responsibilities and the complex relationship of factors. Although four separate themes emerged, their relationships with one another are complex and interwoven. Our journey began through counselor experiences by challenging our definition of “co-occurring medical conditions.” Prior to the interviews, co-occurring medical conditions were defined as a client who had a medical condition, whether it is acute or chronic. Based on Nicole’s experiences, part of the definition may also include clients who are caregivers. This gives us several client type possibilities:



*Figure 3:* Illustrates the complex relationship and interwoven characteristics of the four main super-ordinate themes.

- 1) Client with acute medical condition (with or without habit forming medication);
- 2) Client with chronic medical conditions (with or without habit forming medication);
- 3) Client as caregiver to someone with a medical condition; and
- 4) Client as caregiver and has acute or chronic medical condition.

Each possibility has its own set of challenges, but are all affected by the complexity of the relationship between SUDs and medical conditions.

Figure 4 illustrates how various factors inter-relate and interact with one another.

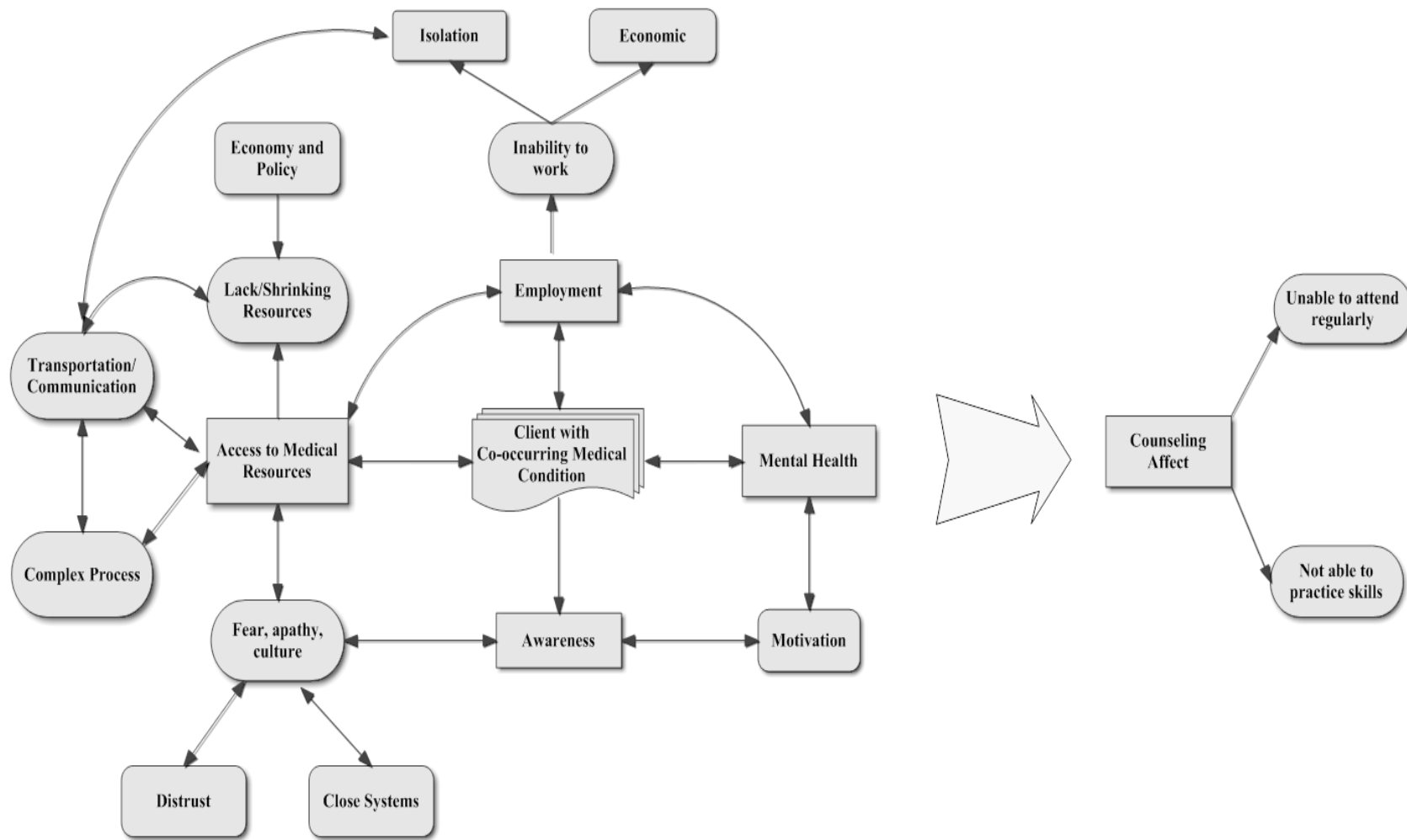


Figure 4: Illustrates the complex relationship of SUDs and co-occurring medical conditions by examining the interaction of various factors around employment, awareness, fear, apathy and culture and mental health.

The client with co-occurring medical condition icon in the center of the diagram demonstrates the multiple layers of pre-disposing, need and enabling characteristics a client may present with. Using three main examples from counselor experiences, we see how employment not only is complicated by a medical condition due to the inability to work, but how it also leads to isolation and economic problems for the client. The client may then become financially reliant on others, which may or may not put them in a role as caregiver. Employment also interacts with a person's ability to access medical care (insurance) and mental health (increased depression and anxiety). Access to medical resources is also affected by the lack of resources and shrinking of available resources due to the state of the economy and new policies (e.g. shortages of Medicaid providers). The client also faces barriers related to their ability to get to medical resources, and patience and interpersonal skills required to interact with the system.

Laura brought up another factor interacting within this web, client awareness. Awareness can take on many meanings. First, the awareness one even has a medical condition or awareness of whether their substance use was a direct result of their illness/injury. Laura takes awareness a step further and describes how clients have a difficult time connecting their substance use and other behaviors on changes in their medical conditions.

Co-occurring mental health was also a prominent issue affecting other factors and most directly linked to a client's motivation and ability to make sound medical decisions. All of these factors are constantly interacting, ultimately affecting a client's ability to participate in treatment. Wayne's automobile metaphor captures the essence of the relationship and the experience. Each part of a person's life, their economic situation, their housing, their medical care, their relationships, etc., are all parts making up an engine moving the client from point A to point B in their life. If the client has a SUD, it is like having a flat tire. Not being able to move, other parts

of the car are affected and vice versa. If an engine is not well enough to move the car after the tire is fixed, the tire will eventually rot. If the basic needs of the client (the engine) are not fixed and kept running, then substance abuse treatment will not be as effective as it could be.

To complicate the phenomenon further, super-ordinate theme two presented us with specific health conditions such as traumatic brain injury and conditions utilizing prescription medications that are potentially habit forming, adding yet another level of complexity. As Figure 5 illustrates, specific challenges affecting clients who are taking prescription medications include legitimacy, re-defining recovery and abstinence, the effect on resources, and stigma. Two interesting discoveries to note include the counselor's discussion of how prescription medication use (potentially habit forming medications) makes us reconsider what recovery truly means. Does it mean that you are not taking any habit forming substance? Or, if you are taking your medication as prescribed and abstinent from other drugs, is that recovery?

The second notable observation in their interviews is the affect taking prescription medications has on resources. First, the counselors described the impact of limited resources to assist with conditions such as chronic pain. Very few pain management specialists are in the surrounding area for counselors to refer patients to. This is also complicated because of the stigma associated with having chronic pain or other conditions requiring prescription medication. The client gets labeled as med seeking. In addition, most residential facilities will not accept a client who is utilizing prescription medications (potentially habit forming); therefore, limiting potential SUD treatment options for the clients.

One health condition discussed by several counselors was traumatic brain injury and other cognitive disorders and the impact this has had on SUD counseling. Whether the traumatic brain injury occurred as a result of domestic violence or accident/injury, the primary challenge

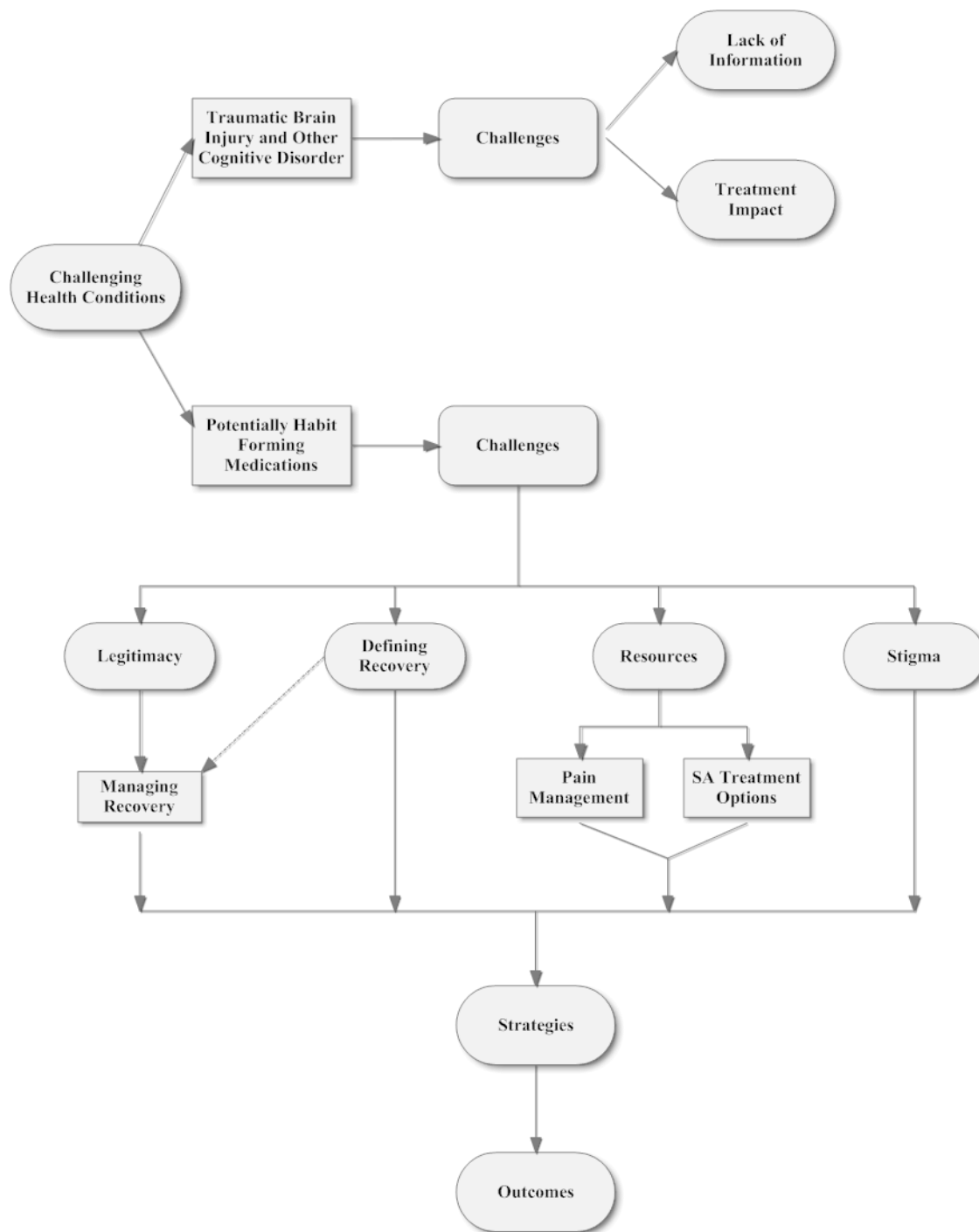


Figure 5: Specific health conditions and their challenges illustrates the specific and unique challenges medical conditions such as those treated with habit forming medication and traumatic brain injury pose in SUD treatment counseling.

was the lack of information counselors had. Information such as the areas of the brain the injury affected and the ability to consult with a physician are necessary for treatment planning.

Currently SUD counselors do not have access to neuropsych testing that would assist in treatment planning. As Don stated earlier, you are left wondering if you are impacting the client or not. These same issues hold true for individuals with cognitive disorders as well.

Having such a complex web of interacting factors affecting a client's life has led to the SUD counselor role expansion. Their roles now include having a certain level of case management integrated into their therapy. Again, going back to Wayne's analogy, one cannot expect a client to be successful with SUD treatment if the client has other needs to be addressed. The counselor is placed in a position to assist a client in navigating complex systems to identify and access resources. This is consistent with counselors describing how their responsibilities have expanded to include more of the person's well-being.

In addition, counselors are responsible for encouraging, motivating and supporting the client as they make one small step after another in their journey to recovery. Counselors utilize smaller goals to help build both client self-efficacy and trust in the therapeutic relationship. The counselor also benefits from using smaller goals as they see their clients achieving successes, no matter how small, to the road of recovery. Building hope requires counselors to also have hope. To build hope, self-efficacy and motivation, counselors pull from an expansive tool kit that includes evidence based practices (CBT, DBT and MI), as well as a host of holistic approaches (yoga, mindfulness and acupuncture).

This leads us to super-ordinate theme four and SUD counselor career development. In addition to building the strategies tool box, counselors also recommended students think about how they define SUD treatment counseling success. For some of the counselors like Lee, every



step a client takes is a success and whether they were able to maintain recovery for 2 days or 2 years, you honor those successes and build upon them. One also provides consistent affirmations and encouragement with each small step a client completes in his/her journey. Counselors noted not many clients will achieve full long-lasting abstinence. Therefore, it is important to focus on assisting the client to address issues that build on a better quality of life which may include total abstinence.

Lastly, the counselors recommended additional educational topics to assist a new counselor entering the field. Their recommendations included more education on areas most prominent in the field including trauma, pain conditions, and grief and loss. Cross discipline education was also recommended by Don who found benefits in taking a course in pharmacology/toxicology in partnership with rehabilitation counseling curriculum.

Treating clients with co-occurring medical conditions is a complex phenomenon requiring counselors to be flexible and adapt to any situation. SUD clients have a host of basic needs, in addition to substance use and medical conditions, needing concurrent therapy, referral, education and support. Having a co-occurring medical condition can complicate and impact a client's ability to achieve SUD treatment outcomes. Providing SUD counseling requires patience, skill, and creativity. Most of all, a counselor needs to be hopeful. As Lee reminds us, people really do get better!

## Chapter 5: Discussion

### Introduction

Counselors' experiences treating clients with co-occurring medical conditions illustrates the complexity of client lives and the many challenges they face on the journey to recovery. Counselors' experiences also illuminate their creativity and approach to treating SUD clients, as well as their dedication to the profession. The following chapter will further discuss counselors' experiences in the context of related literature and draw final conclusions. The discussion chapter will include the following: 1) Summary of the Study; 2) Overview of the Problem and Major Findings; 3) Findings Related to the Literature; 4) Study Limitations; 5) Conclusions; 6) Implications for SUD Field and Rehabilitation Counseling; 7) Recommendations for Further Research; and 8) Concluding Remarks.

### Summary of the Study

The purpose of the Interpretative Phenomenological Analysis (IPA) study was to explore the experiences of SUD community outpatient treatment counselors treating clients with co-occurring medical conditions. The exploration provided an opportunity to fill a gap in the current literature to examine the phenomenon of what happens while trying to provide SUD treatment to clients with co-occurring medical conditions. Although the literature is rich in data about how people with SUDs utilize health care services and their barriers, no one study has looked directly at the experiences of SUD treatment counselors within this phenomenon. The study also provided an opportunity to explore experiences from the counselor's view to

illuminate the rationale behind how we see individuals with SUDs interacting with the health care system, and what role counselors have in that interaction.

The study included administering semi-structured face-to-face interviews with five SUD community outpatient counselors to explore the following research question: How do the SUD community outpatient treatment counselor's experience treating clients with co-occurring medical conditions? A review of the literature found research published in the area of identifying health care utilization patterns of individuals with SUDs. Many predisposing, enabling and need factors were identified as potential predictors of utilization and substance abuse treatment outcomes. Research specifically focused on the experiences of counselors providing SUD treatment to clients with co-occurring medical conditions was, at this time, not found. Instead, most of the literature focused on primary care and emergency room physicians' experiences treating patients with SUDs. Based on the review of the literature, Gelberg, Andersen and Leake's (2000) Behavioral Model of Access to Health Care for Vulnerable Populations was utilized as the foundation for examining the phenomenon. The Gelberg et al. model illustrates how factors can enable and/or impede a person's need and use of health care, and their outcomes. Combining the literature with Gelberg et al., a theoretical model identified gaps in scientific knowledge creating a conceptual framework for the study.

Because the study focused on exploring SUD community outpatient treatment counselors' experiences treating clients with co-occurring medical conditions, a qualitative approach grounded in the Interpretive philosophical paradigm was utilized. IPA provided a qualitative research method focused on exploration, description and analysis of the phenomenon of interest from the participant's perspective. It is a way we can view the experience from the

participant's view point and gain better understanding of the structure, or essence, of the phenomenon.

The IPA study included conducting in-depth semi-structured interviews with a sample of SUD community outpatient counselors. Counselors were selected from a publically funded mental health organization located in Central Virginia. The site was selected because it is known for its extensive use of evidence based practices and previous requests for training and education on medical condition topics such as HIV and chronic pain. The researcher collaborated with the Adult Substance Abuse Manager and obtained permission to conduct the study at the site. The manager provided the researcher with a list of all adult substance abuse counselors in the outpatient program including information on current licenses/certifications, number of years at the site, email addresses and whether or not a counselor had a current active case load. From the list, the researcher identified counselors fitting the following eligibility criteria:

- 1) Had a current license (LPC, LCSW);
- 2) Had five or more years' experience as a substance use counselor at the site;
- 3) Had a current active caseload.

Each eligible counselor (n=9) was sent a recruitment email. Of the nine, five responded and completed the interview. Each participant was given a \$50 Target gift card for their participation.

The researcher transcribed all interviews into Atlas-ti. Each interview was analyzed by first coding for descriptive, linguistic and conceptual coding. Second, codes were entered into Atlas-ti for further analysis. The process of coding provided the researcher the opportunity to identify most prominent areas of interest and develop themes. Each interview was summarized and included themes and related quotations. The summaries were sent to the participants for

member checking. After each interview was analyzed, themes across interviews were compared and contrasted until four super-ordinate themes had emerged.

The researcher engaged in bracketing techniques to identify researcher bias. This included a bracketing interview conducted by Dr. Svikis and consistent engagement in the researcher's reflective journal. Other trustworthiness and credibility strategies were implemented. For example, to increase transferability, Dr. Keyser-Marcus reviewed an interview transcript to assess interview quality. To increase dependability and confirmability, the researcher maintained a transparent and thorough audit trail. This included making all documents and processes available to the dissertation committee in real time by utilizing Virginia Commonwealth University's (VCU) online educational software, BlackBoard.

Four super-ordinate themes emerged from the analysis and are reflective of the four specific aims of the study. Table 9 provides a summary of the four super-ordinate themes and their corresponding Research Aim. In addition to the super-ordinate themes, sub-themes were also identified and presented in the analysis. The counselors provided an overview of how they experience treating clients with co-occurring medical conditions. For many of them, to think of medical conditions in relationship to their counseling was a shift. Often when the term "co-occurring" is used, it is for the occurrence of mental health issues presenting with substance abuse. As counselors described, medical conditions are a factor they assist clients with by providing resources for treatment and adapting to the changes in one's life due to a medical condition. However, to sit down and reflect on the experience and its impact on treatment emphasized how inter-related medical conditions are within SUDs and SUD treatment.

Table 9:

*Super-Ordinate Themes and Specific Aims*

Theme	Specific Aim
<b>Super-Ordinate Theme #1</b>	
Substance abuse clients with co-occurring medical conditions experience multiple layers of factors interacting with one another affecting client motivation and outcomes.	<i>Specific Aim #1:</i> Counselor experience <i>Specific Aim #2:</i> Relationship of SUDs and Co-occurring Medical Conditions <i>Specific Aim #3:</i> Challenges
<b>Super-Ordinate Theme #2</b>	
Medical conditions, including those utilizing potentially habit forming medications, and traumatic brain injuries, present unique challenges to substance use treatment.	<i>Specific Aim #1:</i> Counselor experience <i>Specific Aim #3:</i> Challenges
<b>Super-Ordinate Theme #3</b>	
Counselor roles and responsibilities have expanded and adapted to incorporate a host of strategies building a more holistic view of treatment.	<i>Specific Aim #1:</i> Counselor experience <i>Specific Aim #4:</i> Strategies
<b>Super-Ordinate Theme #4</b>	
SUD treatment counselors' experiences shed light on where additional education and experience can increase the readiness of future SUD counselors	<i>Specific Aim #1:</i> Counselor experience <i>Specific Aim #4:</i> Strategies

**Findings Related to the Literature**

**Characteristics, Experience and Relationship.**

The counselors provided a description of the clients they serve. Their descriptions were consistent with the geographic representation of the area with clients being predominantly Caucasian (estimated 80%) followed by African American (estimated 20%) ranging in age from 18 years old and older. Most clients were described as resource limited which included unemployment, lack of income, lack of health insurance, etc. The client characteristic description was important in describing the setting and identifying multiple factors counselors face in working with clients with co-occurring medical conditions. However, the study is limited in its

ability to make comparisons between the clients served by the sample and the literature presented in Chapter 2.

Where we lack the ability to compare clients referenced in this study to other studies on variables such as gender, age, race and sexual orientation, we are able to make some inferences to social factors, substance use, and their relationships utilizing the Vulnerable Populations Behavioral Health Access model. Table 10 provides an overview of client characteristics mentioned by the counselors embedded into the model. There are a few notable results affecting the experiences and challenges counselors face when treating clients with co-occurring medical conditions.

First is the issue of gender differences. The study is limited in the sense that four counselors work primarily with men and one counselor with women. However, Wayne and Lee both mentioned some gender differences related to access. Lee stated historically it seemed men had less health care resources due to the lack of publically available insurance. However, with some hospitals providing indigent care type of insurance, such as Virginia Coordinated Care (VCC) at Virginia Commonwealth University's Health System, we are left wondering if insurance is available, why are there still differences? Lee and Wayne shed light on this matter. As Lee notes, men are not as apt to admit there is a problem, where women are more likely to talk and act on it. Wayne confirmed this with his discussion on male bravado.

Another characteristic worth noting is helping clients become aware of the relationship between their current lifestyle and their medical condition. Laura described a client who has diabetes, yet doesn't connect between his lifestyle habits and his diabetes. Some possible reasons

Table 10:

*Client Characteristics, Experience and Relationship*

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<b>Predisposing Characteristics</b>	<b>Enabling</b>	<b>Need</b>	<b>Health Behavior</b>
<p><b>Demographics</b>                      Age: 18+                      Race: Caucasian (Estimated 80%)                      African American (Est. 20%)                      Other</p> <p><b>Health Beliefs</b>                      Fear                      Stigma                      Distrust</p>	<p>Personal/Family Resources                      No insurance                      Low income                      Isolation                      Perceived barriers to care (transportation, communication, etc.)                      Shrinking community resources</p>	<p>Perceived health (including vulnerable)                      Multiple health conditions                      Chronic and acute                      Some requiring habit forming medications                      May wait for it to become a crisis</p>	<p>Diet – limited budget                      Unaware of how diet, substance use, exercise affects medical condition                      Smoking                      Difficult to maintain consistent care                      Use of health services                      ED utilization                      Alternative treatments (shortage)</p>
<p><b>Social Structure</b>                      Mostly non-Hispanic                      Education: High School, Less than HS and GED                      Employment: Unemployed seeking work, disabled, laborious positions                      Occupation: Skill/Trade</p>	<p><b>Vulnerable Domains</b>                      Multiple needs                      Public benefits                      Complex system                      Case management support                      Transportation (barrier)                      Communication (barrier)</p>	<p>Hygiene – low                      Unsafe behaviors resulting in shame and guilt</p>	
<p>Unstable housing                      Limited mobility                      Legal                      Trauma due to domestic violence and other victimization                      Co-occurring mental health                      Substance use</p>			



for disconnect could be the lack of education and information, not having the resources to make the necessary diet changes, or denial of the seriousness of the health condition. When you look at a number of behavioral health theories, such the Transtheoretical Model of Behavior Change (Prochaska, Norcross & Diclemente, 1994), the Health Belief Model (Rosenstock, Strecher, & Becker, 1988) and Self-Regulation Theory (Vohs & Baumeister, 2011), reaching a desired behavior/outcome requires some level of motivation, information, awareness, resources and internal strengths to do the preparation necessary to sustain a behavior change. A medical condition is not necessarily enough to change a behavior.

Another surprising result of this study not mentioned in the literature was the role of employment, which is often tied to having insurance. What was noted in this study was employment's role as a cause of some medical related conditions, which then leads to unemployment and loss of resources. As Don and Nicole discussed in their interviews, many of the male clients are/were employed as skill and trade laborers such as roofers, construction, plumbers, etc. These are physically taxing jobs which could result in injury either through an accident or wear and tear on the body (chronic pain). Usually when engaged in this type of employment, individuals do not have the education to support a transition to a more office based vocation. If they become injured or the gradual wear and tear on the body has reached a point where the person is unable to work, trying to regain employment in another field is difficult. If the injury/condition is not severe enough to acquire disability benefits, the client loses the ability to financially support themselves. Not only does this lead to grieving the loss of sense of self as a working person, but also grieving the loss of income, housing stability, etc. This finding could help explain why in Marsh et al.'s study (2009), men were more likely to state they had a need for vocational services.

As Don and Nicole described, this scenario leads clients to being financially dependent upon other people. The financial dependence on family and/or friends may place the client in a caregiver role. As the population ages, more clients are finding themselves in the role of caregiver. Research has primarily focused on parental caregivers with SUDs and child welfare (Small & Kohl, 2012; Chuang, Wells, Bellettier & Cross, 2013), caregivers of individuals with SUDs and mental health issues (Biegel, Katz-Saltzman, Meeks, Brown & Tracy, 2010) and parental caregivers of adolescents with SUDs (Heflinger & Brannan, 2006). Research has found caregivers experience distress leading to depression, negative coping styles, reduced self-efficacy and diminished resources (Mausback, Roepke, Chattillion, Harmell, Moore, Romero-Moreno, Bowie & Grant, 2012). In addition caregivers are more likely to have poor immune system function, more chronic diseases and poorer health status, mental health conditions, social isolation and financial impacts (Barbosa, Figueiredo, Sausa & Demain, 2011).

A recent policy brief conducted by Hoffman and Mendez-Luck (2011) examining the estimated 6 million caregivers in California found more than 1 million had reported moderate or serious distress levels. Most alarming was the finding of middle-aged caregivers more likely to report binge drinking (25.5%), smoking (15.9%) and/or obesity (30.1%). Overall, caregivers reported lacking support, financial strain, self-medication, substance use and social isolation. Imagining a person engaged in SUD treatment whose primary role is a caregiver, one can see how the added stress can create new challenges for the client and counselor. It is complicated further if the client has an existing mental health or medical problem. Thinking in terms of protective factors, clients in a caregiving role engaged in treatment have the support of their counselors to work through emotional issues and connect with resources. Little is known about the experience of a SUD client with or without a co-occurring medical condition in his/her role

as caregiver and the impact it has on his/her ability to reach recovery. A recent scan of the literature did not find specific research studies focusing on the impact of the caregiving for aging parents/family on current substance users.

Another aspect of client characteristics and the relationship between substance use and medical conditions is the high prevalence of both trauma and mental health conditions. Counselors noted trauma prevalence for both men and women well over 50%. Trauma is associated with mental health and substance abuse problems (Ruggiero, Bernstein & Handelsman, 1999, Resnick, Kilpatrick, Dansky, Saunders & Best, 1993), increase for alcohol and drug use (Laweson, Buck, Hartwell, Maria, Brady, 2013) and injury/illness. As Lee noted in her interview, women victimized by domestic violence may have head injuries and/or have chronic pain.

Trauma exposures can also affect the ability of SUD clients to reach recovery. A study by Farley, Golding, Young, Mulligan and Minkoff (2004) conducted a survey among patients at two SUD outpatient treatment centers. A total of 959 patients, 68% male, found the prevalence of trauma to be 89% (at least one traumatic event). Trauma included accidents, being robbed, seeing someone killed or injured, and domestic violence. This finding is important and confirms why trauma was prevalent in our counselors' descriptions. The authors also found those with trauma histories had a history of relapse. No significant gender differences were found (Farley et al., 2004). Although this study is several years old, it is one of the few examining the prevalence of trauma and history of relapse among both men and women in substance abuse treatment centers.

The relationship between trauma and substance use is one of many relationships also impacting client's mental health. Co-occurrence of mental health and substance use has been

demonstrated in population surveys (National Institute of Drug Abuse, 2008). Other studies have also linked the co-occurrence of SUDs, mental health and medical conditions (Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003; Curran et al., 2003; Druss & Rosenheck, 1999; Hoff & Rosenheck, 1998). Through counselor experiences, we see how mental health and substance use relate to one another with clients with co-occurring medical conditions.

Two specific examples were given by the counselors demonstrating the multi-directional relationship between mental health and medical conditions among clients with SUDs. First was Nicole's client who was in need of dialysis, who had lost his family and felt he had nothing to live for. His depression contributed to his struggle to make medical decisions to save his life. Here we see the direct impact of social isolation and lack of family support contributing to depression resulting in medical decision making difficulties. Second was Don's client. Due to a hip injury, the client became socially isolated and was unable to work. His injury resulted in increased depression and suicide ideation.

Lastly, a surprising result in the analysis of client characteristics and experience of treating clients with co-occurring medical conditions was the prominence of gastric bypass surgery among this population. Most of the counselors discussed health conditions that may or may not be related to substance use. It was surprising to hear about the prevalence of gastric bypass surgery among the clients. Lee had mentioned this in terms of her woman's group where half of the clients had gastric bypass surgery. Don also mentioned gastric bypass surgery when he described male clients. Looking back to the Benjamin-Johnson et al. (2009) survey where 41% of clients stated they were obese, the question then becomes what is the relationship of obesity to substance use and what role does gastric bypass play in substance abuse treatment and outcomes?

Helwick (2011) discussed the role of gastric bypass surgery and drug use, particularly alcohol abuse in Sweden. The author mentions gastric bypass patients seem overrepresented in substance abuse treatment programs. In the discussion, alcoholism was greater after gastric bypass surgery. In addition, patients were also more likely to be treated for depression, suicide and substance use post-surgery. One explanation she provides is alcohol metabolism is altered creating greater alcohol concentrations. Unfortunately, it is not known if the women Lee described had surgery prior to treatment or after. It also poses the question of how different medical conditions have different relationships with substance use disorders and treatment. As we will discuss later, health conditions treated by potentially habit forming medications like chronic pain, and head trauma share unique challenges to providing SUDs treatment. Further research is needed to determine if gastric bypass surgery and its post-operative lifestyle changes will also present with unique challenges.

### **Challenges.**

In examining the relationships between substance use, co-occurring medical conditions and counselors' experiences treating clients with health issues, we see the web of interaction between multiple factors posing a host of challenges to both the counselors and the clients. As Wayne noted, clients come in with layers upon layers of issues. Until the layers are peeled a part and basic needs are met, it is difficult for the client to focus on treatment. Wayne provided us the analogy of a car with a flat tire. His use of a metaphor demonstrates his level of experience working with clients who have multiple needs. In order for one part of the car to be fixed and working properly, other repairs must also be made. Part of the challenge then, is to find and access the part stores (resources) to get what is needed to fix the car.

In Gelberg et al.'s model, the ability to access resources to meet basic needs falls under enabling characteristics. As Wayne noted, by the time clients reach substance abuse services, they have lost a great deal including family and personal resources, income, insurance, and finances. A lack of resources in the area means clients must travel significant distances to obtain needed medical care. The geographical location lacks public transportation and many clients may not have access to reliable transportation to reach medical resources. If the client is successful in physically reaching a resource, they are then confronted with a complex process to access the resource. Lee described the process to obtain medical services as a very difficult one. Each resource has their own process by which to approve somebody for health care. Often this can take months of phone calls and submitting forms. As Don noted, engaging the process takes a lot of patience clients may not have.

As Lee mentioned in the interview, even if access to medical care was easier, there remained a question whether or not clients would engage in care. Part of the issue is patience and the ability to navigate a complex system, the other is fear. Client health beliefs such as fear and distrust of the system resonated through most of the interviews. Fear was described in three ways: 1) fear and distrust of the health care system; 2) fear of judgment and stigma related to closed client systems; and 3) fear of finding out there was something medically wrong.

Health care utilization has examined cultural fears and distrust of the health care system. For example, Katapodi, Focione, and Pierce (2007) conducted a survey to explore distrust and decision making among women towards breast cancer screening. They found distrust to be the most important predictor to health services utilization. However, they were not able to determine cultural differences in distrust. For example, in previous research African American distrust of

medical and health systems was associated with past historical events such as Tuskegee (Washington, 2006).

In this research project, fear and distrust of health systems was described in terms of client's previous negative experiences by someone they knew or had heard about. Often the situation involved someone being misdiagnosed or dying. The other component of distrust was related to giving systems private information. There is a fear among people, especially with electronic medical records, of who has access to their information and how the information is going to be used. When stories of breach of private and confidential health information play in the news, it feeds the client distrust of the system further. Clients also fear providing private information because the health care system will see the dysfunction and atrophying closed client system. As Wayne described in his interview, clients are afraid of others seeing the dysfunction and "horrors" of the client's life. They are afraid of being judged and stigmatized.

The last level of fear is related to not wanting to know if there is something wrong or a level of apathy among clients. Lee describes some clients as having apathy and fear of a health condition keeping a client from engaging in more preventative or early treatment. Instead, the client will wait until it becomes a crisis before dealing with it. Also related to client apathy is culture. As Lee and Wayne noted, some clients grew up in families where preventative care was not a value. The research shows substance users who utilized the emergency room had more health conditions in need of immediate attention (Cherpitel and Ye, 2008) and chronic drug users were less likely to utilize primary care (Chitwood et al., 2001). Based on the information and looking at previous research, fear, apathy and cultural influences can be perceived as being significant barriers to utilization, alongside of lack of health insurance and medical care resources.

Although there are many challenges to getting clients engaged in medical care, when medical care is accessed, positive effects can be seen. As Wayne noted, when people begin to have their health issues treated, they begin to feel better and can focus on therapy. During Lee's interview, she described the effect having a part-time nurse practitioner (NP) on-site had on the ability to address some of the client's needs. Her tone during her description was hopeful and encouraging as she described the additional support the NP provided in getting clients engaged in medical treatment. Clients with more serious health conditions had a person who knew the health care system and was able to assist the client in getting the appropriate treatment. In addition, other health conditions which could have led to more serious issues were identified early. However, when funding went away, so did the NP. From the interview, we do not know if clients who had access to the NP had different substance use outcomes. Previous research demonstrated primary care's influence on motivational levels (Friedman et al., 2003). However, the challenge of limited resources remains. The shrinkage of Medicaid providers is a primary concern. As Sterling, Chi and Hinman (2011) note, integrated treatment for people with SUDs, medical conditions and/or mental health conditions is still the exception to the rule and care systems remain separated. There is a hope that health care reform will integrate medical and behavioral services. It is unknown at this time how and when that will happen.

### **Specific Medical Condition Challenges.**

When discussing challenges counselors face treating clients with co-occurring medical conditions, prescription drug use (defined here as potentially habit forming medications such as opiates and benzodiazepines) and traumatic brain injuries were prominent. Prevalence of prescription drug use is linked to patients with chronic pain. A recent study by Marasco, Duckart and Dobscha (2011) estimated 10% of chronic non-cancer pain patients in primary care and 10-



30% of chronic non-cancer pain patients in specialty care, had SUDs. Wachholtz, Ziedoris and Gonzalez (2011) found similar rates of opioid abuse and dependence (3-30%) among comorbid pain patients.

Clients who utilize prescription medications, such as chronic pain patients, have a host of unique challenges. The counselors discussed educating patients on the safety of using their medications with other drugs, talking with their doctor about their substance use, and motivating clients to take prescriptions as prescribed. Studies have found that individuals who had a SUD diagnosis and chronic pain were also using alcohol, cannabis, cocaine, opioids, amphetamines, poly substance use or other drugs (Marasco, Duckart & Dobscha, 2011). In addition, these clients are also more likely to be diagnosed with a psychiatric disorder such as depression and PTSD (Marasco, Duckart & Dobscha, 2011; Wachholtz, Ziedoris & Gonzales, 2011).

According to the literature, several models of how to treat clients with chronic pain are being tested with an integrated services model being the most promising (Donald, Dower & Kavanagh, 2005; Ziedornis, 2004). The integrated model focuses on the mental health provider, substance abuse provider and physician working together to achieve mutual goals. Research focused on individuals with SUDs and mental health issues has demonstrated the effectiveness of integrated treatment (Sacks, Chaple, Sirikantraporn, Sacks, Knickman & Martinenz, 2013). Additional studies have also found improvement in outcomes for individuals engaged in integrated care (Currie, Hodgins, Crabtree, et al., 2003; Brooner, King, Neufeld, et al., 2008 Umbricht-Schneiter, Ginn, Pabst, et al., 1994). More research is needed to examine the effectiveness of integrated care for people with SUDs and chronic pain.

As the counselors discussed, there is limited access to pain management specialists and physicians. In addition, it is difficult to get medical releases signed by the clients. As Laura

stated, they explain to clients the medical release is about collaboration. However, as Lee described, clients fear if the collaboration is open with the physician, they may have to give up their drug. When clients do provide releases, the next challenge is for the counselor to reach the physician. As we think about the counselors' experiences, we can see the idea of an integrated model would assist with many of these challenges. However, the science regarding the effectiveness of the model, the feasibility of the model, and funding to implement such an integrated model has not reached community programs.

What was also surprising during this conversation was substance abuse treatment options are also more limited if the client is using prescription medications. Some residential facilities may not be prepared to manage a client with multiple conditions, one of which requiring a potentially habit forming substance. If residential treatment is struggling to manage clients utilizing potentially habit forming medications, this may be time to open the discussion of a collaborative relationship between pain management specialists and residential treatment. For individuals who have legitimate pain issues, to not be on any pain control therapy during residential treatment could result in greater suffering by the client. These barriers bring more layers of complexity to an already complex situation.

The other main question is what are the definitions of recovery and abstinence among this population? The use of opioids leads to physical dependence among chronic pain users, but does that mean the clients are in need of substance abuse treatment? This question of what defines abuse and dependence among this population is related to the counselor's discussion of what is legitimate use? Is it as long as a person takes the medication as prescribed then it is legitimate? Or is legitimacy based on the physical or mental health condition? Is it the SUD counselor's

responsibility to determine legitimacy based on abuse and dependence criteria? These are far reaching questions warranting further research.

Lastly, the counselors discussed a broad range of interventions and strategies they utilize with clients using potentially habit forming medications including Cognitive Behavioral Therapy, Motivational Interviewing, Mindfulness, Meditation, and Imagery, to name a few. Wachholtz, Ziedoris and Gonzalez (2011) reviewed current strategies and found approaches are potentially promising in helping clients work through conditions such as chronic pain. The use of complementary and alternative medicine (CAM) (e.g. meditation, relaxation, massage, herbal medicine, etc.) has been shown to be utilized by opiate users for pain management (Pillet & Eschiti, 2008). This exemplifies the willingness of clients to use CAM therapies to assist with pain management. However, rigorous research specifically examining the effectiveness of CAM on SUDs population with chronic pain is limited with some available research focused on opiate users in methadone maintenance programs (Pillet & Eschiti, 2008).

### **Traumatic Brain Injury.**

The other challenging medical condition noted by Lee, Don and Laura is traumatic head injury. Traumatic brain/head injury can occur from domestic violence or other injuries (e.g. motor vehicle accidents, falls, etc.). In addition, other cognitive disabilities have been observed by the counselors. The cognitive deficits created by injury or other conditions may be related to substance use and affect a client's ability to achieve recovery (Walker, Saton & Leukefel, 2001). Don stated sometimes it seems like they have little impact on clients with some type of head injury or cognitive disorder. Part of the issue is not having information related to what aspects of cognitive function are being affected.

Substance use has been noted as a contributing factor to injury, as well as an important factor post-injury (Falvo, 2012; West, 2011; Olson-Madden, Brenner, Corrigan, Emrick & Britton, 2012). However, the rates of substance use pre- and post-injury may vary. Individuals with TBI who engage in substance use post-injury may do so as a maladaptive coping mechanism (Falvo, 2012). Continued substance abuse post-injury can result in further impairment and individuals may find increased sensitivity to the effects of the substance. Lastly, substance use post-injury raises the risk of drug interaction (alcohol and illicit substances combined with prescription medication) (Falvo, 2012).

Although research is available on the prevalence and correlates of substance use and TBI, there is still limited research on prevention resources, treatment options and empirically tested treatment modalities (West, 2011). Methodological concerns make research on TBI and substance use difficult. Challenges include standardized classification of TBI (mild to severe), with mild cases often going undiagnosed. Second, there are limitations in standardized screening for TBI beyond client and/or family self-report in substance abuse treatment centers. These challenges lead to undiagnosed TBI among SUD clients. The literature confirms traumatic brain injuries are often unidentified in substance abuse treatment (Solomon & Sparadeo, 1992, in Walker, Saton & Leukefel). This is most prevalent among individuals who seek SUD treatment who may have never gone to a hospital or sought care for a mild TBI. Without proper assessments, the TBI could go undiagnosed.

Previous research is available on head trauma in persons with substance abuse issues (Doninger, Heinemann, Bode, Sokol, Corrigan & More, 2003; Hammond, Grattan, Sasser, Corrigan, Rosenthal, Bushnik & Shull, 2004). Some research has found brain injuries could result in various cognitive deficits such as learning, memory, problem solving and planning, goal

setting, impulse inhibition, and planning (Murrey, Dallas & Maki, 2007; Walker, Staton & Leukefel, 2001). However, the lack of neuropsych testing in SUD treatment prevents counselors from knowing which parts of the brain have been affected and what cognitive impairments clients' experience.

Just as with other medical conditions, trauma can be associated with other psycho-social factors. For example, Lee discussed head injuries related to domestic violence. Although domestic violence has been noted in other studies as a predisposing factor, this is the first time this researcher was made aware of the link of domestic violence and traumatic brain injuries among women in SUD treatment. A study by Murrey, Dallas and Maki (2007) examined the prevalence of history of head trauma among women in substance abuse treatment clinics. Between 2001 and 2006, the authors surveyed 2,198 females in substance abuse programs and investigated if they had a history of head trauma resulting in a loss or change of consciousness, ER visit, or hospitalization. Of the sample, 42.3% reported a history of head trauma and of those, 42.3% stated the head trauma resulted from another person. They noted race/ethnicity differences with history of trauma being reported more often by American Indians (54.9%), followed by Caucasians (43.6%), African Americans (37%) and Hispanics (8%). Also prevalent were the effects of head trauma experienced by women who stated they had problems with concentration, anxiety, and sleep disturbances (Murrey, Dallas & Maki, 2007). Based on the counselors' experiences and the literature, head injuries and cognitive dysfunction seem to be prevalent among SUD clients and adds yet another aspect of services needed in order for SUD treatment to be successful.

Counselors utilize strategies such as Motivational Interviewing to assist in the client in building self-efficacy and motivation. However, as several of the counselors noted, recovery is

more difficult for these clients to achieve and maintain. Would reducing barriers to collaboration and integrated treatment give clients a better chance at recovery? Further investigation into the existing treatment literature found limited research on effective treatments for SUD clients who had a TBI, especially clients who have mild TBI. Graham and Cardon (2008) reviewed 16 studies that evaluated treatments for clients with TBI. What they found was that community based treatment was required, motivational interviewing was not sufficient if used alone, and skill based interventions had more promise. In addition, programs with financial incentives and barrier reduction increased retention into SUD treatment. Lastly, clients with TBI welcomed peer based support, and both individual and group counseling demonstrated promise (Graham and Cardon, 2008). Overall, the authors found the general consensus to effective treatment was a multidisciplinary team approach. Just as with chronic pain and other medical conditions treated through prescription medications, head injuries and other cognitive disabilities could benefit from an integrated care model.

### **Roles and Responsibilities.**

Treating SUD clients with co-occurring medical conditions is challenging. It requires counselors to address a host of competing needs in order for clients to focus on therapy. One way to do this is through case management. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes case management as an integral part of substance abuse treatment. Case management provides a way to increase engagement with other services and to assist clients in linking to the outside world. It also works to resolve immediate needs and is a tool for goal setting (SAMHSA, 2004). Wayne and Lee both stated their roles had changed and adapted to include more case management. Nicole also felt her responsibilities had extended beyond treating substance use to include overall client well-being. The increase in case

management by clinicians is unknown. Some treatment centers, including this site, have designated case managers to assist with addressing client needs. However, funding may be limited to provide enough case managers for all clients. Therefore, case management responsibilities begin to fall on the therapists.

Although case management and service coordination take additional time, it is also a way to build trust in the therapeutic relationship. Wayne stated when things begin to happen for clients, they begin to trust the counselor and a healthy therapeutic relationship develops. Case management is also a way to build client self-efficacy. As therapists work to increase access to services for clients, they also motivate clients to engage in outside systems. As more things happen, clients build more hope and motivation to continue trying.

Another part of relationship building is counselor empathy. Empathy is a critical component in interventions like Motivational Interviewing. A few of the counselors discussed how having their own personal medical issues assisted them in understanding the challenges their clients face. Nicole, although not having a medical condition, stated her understanding has also increased through the natural aging process and in listening to her client's challenges in managing their medical conditions. Looking at this through the lens of Social Identity Theory (Tajfel, 1974), a counselor with a medical condition will hold multiple roles as both therapist and a person with a medical condition. Both of these roles have meaning which influence their attitudes and behaviors (e.g. increased empathy, introducing clients to new concepts) which also affects the decision making of the counselor (increase support for providing alternative therapies). Often our own personal experience with a situation will bring meaning and an ability to reach a new level of empathetic understanding resulting in the development of a healthy therapeutic relationship with the client.

When you look at the adaptation of counseling roles to include case management and well-being combined with empathy, it is not surprising to hear the counselors discuss their approaches and strategies in terms of a holistic approach. Breslin, Reed and Malone (2003) define a holistic approach as,

It focuses on emotional, physical, and social well-being by helping the individual move along a continuum from reactive, chaotic existence to a proactive, productive lifestyle. Holistic treatment encourages growth through self-exploration and appropriate expression of feelings, recognition of difficult emotional states, and learning more adaptive ways to soothe and comfort the mind, body, and spirit. (p. 247)

Priester et al (2009) explains the purpose of holistic treatment is to provide intervention on multiple levels in order to treat the whole person. Not only does this approach, combined with case management and relationship building address immediate needs of the client, but it also assists the clients in developing greater self-care. Greater self-care increases self-efficacy and building these successes can lead to improved quality of life, even if total abstinence is never achieved.

We hear Laura talk about the mind, body and soul connection and Lee's continuous references to alternative strategies throughout their interviews. In addition, each counselor listed a repertoire of strategies they pull from to address the emotional, physical and social well-being of their clients. This also includes working with clients to adapt to lifestyle changes brought on by their substance use and/or physical health condition. However, the utilization of strategies like meditation, mindfulness, yoga, exercise and nutrition are not as prominent in substance abuse



treatment centers. Some programs, specifically twelve step programs, are known for their focus on spirituality and are often incorporated into SUD treatment (Carroll, 1993; Herbert, 2003).

A study by Priester et al., (2009) surveyed 139 substance abuse treatment centers about their frequency of using prayer, meditation and holistic interventions. Although more than half (58%) of centers stated they used some form of meditation, only 33% identified as including some form of holistic approach. A review of CAM in substance abuse treatment found that evidence was limited with none of the alternative and complimentary therapies having significant evidence (Behere, Muralidharan & Benegal, 2009) However, acupuncture, herbal therapies and mind-body interventions demonstrated positive results. One issue related to the lack of research on CAMs in substance abuse treatment is related to the methodological difficulties assessing CAMs (e.g. standardization of use) (Behere, Muralidharan & Benegal, 2009). Price, Wells, Donovan and Brooks (2012) noted numerous community based studies and anecdotal reports suggesting promising results, but rigorous empirical research is still lacking. Another limitation to CAMs research is the small sample sizes. For example, an auricular acupressure study found participants in the acupressure group demonstrated greater reduction in substance use craving and emotional stress compared to control, but the sample was limited to 17 participants (Tian & Krishnan, 2006).

One of the most researched CAM therapies is Mindfulness-Based Relapse Prevention (MBRP) developed by Dr. Alan Marlatt. A review of MBRP studies by Bowen and Vieten (2012) found MBRP to hold promise as an effective intervention. MBRP, combined with cognitive behavioral skills and exercises, can reduce cravings and decrease subsequent substance use (Bowen, Chawla, Collins, Witkiewitz, Hsu, Grow, et al., 2009). Another study by Witkiewitz, Bowen, Douglas and Hsu (2013) found similar results.

We can see from the consistency of the counselors in this study, that as a whole, the counselors support holistic approaches (yoga, walking groups, nutrition groups, parenting groups, meditation, mindfulness, and acupuncture) in combination with evidence based practices (e.g. Motivational Interviewing, Cognitive Behavioral Therapy). This demonstrates the counselor's commitment and recognition of the mind, body and spirit connection. As Lee stated, holistic therapies in combination with other strategies provide concrete tools counselors can provide clients in their road to recovery.

### **Preparing Future SUD Counselors.**

McLellan described SUDs as a chronic disease (McLellan et al., 2000). It is a disease that has a cycle of recovery and relapse complicated by a myriad of other client issues (Oser et al., 2009). This combined with other factors such as organizational politics, colleagues, management issues and limited opportunities lead to counselor burnout (Oser et al., 2013; Vilaradga et al., 2011). As research has demonstrated, counselor burnout has a negative impact on both clients and organizations as a result of staff turnover, absenteeism and lack of continuity of care (McKay, 2009; Schaefer, Ingudomnukul, Harris & Cronkite, 2005). Furthermore, recent research has shown counselors practicing in more rural areas have greater burnout because of the additional stress and limited resources (Hargrove & Curtin, 2012; Kee Johnson & Hunt; 2002).

In a recent focus group conducted by Oser et al. (2013) counselors described burnout related to emotional exhaustion, depersonalization and lack of personal accomplishment. The counselors in this study discussed the importance of counselor self-care and understanding the recovery/relapse cycle of substance use. Don discussed in a supervision session how he builds interventions to help clients obtain skills they may use later on the road. As he states, it is not a way to cop out on the current intervention, but to look at building a skill set the client can utilize

in more intensive therapy later on when he/she is ready. He stated he felt like he didn't fail as much using this approach. Not only does his example demonstrate an understanding of the chronic nature of SUDs, but it is also a coping mechanism for him to reduce the emotional toll and critical awareness of self in his role as a counselor.

Lee also acknowledges the importance of understanding how many clients may not reach consistent abstinence; therefore it is about focusing on what the client has accomplished and utilizing those successes to build more successes. For example, if a client has managed to remain abstinent from a drug for two weeks and relapses, the success is celebrated. First, the client demonstrated his/her commitment and ability to abstain and managed the recovery for a period of time. Although the client relapsed, the client has learned what worked and didn't work in the preparation for the behavior change and has a skill set he/she can utilize for future attempts. The counselor sees the motivation and attempt to change and works with the client to build more skills and change what didn't work the last time. Each process brings the client another step closer to his/her recovery goals. As Lee describes in her interview, the process to reach recovery goals is a slow process requiring hope, motivation and patience.

Laura recommended counselors engage in their "own work" or therapeutic process. Counselors treat clients with a myriad of issues and assist clients to work through heavy emotions. An example of how a counselor engaging in his/her own therapy as part of counselor self-care is looking at the role of trauma in substance abuse counseling. In a review of an article focused on substance abuse counselors' working with trauma, overall trauma exposure among SUD clients is estimated to be between 60-90% with 30-50% of those meeting PTSD criteria (Bride, 2007). Considering the amount of trauma within the SUD population and how counselors assist clients to work through the trauma and the emotions from the trauma, one can begin to

imagine the emotional drain upon the counselor; especially if the counselor also has some previous trauma.

Laura's recommendation of engaging in a personal therapeutic process is a protective factor to assist in reducing the emotional toll working with traumatized clients. As Fahy (2007) notes in her paper on fatigue of compassion,

Addiction treatment may have unique working conditions that may actually manifest trauma stress in clients and expose SA workers to secondary trauma stress more often because of the special nature of the work and the potential chronicity of some clients. (p. 202).

Laura's discussion of engaging in the counseling process and the example of the effect trauma has on counselors, supports Lee's recommendation of including additional education on counselor burnout and self-care. In addition, she recommended counselors immerse themselves into the community. Not only will this help counselors identify current resources, but also provide new counselors with a way to experience what is happening within their community.

Just as counseling has adapted to the changes and needs of the population, research and education must also change to meet the needs of the counselors as they arise. Substance abuse counseling education is often a component within graduate education programs in rehabilitation counseling, psychology, and social work. In addition, through mechanisms such as National Institute for Drug Abuse Clinical Trials Network (NIDA CTN) and SAMHSA Addiction Technology Transfer Centers (ATTCs), new interventions and evidence based practices can be disseminated as part of continuing education. A recent study by Morris, Wooding and Grant (2011) found the average lag time between research to practice averaged 17 years with various ranges depending on health condition. For example, the HERG (Health Economics Research

Group, Office of Health Economics, RAND Europe) (2008) study reviewed in Morris, Wooding and Grant found the lag time for mental health was 6-11 years with an average of nine years.

In 1998, the Institute of Medicine (IOM) released a report, *Bridging the Gap between Practice and Research* (Lamb, Greenlick and McCarty, 1998) recognizing the separation between research and clinical practice. Although research provides the empirical evidence needed to determine the efficacy of an intervention, there are gaps between what happens on the front lines, research, and the dissemination and technology transfer of evidence based practices. Barriers to adoption of research based practices have been noted by several researchers. Challenges to adoption include: 1) differing perspectives, objectives and audiences of the researchers, community providers and organizations; 2) organizational structural and financial barriers; 3) policies; 4) education and training; and 5) inaccessibility of research to community providers (Miller, Sorensen, Selzer, & Brighma, 2006; Flynn & Brown, 2011; Squires, Gumbley & Storti, 2008). These challenges may explain the presence of isolation between researchers and front line staff.

Based on the IOM report, several events materialized to begin addressing the gap specifically related to substance abuse treatment. The first was the development of the NIDA CTN in 1999. The CTN consists of researchers and treatment providers working collaboratively to develop and implement new treatment options in community settings. The second was the SAMHSA ATTCs whose mission is to assist and support community programs in the adoption of evidence based interventions (Michel, Pintello, & Subramaniam, 2013). Together, the CTN and ATTCs work together on the Blending Initiative, which create dissemination and training products for interventions tested through the CTN.

According to the Diffusion of Innovation Theory, five factors increase the likelihood of adoption of new practice. They include: 1) the new practice meets a particular need and is perceived to be an advantage over current practice; 2) the compatibility of the practice and how it fits with the current provider; 3) simplicity of the new practice; 4) having opportunity to try out the new practice before fully committing to it; and 5) observability of benefits to their clients (Rogers, 2003). The ATTCs utilize these principals in their Technology Transfer Model Science to Service Laboratory. Their strategies include working collaboratively with individuals and organizations to address challenges and to provide training, technical assistance and support in the adoption of new practices (note: The ATTC Technology Transfer Model can be further examined in *The Change Book: A Blueprint for Technology Transfer*) (Squires, Gumbly and Storti, 2008). Through this model, the ATTCs provide a valuable resource for community providers to identify various practices and implement them in their community settings.

As Don noted, the availability of continuing education is one way for him to stay current with changes in the field. The study participants are, who Rogers would call, early adopters. They seek innovative ways to provide the best services possible to their clients. They are ready for change and accepting of new ideas. This is demonstrated through their wide use of evidence based practices, their willingness to try new practices (e.g. yoga, mindfulness and other CAMs), as well as their utilization of the ATTC for continuing education.

Through sharing their experiences, they have identified many areas in need of further research. As researchers and community treatment providers continue to find the best means of collaboration to bridge the gap between practice and research, the counselors' experiences remind us that treatment programs are addressing immediate needs and must respond to changes in the population at a rapid pace. SUD counselors are the key to identifying and addressing the

most current needs of the community they serve. As researchers, we are in position to not only collaborate with community treatment providers to develop research, but also empower them to have a stronger voice in the development, implementation and dissemination of research and the education of future counselors.

### **Study Limitations**

The study's purpose was to gain in-depth understanding to SUD community outpatient counselor experiences in treating clients with co-occurring medical conditions. This is the first step in understanding what is occurring on a day to day basis in SUD community outpatient counseling. The findings described the experiences treating clients with co-occurring medical conditions, looked at the complex relationship between numerous factors, discussed challenges, and illuminated how counselor roles and responsibilities have adapted and changed. However, there are a number of limitations to the study.

The sample consisted of five SUD community outpatient counselors. Although the sample size is sufficient for an IPA study, it poses a risk to participant identification. All precautions were taken to reduce the risk of participant identification. However, the risk may have deterred them from providing thorough responses regarding their feelings. In addition, nine counselors were invited to participate. Characteristics of the four counselors who did not participate are unavailable. Information to determine if there are differences between counselors who participated and those who did not is not available and selection bias cannot be ruled out.

The sample also consisted of four counselors who worked primarily with men and one who worked primarily with women. We do not know if interviews with more therapists who treated women would have brought out further differences in their experiences. Lastly, the distribution of time as counselor and time at site (e.g. with one having five years and others have

10 or more years) is skewed. Unfortunately follow-up interviews were not conducted to determine if there was an effect of this on the experiences. Findings from this study cannot be generalized to the larger population of SUD community outpatient counselors or SUD counselors in other treatment modalities and locations.

Another limitation is the novice experience of the researcher in conducting IPA. This was the researcher's first qualitative study using this methodology. Unfortunately, follow-up interviews to gain further information on client characteristics or other questions that arose during analysis was not planned for nor conducted. This may have limited our ability to further explore various super-ordinate themes and sub-themes and may have contributed to the significant overlap between themes. In addition, the researcher faced some challenges in the interviews. Although she focused on the counselor experiences, incidents where follow-up questions could have led to further depth were missed.

There is also a possibility of researcher bias. All efforts to document researcher bias and assumptions were completed including the bracketing interview and reflective journal. However it is a natural part of the interpreting process that the researcher's world view may have been incorporated into or influenced the results during the analysis. In relation to this, the study does not have a rigorous triangulation method as its prominent validity tool. Some triangulation occurred between the analysis, the literature review and the reflective journal. However, the overall study lacks the opportunity of having another independent coder of the transcripts. Lastly, the study is limited as this is a presentation of one researcher's interpretation of SUD community outpatient counselors' experiences (Pringle, Drummond, McLafferty & Hendry, 2011).



## Conclusions

Despite the limitations of the study, the findings illuminate the experiences of SUD community outpatient counselors treating clients with co-occurring medical conditions and begin to fill in a gap in the literature related to SUDs and medical co-morbidity. Without their voices, an in-depth understanding of what counselors experience and what it means to them in SUD counseling cannot be incorporated into the integration of behavioral and physical health. From their descriptions of the experience, several conclusions can be made.

First, SUD clients with co-occurring medical conditions ability to achieve substance abuse treatment outcomes is complicated by a host of predisposing, enabling, need and health related factors. These bio-psychosocial factors are inter-related and constantly interacting with one another. The multi-faceted relationship between factors, in combination with resource challenges and client internal emotions, has resulted in SUD treatment to expand from therapy to a holistic care model for the client.

In essence, counselors are trained to treat a chronic disease which is then affected by and has a relationship with other physical diseases. Add on to this the psychosocial needs of clients; it is not surprising to hear the counselors talk about how few clients manage to have sustained recovery and abstinence. Because SUD counselors are experienced in addressing the basic needs of clients while providing therapeutic treatment for SUDs, they bring a level of knowledge and a unique perspective to the integration of behavioral and physical health.

The second conclusion reached from the findings is the critical importance of policy makers and researchers to collaborate and be open to the SUD counselor treatment experiences in treating this population. As we have seen through counselor descriptions, not only is the lack of health insurance an issue, but a lack of providers and the fear and distrust of the system

creating a host of barriers related to accessing and utilizing care. Integration models need to be developed focusing on all barriers related to access and utilization of health care. The models must be feasible and work within the current resources of a geographic location. For example, the expansion of health insurance coverage to underserved populations is desirable or needed. However, if the client does not have transportation and/or reliable means of communication and are unable to effectively communicate with front line staff or maintain the patience for processing forms, then coverage may not have the impact that is desired. In addition, integration of behavioral and physical health must include a level of case management or care coordination to address other basic needs such as food and shelter, as well as transportation.

Third, there are a number of medical conditions, such as chronic pain, head trauma, cognitive disabilities and gastric bypass surgery, which present unique challenges to SUD treatment and warrant further exploration. These medical conditions require a level of collaboration between the SUD counselor, the client and the attending physicians. First, the challenge is to find physicians and other health care specialists amenable to collaboration. Resources are limited and difficult to access. Second, the client has to be willing to engage in the collaboration.

Fourth, the substance abuse field may want to re-examine what is meant by “recovery,” “abstinence” and “successful treatment outcomes,” within the chronic disease model of SUDs. Especially when discussing SUD clients who have a medical or mental health condition treated by a potentially habit forming substance. If the client uses the medication as prescribed and is abstinent from other drugs, does that mean the person achieved a positive SUD treatment outcome or recovery? Are these terms still relevant in the changing SUD field or should a more public health model of harm reduction and improving quality of life serve as a new model?

Further discussion is needed in this debate. As more and more individuals are being treated with potentially habit forming medications (and in some states with medicinal marijuana), the time has come for deliberating the definitions of positive SUD treatment outcomes.

Lastly, substance use education, both at the graduate level and through continuing education, are important sources of information counselors look to for information and skills to effectively provide treatment. Additional effective knowledge translation and technology transfer is needed. This includes continued collaborative research and training activities through the CTN and ATTCs to provide the opportunity for community based treatment centers to engage in research, intervention development and adaptation, and dissemination. In addition more focus on holistic approaches and counselor self-care are needed in order to properly prepare and sustain the SUDs treatment workforce.

### **Implications for Rehabilitation Counseling and SUD Addiction Field**

Based on the findings and the conclusions, there are several implications for both the addictions field and in particular for rehabilitation counseling. Overall, the findings demonstrate the need for continued education and skills training in providing whole person, client-centered counseling, including increased instruction on holistic treatment through cross-disciplinary education. For example, educational programs in rehabilitation counseling, psychology and social work may want to encourage or even require classes on pharmacology/toxicology, basic nutrition, spirituality, pain conditions and positive health psychology focused on building strengths and well-being. Even more so, education providers should examine including more courses and skills training on assisting clients to adapt to a disability or health condition.

Rehabilitation counseling has an opportunity to lead the way in assisting the SUD counseling field in developing skills to support SUD clients with medical conditions to adapt to

lifestyle changes. In particular, rehabilitation counseling's emphasis on vocational rehabilitation could assist clients who face employment issues due to their health. For example, substance use is often seen as a barrier to employment. However, clients experience a myriad of other challenges that may contribute to their lack of employment. Research has demonstrated that clients with SUDs engaged in vocational rehabilitation experience other barriers including, lack of education/job training, stigma, other physical and mental health issues, and fear of losing current benefits (Melvin, Davis, & Koch, 2012). Vocational rehabilitation counselors are immersed in the challenges their clients experience in their journey to self-efficacy, increased quality of life and well-being. Their experience can be shared and utilized as one potential model of treating various bio-psychosocial needs of SUD clients who have co-occurring medical conditions.

According to the Office on Disability-Substance Abuse and Disability (2010), approximately 4.7 million Americans with disabilities experience co-occurring substance use. SAMHSA has also found high levels of substance use among people with disabilities including 50% of individuals with traumatic brain injury, spinal cord injury, or mental health issues. Alcohol use, particularly heavy drinking, is found among 40-50% of individuals who have spinal cord injury, orthopedic disabilities, vision impairment and amputations (SAMHSA, 2011). Overall, it is estimated that SUDs occur 2-4 times more often in people with disabilities. Studies have found that over 79% of rehabilitation counselors reported treating a client with SUDs. Additional research has also highlighted this prevalence (Cardoso, Chan, Pruett and Tansey, 2006).

The prevalence of rehabilitation counselors' exposure to clients with SUDs (who may or may not already be engaged in SUD treatment) illustrates the existing experience rehabilitation

counselors have working with SUD clients. By providing more opportunity for SUDs and co-occurring medical conditions education and training, rehabilitation counseling can also increase its curriculum focus on SUDs in general. This would place rehabilitation counselors in the forefront of providing bio-psychosocial services that are client-centered and meeting the basic needs of clients.

In this study, the participants included three counselors with a social work background and two with rehabilitation counseling backgrounds. Being early adopters of innovation, they exemplify the cross disciplinary collaboration between these two fields creating a bio-psychosocial model of care focused on improving quality of life and well-being. All five counselors illustrated their extensive knowledge and utilization of various treatment strategies and their willingness and self-motivation to engage in the research (e.g. Lee's example of sending out a research article to colleagues; Laura's acknowledgement and wish for further research on CAMs; Don's utilization of ATTC resources). As Rogers states, early adopters are one's who seek out and are willing to implement innovative ideas. In order to so, the organizational environment must be one of open communication and collaboration. The participants demonstrated that although they come from two different counseling programs, there is a level of interdisciplinary collaboration and communication. Otherwise, early adoption of new practices would not be as successful or widely implemented across the organization.

SUDs are a chronic disease cycling through periods of recovery and relapse. As described by the counselors in this study, SUDs combined with co-occurring medical conditions, impacts all aspects of a client's life requiring adjustment and adaptation. As health care reform moves to integrate behavioral and physical health, this exploration focused on what is experienced by current SUD treatment counselors' offers insight into the complexity of SUD

counseling. It identifies the need for more integration of behavioral and physical health, but also reminds us of the complex needs of SUD clients. Rehabilitation counseling leadership has an opportunity to learn from this study and move the field to the forefront of behavioral and medical care integration by increasing interdisciplinary education and developing a substance abuse counselor education curriculum for graduate counseling students from various fields of study that focuses on the bio-psychosocial aspects of individuals with behavioral and physical health issues.

### **Recommendations for Further Research**

The following study set out to explore community outpatient counselors' experiences treating clients with co-occurring medical conditions. The result was a picture of the complexity of various factors that influence how counselors approach substance abuse treatment. The extent the themes were interwoven illustrates that current research needs to take into account not only the influence of psychosocial factors affecting clients, but physical health conditions and how they impact treatment delivery and outcomes. As demonstrated through the results, this may also mean clarifying the type of medical condition, whether it is acute or chronic, and whether potentially habit forming medications are being utilized.

The results not only provided a description of their experience, but also generated a multitude of possible further research areas. From the four super-ordinate themes that emerged from the counselor's experiences treating clients with co-occurring medical conditions, a series of recommendations for further research are made.

Research recommendations for super-ordinate theme one include taking a closer look at the various factors and their influence on SUD counseling and outcomes. Future research directions include:

- Exploring the differences between chronic and acute medical conditions, the role of caregiver (for aging parents) and medical conditions treated with potentially habit forming medications, and how different types of co-occurring medical conditions have different relationships with substance use and SUD treatment.
- Exploring the impact of medical conditions from the SUD client's, counselor's, organization's and policy maker's perspective.
- Determining the role of co-occurring medical conditions as they relate to other predisposing, enabling, need and health re-related factors in SUD treatment.
- Developing and testing integrated care models designed to fit existing community resources and funding limitations.

Research recommendations related to super-ordinate theme two focuses on the prominent medical conditions described by the counselors and include:

- Exploring the role of potentially habit forming medications within substance abuse treatment including counseling and treatment outcomes on people who have medical conditions being treated with such medications that may have led to an addiction, and clients who are utilizing prescription medications as a replacement for street drugs.
- Identifying what is similar and different among this client sub-population versus other clients, and what are the most effective treatment strategies.
- Identifying what “recovery” and “abstinence” means to both clients and clinicians and begin the conversation of how recent trends in prescription drugs use may change the definitions.
- Developing and evaluating strategies to identify clients with TBI and other cognitive impairments and utilize the most effective strategies to assist in their client's recovery.

Research recommendations for super-ordinate theme three relate to the changes in counseling roles and responsibilities and providing holistic care inclusive of alternative treatment strategies and lifestyle adaptation including:

- Exploring the changes and adaptations of counseling roles and responsibilities as needs of the clients has changed.
- Sound methodological studies on holistic treatment models and alternative care strategies (e.g. yoga, meditation, mindfulness). As SUD treatment centers begin to integrate more holistic approaches into their treatment centers exploration of those strategies impact client outcomes including recovery and overall improvement in quality of life and function.
- Testing and evaluating existing and new strategies aimed at lifestyle adaptation and increased well-being.

Research recommendations for super-ordinate theme four are focused on the development of the SUD counseling workforce and include:

- Exploration of SUD counselor's confidence level of treating clients with co-occurring medical conditions.
- Identifying skills to treat clients with co-occurring medical conditions.
- Building and evaluating an interdisciplinary model of substance abuse education curriculum for both graduate level training and continuing education.

Each of the research recommendations are centered in the direct experiences of the study's participants and reflect the present issues they face. For researchers, their willingness to share their experiences provides an opportunity to conduct research on current issues and encourages counselors to be a part of research. Counselors know best what is happening in their



communities and have a wealth of information and guidance that can support and accelerate research in the field and work to reduce the time lag between science and practice.

### **Concluding Remarks**

Through this exploratory journey discovering SUD community outpatient counselors' experiences treating clients with co-occurring medical conditions, the commitment and dedication of the counselors is undeniable. Most impactful was how several noted what an honor it was to work with their clients and to be part of their journey to greater well-being. In spite of all of the challenges, limited resources and the complexity of issues counselors face with their clients; they work diligently to provide the highest level of care possible. Their interviews were filled with hope and celebrations of the steps clients make in improving their quality of life. At first, the findings seem overwhelming and frustrating with the layers of needs and limited resources. However, through patience, empathy and skills, counselors work with their clients to build one small success upon another. Small successes are welcomed with praise and respect. Counselors provide a source of continuous motivation and encouragement to clients which help them continue on, even if they don't physically feel like they can do much more.

When the research first began, the researcher assumed we would see the relationship between medical conditions and SUDs and it was confirmed. The relationship is bi-directional with some medical conditions a result of substance use, while other medical conditions led to an addiction. The researcher anticipated seeing unique challenges related to medical conditions treated with habit forming medications, which was also confirmed. However, the researcher did not anticipate how complex treating clients with co-occurring medical conditions was. In order to visualize the dynamics of the interactions, one would need to construct a three dimensional model with factors woven together in a complex web of interaction. This study was the first step

in discovering what SUD treatment counselors are experiencing working with clients with co-occurring medical conditions. The researcher's goal is that this will just be the beginning and lead to more qualitative and quantitative exploration of the phenomenon.

Through this process, the researcher gained a new level of respect for SUD treatment counselors. The role of medical conditions is more than just another basic need of a client to be addressed. The medical condition requires the client to grieve the loss of their self-identity (how they were before the medical condition), interact with a complex system, and learn to adapt to any lifestyle changes, all while trying to address other bio-psychosocial issues. SUD counseling is not just about reaching recovery, but improving the overall well-being and quality of life of a client. Counselors willingly go beyond therapy and provide whatever is necessary to address the needs of the client, giving he/she every opportunity to regain power and control over his/her lives. Also impressive is the counselors' creativity to combine evidence based practices with alternative treatments to fit individual client needs.

The researcher hopes through this project the substance abuse treatment field and policy makers will begin to understand the need for integrated care, not just from the perspective of identifying SUDs among emergency room or physician patients, but to bring much needed medical care to SUD clients who are more than likely not interacting with the health care system. Lastly, the researcher hopes through this presentation of research findings, she has honored and raised the voices of the counselors who participated in this study and all SUD counselors who provide a valuable service to their communities; may they always remain hopeful.

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## Appendix A

### IRB Approval Initial and Modification





# VCU

Make it real.

Office of Research  
Office of Research Subjects Protection  
BioTechnology Research Park  
300 East Leigh Street, Suite 3000  
P.O. Box 980568  
Richmond, Virginia 23298-0568  
(804) 828-0868  
Fax: (804) 827-1448

DATE: February 1, 2013

TO: Amy Armstrong, PhD  
Department of Rehabilitation Counseling  
Box 980330

FROM: Andrea Hastillo, MD *Andrea Hastillo MD*  
Chairperson, VCU IRB Panel C *Feb 1, 2013*  
Box 980568

RE: **VCU IRB #: HM14896**  
**Title: Exploring Substance Use Disorder Community Outpatient Counselor's Experiences Treating Clients with Co-Occurring Medical Conditions: An Interpretive Phenomenological Analysis**

On February 1, 2013, the following research study was approved by expedited review according to 45 CFR 46.110 Categories 6 and 7. This approval reflects the revisions received in the Office of Research Subjects Protection on February 1, 2013. This approval includes the following items reviewed by this Panel:

**PROTOCOL: Exploring Substance Use Disorder Community Outpatient Counselor's Experiences Treating Clients with Co-Occurring Medical Conditions: An Interpretive Phenomenological Analysis**

- Research Plan (Version #3, dated 01/31/13; received by ORSP February 1, 2013)
- Measures:
  - Appendix C: Study Design (Version 2, dated 01/26/13; received by ORSP January 29, 2013)
  - Appendix E: Demographic Form (Version 2, dated 01/26/13; received by ORSP January 29, 2013)
  - Appendix F: Interview Schedule (Version 2, dated 01/26/13; received by ORSP January 29, 2013)

**VCU IRB APPROVED CONSENT/ASSENT FORM (attached):**

- Appendix C: Research Subject Information and Consent Form (Version 3 01/31/13, 5 pages; received by ORSP February 1, 2013)

**ADDITIONAL DOCUMENTS:**

- Appendix A: Permission Letter (Version 1, dated 01/16/13; received by ORSP January 29, 2013)
- Appendix B: Sample Email (Version 1, dated 01/16/13; received by ORSP January 29, 2013)
- VCU IRB Study Personnel Roster (Version date: v.1 9/22/12; received by ORSP November 27, 2012)

**This approval expires on January 31, 2014.** Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review report forms will be mailed to you prior to the scheduled review.

The Primary Reviewer assigned to your research study is Solomon Lockett, MS. If you have any questions, please contact Mr. Lockett at [sluckett@raaems.org](mailto:sluckett@raaems.org) or 254-1193; or you may contact Elicia Preslan, IRB Coordinator, VCU Office of Research Subjects Protection, at [IRBPanelC@vcu.edu](mailto:IRBPanelC@vcu.edu) or 827-0899.

Attachment – Conditions of Approval



Office of Research Subjects Protection  
 Bio-Tech Research Park, Building 1  
 800 E. Leigh St., Ste.#3000  
 P.O. Box 980568  
 Richmond, Virginia 23298-0568

DATE: May 13, 2013

TO: Amy Armstrong, PhD  
 Department of Rehabilitation Counseling

FROM: Andrea Hastillo, MD  
 Chairperson, VCU IRB Panel  
 Box 980568

RE: **VCU IRB #: HM14896**  
**Title: Exploring Substance Use Disorder Community Outpatient Counselor's Experiences Treating Clients with Co-Occurring Medical Conditions: An Interpretive Phenomenological Analysis**

*Maria Stuchlik  
 In #4*

On April 19, 2013 the changes to your research study were approved in accordance with 110 (b) (2). This approval includes the following items reviewed by this Panel:

**PROTOCOL:** Exploring Substance Use Disorder Community Outpatient Counselor's Experiences Treating Clients with Co-Occurring Medical Conditions: An Interpretive Phenomenological Analysis – Research Plan Template, Version #4 dated 04/05/13-stamped received 4/10/13

**CONSENT/ASSENT (attached):**

- Appendix C: Research Subject Information and Consent Form, Version 4 dated 04/05/13-stamped received 4/10/13; 5 pages

**ADDITIONAL DOCUMENT:**

- Study Personnel Roster, v. 2 dated 04/05/13-stamped received 4/10/13
  - Addition of Lori Keyser-Marcus, PhD, to the study

**As a reminder, the approval for this study expires on January 31, 2014.** Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review report forms will be mailed to you prior to the scheduled review.

The Primary Reviewer assigned to your research study is Solomon Luckett, MS. If you have any questions, please contact Mr. Luckett at [sluckett@raaems.org](mailto:sluckett@raaems.org), 254-1193; or you may contact Ingrid Rosiuta, IRB Coordinator, VCU Office of Research Subjects Protection, at [IRBPanelC@vcu.edu](mailto:IRBPanelC@vcu.edu) or 827-1446.

## Appendix B

### Permission Email

Lauretta A. Cathers, MSW  
1000 E. Marshall Street Room 422  
Richmond, VA  
(804) 683-9060

(deleted to protect site identity)

January 26, 2013

Greetings!

I am a doctoral student in the VCU School of Allied Health, Rehabilitation Counseling Department. I'm interested in conducting interviews with adult outpatient substance use counselors at your location. The purpose of this qualitative study is to explore the experiences of community outpatient substance use disorder (SUD) treatment counselors who treat clients with co-occurring medical conditions. This exploration is important in order to discover what is happening within substance use treatment and how treating clients with co-occurring medical conditions affects a counselor's implementation of evidence based practices. The study provides the opportunity to explore their experiences so as to challenge and/or confirm current assumptions and provide a glimpse into treating individuals with SUDs and co-occurring medical conditions.

I would like your permission to conduct the study at your site. This will include permission to obtain the names, credentials/licenses (i.e. the LCSW, LPC, etc. designation appearing at the end of a counselor's name), years of service, whether or not a counselor has an active counseling case load and email address of all counselors in your adult substance use outpatient program and permission to contact eligible counselors via email. From the list you provide, I will identify counselors who fit eligibility criteria and contact them via email inviting them to participate. If a counselor does not respond within 10 days, they will be considered not interested in participating and no further contact will be made. As part of protecting their confidentiality and privacy, I will not share who is eligible to participate and who agreed/didn't agree to participate. Their names, as well as the name of your organization, will not be published in the dissertation and potential future publications. This is to protect the identity of the research participants. All counselors who are eligible will be invited to participate. It is estimated that up to seven counselors will be eligible. Interviews will take place off site and during non-work hours.

Please feel free to email me at [s2lasaff@vcu.edu](mailto:s2lasaff@vcu.edu) or call me at 804-683-9060 or you can contact the Principal Investigator, Amy Armstrong PhD, Chair, Rehabilitation Counseling (804) 827-0913

[ajarmstra@vcu.edu](mailto:ajarmstra@vcu.edu) if you have any questions. An email with your decision will be greatly appreciated.  
Thank you for your time and consideration.

Thank you  
Lauretta Cathers



## Appendix C

### Recruitment Email

Subject Line: Participant Invitation: Research Study to Explore Substance Use Counselors experiences treating clients with co-occurring medical conditions

Greetings!

I am a doctoral student in the VCU School of Allied Health, Rehabilitation Counseling Department. I'm interested in conducting interviews with substance use counselors in an adult outpatient substance abuse program. The purpose of this qualitative study is to explore your experiences as a community outpatient substance use disorder (SUD) treatment counselor who treats clients with co-occurring medical conditions. This exploration is important in order to discover what is happening within substance use treatment and how treating clients with co-occurring medical conditions affects a counselor's implementation of evidence based practices. The study provides the opportunity to explore your experiences so as to challenge and/or confirm current assumptions and provide a glimpse into treating individuals with SUDs and co-occurring medical conditions.

With permission of the (removed to protect identity) I obtained the names, license/credentials (i.e. the LCSW, LPC, etc. designation appearing at the end of a counselor's name), years of service and email address of all substance abuse counselors in the adult outpatient program. Those counselors who met eligibility criteria are being contacted. You are invited to participate in the study. The study includes an interview with me that will last 60-90 minutes and cover a range of topics related to working with clients with co-occurring medical conditions. Interviews will take place either in a private meeting room at the County library or my VCU office. You will be compensated \$50 (Target gift card) for your time.

Potential risks of participation include being identified. Your information will not have your name, nor will anyone on staff or acting manager be told who was invited to participate, and who participated/not participated. Participation is completely voluntary. If you choose to participate, you will also have the right to refuse/skip any question and can withdrawal from the study at any time without penalty. If you would like to participate or have additional questions, please email me at [s2lasaff@vcu.edu](mailto:s2lasaff@vcu.edu) or call me at 804-683-9060 or you can contact the Principal Investigator, Amy Armstrong PhD, Chair, Rehabilitation Counseling (804) 827-0913 [ajarmstra@vcu.edu](mailto:ajarmstra@vcu.edu). If I do not hear from you by (insert date), I will assume you are not interested in participating and will not contact you further. I appreciate your time and consideration.

Thank you  
Lauretta Cathers



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11. Number in Active Caseload: \_\_\_\_\_



## Appendix E

### Interview Schedule

**Interviewer:** Thank you again for agreeing to participate in this exploratory study on SUDs community outpatient treatment counselor's experiences of working with clients with co-occurring medical conditions. Remember you have the right to refuse/skip any question.

First, I'm going to ask you some basic demographic information.

*(Administer Demographic Form Here)*

**Interviewer:** Thank you for your information. Now I would like to get to know more about the clients you serve. Please describe the demographic characteristics of clients on your current case load. *(Note to interviewer, include gender, race/ethnicity, average age, sexual orientation and gender identity, legal system involvement, trauma, and substance most common, etc. Please remind counselor to not be client specific, but to provide an overall description of their current caseload).*

In working with your clients, you may use a range of counseling styles and evidence based practices. Please describe your counseling style and evidence based practices that you use and how you determine what style to use with clients.

**Interviewer:** (Q1) As we discussed earlier in the consent, the focus of this study is to explore your perceptions of counseling clients with co-occurring medical conditions. This can include treating clients whose substance use may be contributing to health issues or clients whose health issues may be a factor in their substance use. Please describe your experiences in working with clients with co-occurring medical conditions.

**1a:** What are some examples of treating clients with hypertension, chronic pain, HIV, etc.?

**1b:** In what ways do you think clients without co-occurring medical conditions and those with co-occurring medical conditions differ? Are the same?

**1c:** Different populations experience different health disparities and access to health care issues. In thinking about the characteristics of the clients you serve, describe the health disparities and access issues you have experienced in working with your clients.

(Q2) How have these experiences shaped your perceptions of the relationship between SUDs and co-occurring medical conditions?

**2a:** How do you feel treating clients with co-occurring medical conditions has shaped your counseling style?

**2b:** What experiences have you had, if any, where a client with a co-occurring medical condition has impacted the SUDs treatment course?

(Q3) Through the experiences you describe, what do you perceive are challenges to treating clients with co-occurring medical conditions? What are some strengths in treating clients with co-occurring medical conditions?

**3a:** What are your perceptions of co-occurring medical conditions impact on achieving abstinence?

(Q4) We talked earlier about your counseling style and evidence based practices and the potential impact treating clients with co-occurring medical conditions may have. What are strategies or ways by which you adapt in treating clients with medical conditions?

(Q5) Thinking about when you first started counseling to where you are now, how have your experiences shaped your perceptions of SUDs counselors' roles and responsibilities ?

**5a:** Based on your experiences, what advice would you give to new substance use counselors in treating clients with co-occurring medical conditions? What advice would you give future educators and trainers?

Interviewer: Thank you again for taking the time to share your experiences in treating clients with co-occurring medical conditions. As we wrap up the interview, is there anything else you would like to add?

**Appendix F**  
**IRB Approved Consent Form**

## Appendix C: RESEARCH SUBJECT INFORMATION AND CONSENT FORM

**TITLE: Exploring substance use disorder community outpatient counselor's experiences treating clients with co-occurring medical conditions: An Interpretative Phenomenological Analysis**

### PI Contact Information

**Amy Armstrong, PhD, Chair, Rehabilitation Counseling**  
(804) 827-0913  
ajarmstra@vcu.edu

### Student Contact Information

**Lauretta A. Cathers, Doctoral Student**  
804-683-9060  
S2lasaff@mail1.vcu.edu  
1000 E. Marshall Street  
Richmond, VA



**VCU IRB NO.:** HM14896

If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

### PURPOSE OF THE STUDY

The purpose of this qualitative study is to explore your experiences as a community outpatient substance use disorder (SUD) treatment counselor who treats clients with co-occurring medical conditions. This exploration is important in order to discover what is happening within substance use treatment and how treating clients with co-occurring medical conditions affects a counselor's implementation of evidence based practices. The study provides the opportunity to explore your experiences so as to challenge and/or confirm current assumptions and provide a glimpse into treating individuals with SUDs and co-occurring medical conditions.

You are being asked to participate in this study because you are a licensed substance use disorder clinician (LCSW or LPC), who has been practicing for more than five years at your current location and have an active caseload of clients. This site was selected based on the interests and requests for presentations/trainings related to clients with co-occurring medical conditions (e.g. chronic pain). Up to 10 interviews will be conducted.

### DESCRIPTION OF THE STUDY YOUR INVOLVEMENT

If you decide to be in this research study, you will be asked to sign this consent form after you have had all your questions answered and understand what will happen to you.



This Box for IRB Office Use Only  
Do Not Delete or Revise  
Template Rev Date: 5-15-12

Your participation will include filling out a demographic information sheet and participating in a 60-90 minute semi-structured face to face interview with Mrs. Cathers. With your permission, the interview will be audio recorded. Questions in the interview will include describing your experiences treating clients with co-occurring medical conditions, challenges to counseling clients with co-occurring medical conditions, how co-occurring medical conditions may impact delivering evidence based practices (e.g. motivational interviewing) and what strategies you use or ways you have adapted evidence based practices to fit client needs. After the interview, I will analyze the transcript and prepare a summary of key themes. You will be given the opportunity to review the summary and any quotes chosen to be used in dissertation and/or future publication and make corrections.

Significant new findings developed during the course of the research which may relate to your willingness to continue participation will be provided to you.

#### **RISKS AND DISCOMFORTS**

There is a risk that you may be identified. To protect your privacy and confidentiality, your place of employment will not be identified and your identity will only be known to Mrs. Cathers. In addition, you may feel some discomfort during the interview, especially if you discuss your current employment. We ask that you only disclose the information you feel comfortable with.

#### **BENEFITS TO YOU AND OTHERS**

You may not get any direct benefit from this study, but, the information we learn from people in this study may help bring outpatient SUDs counselors voices into the integration of health care discussion.

#### **COSTS**

There are no costs for participating in this study other than the time you will spend in the interview and reviewing your summary.

#### **PAYMENT FOR PARTICIPATION**

You will receive a \$50 Target gift card at the end of the interview. If you terminate the interview early you will still receive the gift card. You may also withdrawal your participation at any time without penalty. You may also refuse to answer any question without penalty.

#### **ALTERNATIVES**

Your alternative is not to participate in this study. Replace with N/A

#### **CONFIDENTIALITY**

Potentially identifiable information about you will consist of the demographic form, interview notes and recordings and audiotapes. Data is being collected only for research purposes. Your data will be identified by an ID number not your name. The only linking document to match your name to the data will be stored on the student's encrypted and password protected laptop. Only Mrs. Cathers will have access to the linking document

Version 4.04/05/13

Page 2 of 5

APPROVED

SL / IR / 4.19.13



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and your consent form. Your consent form will be stored in a locked filing cabinet within the students locked office at VCU. Your demographic form will be stored in a separate locking filing cabinet in students VCU office. Your audio recording will be downloaded from the recorder to an encrypted and password protected laptop within one hour of the interview and deleted off of the audio recorder. Your demographic form and audio recording will be given a study number. Any hard copies of your interview transcript will be kept in a locked filing cabinet and shredded when analysis is complete. Your audio recording will be deleted at the end of analysis and dissertation defense. De-identified transcripts will be stored on an encrypted and password protected computer for three years in the event that another researcher would like to conduct a quality insurance check on the analysis. After three years, the transcript will be deleted. Other records including demographic form will be kept in a locked file cabinet for three years after the study ends and will be destroyed at that time. Access to all data will be limited to study personnel. A data and safety monitoring plan is established.

We will not tell anyone the answers you give us; however, information from the study and the consent form signed by you may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized officials of the Department of Health and Human Services (if applicable).

What we find from this study may be presented at meetings or published in papers, but your name will not ever be used in these presentations or papers.

#### **CONSENT FOR AUDIO RECORDING**

Your interview will be audio taped, but no names will be recorded. At the beginning of the session, all participants will be asked to use a pseudo name only so that no names are recorded. After the information from the tapes is typed up and analysis is complete, the de-identified audio recordings will be stored on the encrypted password protected computer until the dissertation is complete. If the student is unable to successfully defend her dissertation, the audio recordings will be destroyed.

1. I give permission for my interview to be audio recorded (please initial):

YES \_\_\_\_\_ NO \_\_\_\_\_

#### **VOLUNTARY PARTICIPATION AND WITHDRAWAL**

You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. If you choose to withdraw from the study none of the information collected from you will be used.

Your participation in this study may be stopped at any time by the study staff or the sponsor without your consent. The reasons might include:

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- the study staff thinks it necessary for your health or safety;
- you have not followed study instructions;
- the sponsor has stopped the study; or
- administrative reasons require your withdrawal.

#### QUESTIONS

If you have any questions, complaints, or concerns about your participation in this research, contact:

**Lauretta A. Cathers, Doctoral Student**  
**804-683-9060**

**S2lasaff@mail1.vcu.edu**

**1000 E. Marshall Street**

**Richmond, VA**

*and/or*

**Amy Armstrong, PhD, Chair, Rehabilitation Counseling**

**(804) 827-0913**

**ajarmstra@vcu.edu**

The researcher/study staff named above is the best person(s) to call for questions about your participation in this study.

If you have any general questions about your rights as a participant in this or any other research, you may contact:

Office of Research  
Virginia Commonwealth University  
800 East Leigh Street, Suite 3000  
P.O. Box 980568  
Richmond, VA 23298  
Telephone: (804) 827-2157

Contact this number for general questions, concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk with someone else. General information about participation in research studies can also be found at <http://www.research.vcu.edu/irb/volunteers.htm>.

#### CONSENT

*I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. My signature says that I am willing to participate in this study. I will receive a copy of the consent form once I have agreed to participate.*

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Participant name printed Participant signature Date

Name of Person Conducting Informed Consent  
Discussion / Witness <sup>3</sup>  
(Printed)

Principal Investigator Signature (if different from above) Date <sup>4</sup>

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## Appendix G

### Summaries

#### Interview Summary

**Interviewee: 1001 “Wayne”**

**Interview date: May 30, 2013**

**Summary date: June 6, 2013**

#### **Description: Counselor Characteristics**

(Deleted to protect identity)

#### **Description: Client Demographics**

Wayne describes the population he works with as adult males 18 years of age and older. In general, clients are described as reflective of the current population (predominantly Caucasian, followed by African American, with few Hispanic/Latino or other race/ethnicity). Wayne describes approximately a third of the clients are currently involved with the legal system for a substance use related charge such as underage possession of alcohol, possession of marijuana, or possession of paraphernalia. The clients in this segment of the population vary in levels of motivation from pre-contemplative to contemplative, with a small minority in the preparation phase.

Of the remaining three-fourths of the clients, co-occurring mental health disorders are common. Mental health disorders are severe and include depression, anxiety, bi-polar and some episodes of psychosis. Previous suicide ideation and/or attempts are also common. Although severe, clients do not meet the classification of severely mentally ill which would result in being assigned to a different department (Mental Health). Also within this population are a small percentage of people known as the “good ole straight substance abuse client.” They usually come in highly motivated (action phase) and are committed to complete abstinence. Among the men’s unit, Wayne has observed the primary drugs of use include alcohol and marijuana, followed by cocaine and heroin. He states that a lot of clients have been exposed to trauma and some counselors are using Emotion Focused Therapy and EMDR. The 12 step model is also utilized.

Wayne describes that the majority of male clients have some health problems, dental problems, housing problems, economic problems. A small minority have access to resources for health care and dental care because they may be employed or are engaged in the legal system (which may open resources for them). However, the other 70% of the people they see struggle financially which impacts their ability to access health care. Clients have multiple layers of issues they struggle with. Health problems include rotten teeth, poor vision, hypertension, pain issues, GI problems, COPD. Health conditions prevalent in the population are either caused by their

substance use or because of injury/wear and tear from laborious employment. Clients may not share their health conditions with their counselors or be unaware of the extent of their health conditions.

### Quotations for Client Characteristics

*“Obviously, they have some health problems. They have dental problems. They have housing problems. They have economic problems. But for the most part they tend to be, have much better access to resources for health care, dental care, eye care. Many are employed. So they are not representative of the other 70% of people we see.” (1001:092)*

*“Because we are a community based program, we work on a sliding scale. Many of the people that come to us have no other place to go. So they’ve, and they’ve lost a great deal along their way with their struggle with mental health and substance abuse problems.” (1001:092)*

### Description: Main Themes

**Description Theme #1: Clients face multiple bio-psychosocial factors that may serve as barriers to treatment and successful goal attainment, with only a small proportion having access to needed resources to address those factors.**

- Most clients are unemployed/underemployed and lack the financial resources to access health care.
- Many clients have struggled with addiction and lost the majority of their resources including family, friends, financial support, etc.
- When clients enter SA services, it is often their last option/resource.

### Quotations

- *“I would say the majority of those 70% have issues related to health care or have physical, dental, hygiene, housing, economic problems that pile up on top of them.” (1001:092)*
- *“And you talked a little while ago about fear, even though they’re sick, there’s also this fear how sick they are. So to them it seems less scary to say “oh” and it also supports the addiction, “Well maybe I got cancer. Maybe I got heart disease. So why should I even quit drinking? The doctor is just going to tell me to quit drinking or something.” So there’s a lot of factors, even if they had access to health care, easy access to health care, whether they connect with it or not, related to the addiction, to the mental health symptoms. And just cultural fears around doctors, medicine and even these good ole Caucasian guys, the culture they grow up in, you just don’t go to doctors. They don’t trust doctors. You hear a common story about some Uncle or some parent or somebody that went to the doctor and that experience somehow caused the illness that the person has. They were either misdiagnosed or in the process of diagnosis, that exacerbated the situation. You know, it’s all these urban legends they bought into around health care; especially preventative health care.” (1001:176)*

**Description Theme #2: Prescription drug use is a different phenomenon in treatment because people feel prescription drug use is legitimate.**

- Prevalence of prescription drug use is observed as high; although monitoring programs are making access to prescriptions more difficult.
- Counseling involves providing education about the dangers of mixing prescription medications with other drugs and the addictive potential of the prescription medications.
- Clients feel their prescription drug use is legitimate because it was provided by a physician.
- Counselors look for ambivalence and change talk to identify if a client feels they may have some issues around using their prescription medications. Strategies to address potential misuse or abuse of prescription medications are dependent on the individual's motivational level.

**Quotations**

- *"I look for opportunities for us to discuss that and pull from the client his perception of cost/benefits, that kind of stuff. But it's not a requirement in our program that you be sober and if that is something that a doctor's prescribing for them, #1: we are not doctors so we can't give them medical advice and #2: you know if a person is not ready, they're not ready." (1001:116)*
- *"I'm seeing more people coming into treatment now that have been caught for prescription fraud and that is why they are being referred for treatment. Well, they've gone to their probation officer and they've said, "Look I did this because I have an addiction." So the probation officer refers them to us. Many times they are motivated. But anyway, I think it is becoming harder to do so maybe that's why we are bringing, we're seeing more people coming into treatment talking about this. But it's still, it just seems epidemic." (1001:124)*
- *'...It's a different animal because people feel that it's legitimate and they are taking it many times as the doctor indicates. So maybe one of the things to answer your question is if you start to hear people say, you start to hear change talk, you start to hear some ambivalence, then you can talk to them about "Well how would you know if this was a problem for you?" What is...and give them an example, you know with permission, "is it ok if I make some suggestions?" And they say sure. "Well do you ever find yourself taking your medication even when you don't have pain?" And that seems to be the one most commonly that they will respond to, "Well, yea." "Well what's that all about? Well I really like how they make me feel." So then you have something to talk about." (1001:132)*
- *"It is just amazing. It's, it's, we'll sit around and talk about shared clients we have and certain areas like, there's certain parts of (street name omitted), where it seems like everybody in that community has a valid prescription for opiates. How in the world does this happen? Because most of us when we go to the doctor and we have legitimate pain, are very cautious about prescribing opiates and monitor that pretty closely. But these people, they even talk about it in group, "oh yea everybody in my trailer court has a prescription," so it's, it's something we see a lot of now in what I do whether your question was has it increased over time, I can't say." (1001:120)*

- *“And, and some people talk about getting opiates over the internet! That they can just go pass the whole going to my doctor or forging prescriptions and all that, go on the internet if you got enough money and get a prescription mailed to your house. You see some younger people coming in with that kind of stuff. It seems more prevalent now than in the past that people have access to prescription opiates over...typically in the past it was heroin either being snorted or injected was primarily where you saw the addiction there.” (1001:124)*
- *And there’s times when people are in the action phase when you move out of that and you confront, but that’s a different population, like you are saying “yea, well, I’ve been sober for six months, but the doctor’s prescribed these pills and I do find myself craving them and sometimes taking them when I don’t need them.” Then you don’t sit around and tease out the ambivalence. You say, “Well that’s your addiction, clearly.” So it depends on where people are and how you, how I, interact with them as a therapist. (1001:136)*
- *“But do I use the old model of beating down denial and say, ‘look you got a problem and I don’t give a crap what you say, I know you got a problem.’ No I don’t do that.” (1001:132)*

**Description Theme #3: If basic needs such as housing, food, and health care, are not being met, counseling and client outcomes will be affected.**

- If basic needs are not being met, counseling attendance is affected and the client’s focus and ability to practice skills learned in therapy is inhibited.
- There are client differences with the more diligent and more motivated clients have greater success, whereas others who are not as diligent or motivated to engage support systems may have slower progress.
- Counseling strategies include treating the whole person and providing access to needed resources and provide encouragement and support.
- Ethically, counselors do their best to encourage and support clients to get a physical to identify any health problems that may also seem like a mental health problem.
- By obtaining access to health care, clients start feeling better and then respond better to treatment.

**Quotations**

- *“When you look at Maslow’s hierarchy of needs, if they don’t have housing, if they’re in poor health, if they’re struggling to have enough to eat, then obviously mental health therapy is going to be difficult because they are not getting their basic needs met.” (1001:140)*
- *“When you see the difference in the people that do (get access to health care), they start getting better right away even without therapeutic intervention, without medications for depression, anxiety or bipolar disorder. Just starting to feel better and having some health care, just that, achieving that goal and starting to treat those medical problems, they start getting better and then of course, they start responding better to treatment.” (1001:148)*

- *“Regular attendance in counseling. If we are talking about all the socio-economic factors that come into it, the housing is an issue. Financial is an issue. Health is an issue. Transportation is an issue. They are all tied together. So their ability to regularly attend counseling is impacted. Their ability to focus on the things that we focus on in that 50 minute counseling session or that hour and half counseling session, to be able to go out and practice them because talking to me for an hour a week don’t do a whole lot of good unless you go out and put it to use. But when you’re trying not to hurt; to worry about floaters in your eye from your high blood pressure and not being able to breathe well with COPD or all the gamut of the other, it’s, it’s very difficult.” (1001:156)*
- *“Do the best you can. You encourage them. You, you, you, you make health care access available to them; which we are very fortunate in this area through (name omitted) and have (name omitted) insurance. But anybody that’s ever gone through that process usually comes back a tad traumatized because it is a lot of call and wait, call and wait a lot of these people might have three different telephone numbers in two months and you know, its leave messages and get back.” (1001:148)*
- *“It’s like trying to change a flat tire when you got a blown engine. It’s just, you know, it’s not going to fix the problem.” (1001:156)*

**Description Theme #4: Counseling has adapted based on changes in the populations being served and counselor maturity.**

- Primary role of the SA counselor is as therapist and to provide therapy.
- Counseling has adapted to include more case management.
- Counseling is also adapting to changes in the populations counselors serve.
- Counseling strategies are flexible to meet the needs of the population and start with simpler goals and understanding client strengths.

**Quotations**

- *“I guess my expectations of the gains that we make in therapy are different from when it was 5, 10 years ago. I, you know, my primary role I see as a therapist is to provide therapy. What I’ve had to adapt to is doing more case management stuff to try and get people access to these things that will support them so they can focus on what we need to try to accomplish in that therapeutic relationship.” (1001:156)*
- *“You jump out of school thinking you have a great deal of power and the older you get you realize the best thing you can do is just have a healthy relationship that encourages, supports, builds on a healthier lifestyle.” (1001:194)*
- *“But the question is, how has it changed? The changes have come to adapt to the populations. With the individuals that I work with now, my approach, as we talked about earlier, has moved more from, moved away from the sophisticated, the more ego psych type of skills that you focus on to help people grow emotionally, psychologically to a*

*more basic, developing the relationship and once you have that, encouraging, supporting, pointing towards the areas of their life that will help stabilize the goals that they want to accomplish. Cause it just doesn't do any good to get somebody to quit drinking when they got nothing else to fall back on.” (1001:194)*

**Description Theme #5: The key to building a healthy therapeutic relationship is getting the client engaged.**

- A primary strategy to getting a client engaged is to identify what the client feels they need and providing resources to fulfill those needs.
- For the counselor to identify the client's goals and how much energy the client is willing to put in to meet those goals.
- Counselors work with clients to build interpersonal skills to assist them in engaging systems.
- Part of the engagement process is getting clients motivated to overcome closed systems, fear of disease, cultural fears and distrust of outside systems.

**Quotations**

- *“I have to develop a relationship with a human being that has never met me before; that may not have a whole lot of hope that things can be much different; and may think I have some magic pill or phrase that I'm going to say that's all of the sudden going to make them feel better.” (1001:168)*
- *“As men, they put on a bravado and “arrrrr, I don't want to mess with that stuff.” But it has a whole lot to do with fear, about their educational level, how they feel like they can interact, passed experiences where they turned anxiety and feelings of helplessness into anger and they ended up making a ruckus and going to jail or being disconnected for services.” (1001:168).*
- *“You develop a relationship with people and they begin to trust you and they're willing to step outside of their comfort zone because they trust what you are telling them are true. They start feeling a little better when some of this stuff happens and that builds on it; it's almost a contingency management kind of thing. You get some positive out of the advice, I'm willing to do some more. And it's always best when it's their idea even if it wasn't.” (1001:188)*
- *“But if you are working within your ethics, the ability to do harm is, many young counselors spend many nights worrying about, “Oh my God, did I do the right thing? Did I destroy this person?” It just doesn't happen. So let go of some of those fears and the other is you got to figure out what the client wants before you start trying to help them change; because we make a lot of assumptions when people come into therapy that since they are coming to a male substance abuse unit, clearly they want to get sober, right? Nah..it may have nothing to do with why they came in.” (1001:206)*
- *“They can't allow information in to see the level of dysfunction that goes on. Well in a closed system, going outside of that system and telling people about anything is a taboo.*



*It's a dying, atrophying system, but it's holding on to its last breath because it can't let the world see what is going on inside; the horrors that are going on inside." (1001:180)*

- *"So sometimes it's, it's working with people about how do you deal with the front line people at social services, at (name omitted) when things are getting in your way of accessing these services. Things that you and I would figure just basic human skills, they don't have them." (1001:168)*

**Description Theme #6: To develop a trusting and healthy relationship, counselors should lose their assumptions and lower their expectations.**

- Counselors should first figure out the client wants before attempting to help them change.
- Lose your assumptions of why clients have entered treatment.
- Counselors should be slow in forming impressions of the client.
- Relationship building and developing trust takes time and will not occur in the first few visits.

**Quotations:**

- *"So you kind of have to throw away some of the stuff you typically would say, ok these are some basic one, two, threes of what recovery is. And as we love to say in social work, meet the people where they are to really develop the relationship, understand what strengths they have, what...where they want to start and what they have to start with. And then have simpler basic goals as compared to the big goal. (1001:194)*
- *"So if my expectation is that they want to get sober and I want to help them get sober; I'm never going to have a good relationship with them." (1001:206)*

**Description Theme #7: SUDs education and training can assist in training counselors in utilizing the assessment as a living process that begins with the first visit and ends with the last.**

- Increase training on why we ask the questions we do on an assessment.
- Counselors training should include how to let the assessment to grow and change as the relationship builds.

**Quotations:**

- *"It (the assessment) is a task you complete before you can get to therapy and want, I would want people to learn from what I'm saying now, encourage people, to see that as a living document that begins the first day and continues to grow and is constantly referred back to with both the therapist and the client; because it changes and as people grow in that relationship. They say, "you know I really wasn't honest with you there, this is something" and it needs to be an ongoing thing instead of this task we complete and then move on." (1001:220)*
- *"And you know clinicians are human beings. They have good days, they have bad days." (1001:224)*

- *“You are seeing twenty some people and you are not referring back to it, you know, you just say, ‘Hey, what’s going on with you today? Are you taking your medications? Are you still sober?’ Instead of, ‘Remember when you said it was really hard, I noticed you are having some trouble with sadness and about a year ago you said you lost your mom and you never really grieved that, I wonder if that’s affecting you in anyway?’ Number one, that is one of the most powerful tools in the world when people say, ‘You remember that about me?’ all of the sudden they become important to somebody and you know, ‘hmmm I hadn’t thought about that for a while, but I, you know, I saw somebody the other day that reminded me of my mother and that really had this big urge to drink.’ Then you got a chance to talk about how emotions relate to this need to change the way you feel.” (1001:231)*



**Interview Summary**  
**Interviewee: 1002 “Lee”**  
**Interview date: June 12, 2013**  
**Summary date: July 4, 2013**

**Description: Counselor Characteristics**  
(Deleted to protect identity)

**Description: Client Demographics**

Lee states she works with adult women (ages 18+). The women often have substance abuse issues that are co-occurring with trauma and mental health disorders. She states that probably 80-90% of the women in her unit have trauma or a co-occurring mental health disorder. Clients are predominantly Caucasian and some African American. She notes there have been a few Hispanic and Asian clients over the years. Lee states that many of the women are parents with or without custody of their children. Domestic violence is a common issue among the women. Women enter their site through a variety of referral sources including family members, social services, courts, corrections and self-referral, to name a few. The challenges women face getting into services include poverty, unemployment, lack of support, lack of transportation and child care. Some of these issues the site attempts to address (e.g. transportation and child care). In addition, the women are sometimes reluctant to engage, and/or are scared/fearful of getting their children engaged in services.

Lee states over the years, the women have discussed a number of different medical conditions. Chronic pain, including fibromyalgia, is probably one of the most common medical issues. Other health conditions include diabetes, head injuries (especially from domestic violence), high blood pressure, cancer, a few HIV positive clients, and working with clients who are living with the lifestyle change that occurs after gastric bypass surgery.

**Client Characteristic Quotes**

*“Reluctant to engage, let their children get involved in services with us. That’s a real scary one for most women, though we’ve tried to do some of that.” (1002:032)*

*“They said, they were talking about nutrition. It was the first class and five women out of the ten had had gastric bypass surgery and I was blown away. And they all lifted up their shirts to show their scars and I’m going, “you got to be kidding me.” Five women, because one woman had brought it up, she wanted, a sixth, wanted to get some kind of gastric bypass surgery and they were talking about the pros and cons and how it changed their life and I’m thinking, “WOW!” What does this say about some of the women that we treat? How many have had that kind of issue, gotten surgery and now they have to deal with the after effects of it?” (1002:088)*

**Description: Main Themes**

**Description Theme #1: Clients face multiple intrapersonal and interpersonal challenges when managing a major chronic illness and substance use.**

- Describe the story of the HIV client.

Managing the stigma – stigma of what people thought of her being pregnant, yet having difficulty raising three other children

*“And just dealing with the feelings about that (HIV) and the possibility of her life span being shortened and she’s got four children now and how to deal with that. Not wanting to tell anybody”*

Because of the stigma, clients may self-isolate which includes being resistant to tell family and friends.

Strategies – combining strategies to fit the person’s needs and cultural values

*“That she was now the matriarch and she could not let them see that she had any of these weaknesses. She was African American and that was just not in her culture. You just kept that to yourself to her.” (1002:48)*

*“Not often are the women, they’re not as knowledgeable about resources or what their rights are” (1002:052)*

Strategies - Working with the client to identify the impact of keeping secrets from the family.

*“The impact of keeping secrets in that, the MI (Motivational Interviewing) to keep her engaged, skill building, education, CBT (Cognitive Behavioral Therapy) stuff..but again she was very good at taking care of herself. She didn’t in terms of case management, she was a very good advocate for herself. So I just offered a lot of support and education. Again she was just more supportive therapy with her. Because she knew what she was going to and not do. (1002:048).*

*“Weighing the pros and cons of being on methadone. How was she going to get off it because she really couldn’t afford it. That’s a big issue for most of our women on methadone. You know the cost of it is prohibitive. She was constantly I mean financially she didn’t have any money. They couldn’t cut her off of methadone because she was pregnant.” (1002:048)*

Strategies - Role of grief work

## **Description Theme #2: Substance use counseling with clients with co-occurring medical conditions involves case management, therapy and assisting to accept the diagnosis.**

- Counselors focus on helping the client adjust to the medical diagnosis and to the lifestyle changes that may occur.

*“I think part of it is the adjustment and kind of working with accepting the diagnosis. What does that mean? Lots of education and support around that, looking at the impact on the family, their job, the resources that, you know, I think a lot of our women don’t have access to transportation, so they don’t have some kind of Medicaid or somebody that can drive them, getting to the resources.” (1002:56)*

- Assist clients to work through what role their substance use may have played in their medical condition.

*“And with the substance use, and I think some of it comes to grieving, is that how they ended up contracting the disease? Is that part of it? Reminding folks about just the risky behaviors that some women are, the prostitution they have to go through, and again, helping them not beat themselves up. Because, you know, their addiction led them to a lifestyle that put them in some danger. And some of that stuff, our women feel powerless to ask a man to use a condom, to really push that, I mean, they don’t have, when you are in the midst of that, sometimes you don’t have that choice.” (1002:56)*

*“Well, maybe some shame and guilt. I mean, they could, they can get stuck in blaming themselves. I mean, what did I do with my life? I really again, not entering that, helping them to grieve that’s, it’s a workable issue; that the treatment again, that it’s a process of grieving. Yes, it’s the consequences of your addiction and what are you going to do about it. You know, you can’t, you can sit here and wallow in it and kick yourself and go all my God and you can decide you need to do something about it. So it’s a balance of both helping them grieve, let go of that guilt, stop beating themselves up and then also what are we going to do about it so you can live as a quality of life as possible at this point.” (1002:72)*

- Example of the Cancer Patient

*The recovery and her trying to work that with her program because she had to be on pain pills, you know, and she’s alcoholic and balancing that with what she needed and staying in recovery and being so...the lack of, nobody prepared her for how physically ill she’d get from chemotherapy. And so she was just knocked off her feet for as long as that went on. So for years, a couple of years of recovery, it was devastating and she also has a mental illness and she had children and balancing all of that and she, well she really didn’t, her husband took care of everything mostly and her children did. She was just debilitated. (1002:72)*

- Discuss family support during recovery and role of support.

*“In matter of her husband supporting her and monitoring her, to my knowledge, she took the meds as prescribed. There was never a question and she continued to attend AA and really, there were, and her experience in AA was some folks were understanding about her need to be on pain meds and others were, from her perspective, pretty shaming about that.” (1002:76)*

*“Oh yea, that was a big one for her. Again some folks were pretty accepting, others were you don’t need anything. And in her case she needed to be on everything she was on. Then, again she dealt with it by just sticking with folks, staying in therapy, talking about it.” (1002:76)*

*“She was just debilitated. Doing much better now, but that’s still an issue. That’s still a theme and it’s been, she’s maybe at the five year mark, I’m not sure of where she’s at. And what a shift her total life went when she got that diagnosis of breast cancer.” (1002:76)*

- Discuss strategies – the use of writing the book.

*“The cancer, she started writing, encouraged her to just kind of draw, do mandalas and kind of communicate and to begin writing a book of her story in terms of what nobody prepared her for with cancer. And kind of gaining some power over that and what, how it took, changing my life and then what I wish I knew then that I know now. And so trying to get some power back.” (1002:76)*

- Strategies.

*“I’m trained in guided imagery and music. I’m trained in EMDR. The one though, I probably use the most is DBT (Dialectical Behavior therapy) skills. The way that particular, Linehan laid out those use of skills, I talk about distract skills, emotion regulation, emotion, I mean just interpersonal effectiveness, mindfulness, that whole, I use that a lot with clients, the tools of using a diary card, that kind of take a snapshot of your day. What is going on emotionally, physically, your meds, any alcohol use, stressful situations and those, I find those tools very helpful because they are concrete and if the person is willing to use them, they work.” (1002:124)*

**Description Theme #3: Substance use counseling includes treating the client holistically, including building self-care skills.**

- For the counselor to work with the client to address self-care including nutrition, exercise and taking better care of themselves.

*“So the work is getting them engaged in services, staying in services so that again hopefully addressing the SA where they are taking better care of themselves ....your nutrition, your health, just your whole body. Learning that lesson of taking care of yourself is not often an easy one or getting somebody in the habit of improved self-care. And what a difference that makes in whatever disease, or whatever you got going on with it whether it’s the substance use or HIV or hepatitis or whatever.” (1002:56)*

*“Some of it again is good self-care, is learning to be assertive, set some boundaries and sometimes that might be one that they can take a little steps in. Watching your smoking. How much are you smoking? You know, hooking them up with smoking cessation stuff. So yes, very much that the treatment, at least I try to do it, the team too, is it’s a holistic thing, you look at the whole person and their body and everything. Hopefully, and if they can’t do it right now, introduce them to some different concepts and I think we do a pretty good job of bringing stuff there to them.” (1002:64)*

- Discussion providing exercise and nutrition groups.
- Push for integration of behavioral and physical health.
- Clients will often try access services that support changing their lifestyle, however it is often difficult. So the counselor tries to instill hope and motivate the change to happen, then quickly open the resources to support that change.

*“It would be nice to be able to improve the access, remove whatever obstacles are there and if they still don’t want to go, then that’s on them. But us making that a little bit easier and maybe health care reform will do that. I don’t know. Just to remember to treat it, like I said, it’s a holistic approach, it’s not a one this will do it. And helping folks stay patient with, that it’s not a short, this is not a short two, three session. We are talking about asking folks to make lifestyle changes. Whether it’s their addiction or chronic illness and that is a slow process.” (1002:140)*

- Discuss the study Lee spoke about related to when clients are sober after a few years, their lives get better, they are employed, pay taxes, etc.

*“You know the people we work with don’t have a whole lot of (referring to hope), not all them, but they, but my guess is, my knowledge is they’ve tried and tried and tried. You know, in some way or another, they know what’s going on for the most part. They know their life’s not working, but believing they can make a change. Then our problem is access, getting in quick enough.” (1002:140)*

**Description Theme #4: Clients are responsive to the information, education and skills building treatment has to offer, but there are challenges that make follow-thru difficult.**

- Clients are responsive to the services offered, but access issues or other challenges may impede their ability to act on the change.

*“I think being responsive to it and actually making some changes are two different things and that’s where the MI might come in; working with them or adding some incentives to do some... like we added a yoga group and we’re encouraging the ladies to do yoga. We’ve done walking groups. We’ve done, you know, I mean, it is, that’s the piece that yes, it sounds wonderful, but...I don’t have the money to eat healthy and so again, that’s part of what the new group that we educate about how to do that on a tight tight budget. Like I said the response is often positive, being able to do it are two different things.” (1002:64)*

- Sometimes internal motivation or fear may be the impeding factor.

*“I think not really wanting to believe you might have a serious problem. Maybe you didn’t grow up taking the family, that wasn’t a value, that good physical health care. Fear is always a big one. Then what am I going to do if you tell me I have something. I think those kinds of things are just, you know, apathy. I mean it’s just easier not to. It takes less energy not to mess with something. Often it’s the things we wait and become urgent that we mess with, as opposed to preventative, not getting the, a lot of this stuff could be prevented if we did some things early. It’s the crises that get our attention.” (1002:92)*

- Men have historically had more difficulty accessing services or they don’t want to access the services. Men and women struggle accessing services in similar ways.



*“I think men historically probably have more difficult accessing. They don’t want to. I mean, even stronger than with women. Often at (site name) we still have a high unemployment rate with men too. Because maybe, the kinds of things. I don’t see, I don’t think it’s real different other than I think men have traditionally just kind of not wanted to admit there might be a problem and women maybe more apt to talk about it or do, you know. But as you are doing something about, that can be the obstacle. So that becomes part of our job, hopefully to motivate them, help them find some motivation to take better care of themselves. So I don’t see those as real different with men either whether it’s to stop smoking or the getting a checkup or... (pause)” 1002:92)*

- In terms of prescription misuse, the client may not want to lose their alcohol or share with their physician about their substance use. It’s about encouraging them to the make the lifestyle changes.

*“And how one it could, if you are taking this medication for your depression and you're drinking, they are going to counteract each other or they may, or if you are taking this for anxiety and your drinking it's going to make it, it's more dangerous. Or if you're taking methadone and taking benzos for this, it's more dang, you could kill yourself. Or you're on narcotics but you are continuing to mix it with alcohol. You know, again making sure they understand. And we have no control over that, if I don't have a release communicating that with their doctor, my preference is the client communicate it and I facilitate that. Not me tattling to their doctor, but trying to emphasize safety. You are mixing some powerful drugs and the folks you're working with, and that's a tough sell sometimes. Cause again, they don't want to let go of their drug. Their getting it, they don't want to lose that and if they are not ready to give up the alcohol, often times most of them do not share that with the physician.” (1002:136)*

#### **Description Theme #4: Counselors assist clients in accessing a complex and confusing health care system that often has different rules and procedures to accessing services.**

- When onsite care was available, it was utilized by the clients, identified serious medical issues needing further treatment and assisted the counselors with providing additional resources.

*“We got five hours of a nurse practitioner once a week and they took the funding last year. That was so wonderful because they came there. There, we could provide transportation. They met her (nurse practitioner), she got them hooked up with everybody and anybody. Really, we had a woman diagnosed with cancer that she helped. I mean we had so many serious physical problems that got, because it was right there and accessible.” (1002:084)*

- When offsite care is not available, the counselor’s provide referrals and help identify different places clients can go, but follow-up is difficult.
- Counselors seek ways to make passive referrals, active referrals.

- Describe the different eligibility criteria for services at different hospitals and the changing nature of the policies especially when client's telephone service may not be reliable and steady.

*"I just think we make it so hard, I mean, sometimes, I just want to cry at how we make it so hard. Some of it is location, some of its (the area name) can be pretty isolated in terms of, but if people need it, there needs to be an easier way to access it. You know what I'm saying, and then again their willingness to use it even if it was easier to access. I don't know if they would use it." (1002:88)*

**Description Theme #5: Treating clients with chronic pain or other condition that requires potentially habit forming medications is very challenging.**

- *"I just think they're a real challenge. I just saw an article this weekend about how heroin is coming back too. Because we've gotten so good at monitoring prescription drug abuse, that the supply, it's easier to get heroin, then it is drugs; which is interesting." (1002:104)*

- Treating clients with chronic pain is one of the most challenging aspects of substance use counseling due to the stigma of chronic pain patients.

*"Well, I think, the first thing that comes to my mind is the stigma associated with being substance user and having chronic pain because immediately they just think you are med seeking. And it's, that certainly could be some of that, but we also have folks who legitimately have chronic pain and how do you work around that?" (1002:104)*

*"But when you have somebody that, I mean we get folks who've got, the woman I was talking about who was sent for acupuncture, she walks with a walker. She's got horrible muscle-skeletal. She's had major back surgeries. I mean what do you do when somebody has an addiction and they truly do have need?" (1002:112)*

- In addition to the stigma, it is challenging to work with clients with chronic pain because we are a quick fix society, where a pill is preferred because of its quick acting relief compared to using alternatives that will relieve the pain, but may take longer to work.

*"I think that the lack of alternatives, instead of going to immediately a pill, which we all want; what about working with them to learn mindfulness and yoga. Because when I'm with my clients I try and do is teach them mindfulness skills to work with the pain, the value of exercise in working with the pain because I think we've gotten so used to give me a pill and make it go away. And again I understand the clinic needs to keep things safe and the doctors license in place and the client's just want to feel better and trying to work a balance of it's not just a pill." (1002:104)*

*"Which is what we see with a lot of things, just give me that pill and I'm not going to be depressed. That's the big challenge and finding, there are very far and few between and*

*they're hard to access. Again that's another access. They're just not out there. Again, the ones doing alternative stuff, I don't even know of. So that, I mean, that in hearing from the clients what that's like and how painful it is and again how to you tease out what's 'I'm just hurtin' cause I need to use' and 'I'm really in a lot of pain?'" (1002:104)*

- It is difficult to tease out what is related to addiction and what is true pain.

*"I think that's a tough question. I wouldn't want to be a doctor prescribing for them. But I also don't want to see them hurting. I go back to my, I like to encourage people to take as much control as they can and again that's a tough sell when the pill makes it go away a lot quicker." (1002:112)*

- Counselors can use a variety of strategies to assist their chronic pain patients.

*"Practice. The thing I do with them, is practice in the office. Maybe not the yoga, we do have the class, but even showing them some of those kinds of moves, talking about it, but certainly the mindfulness. And educating them about kind of riding through some pain, distracting from the pain, teaching some specific skills for, you know, dealing with it, how rest can make a difference, your diet can make a difference. Those are some things they have control over." (1002:116)*

*"And how one it could, if you are taking this medication for your depression and you're drinking, they are going to counteract each other or they may, or if you are taking this for anxiety and your drinking it's going to make it, it's more dangerous. Or if you're taking methadone and taking benzos for this, it's more danger... you could kill yourself. Or you're on narcotics but you are continuing to mix it with alcohol. You know, again making sure they understand. And we have no control over that, if I don't have a release communicating that with their doctor, my preference is the client communicate it and I facilitate that. Not me tattling to their doctor, but trying to emphasize safety. You are mixing some powerful drugs and the folks you're working with, and that's a tough sell sometimes. Cause again, they don't want to let go of their drug. Their getting it, they don't want to lose that and if they are not ready to give up the alcohol, often times most of them do not share that with the physician." (1002:136)*

- Individuals, such as chronic pain patients, may not be as successful as other clients in reaching their substance use treatment goals.

*"Well I think for the ones that have to use some kind of medicine that may be addictive, they're not always as successful as some of the others ones." (1002:132)*

*"Well it puts them at higher risk because they are still continuing to use something. They're not able to be abstinent and learning how to manage that and whatever cravings that may or may not create or problems that creates with them or when their tolerance goes up and they've got to take. I think just maintaining that line, if they're in recovery. Now you got to realize a lot of folks we work with don't ever reach, you know, they continue to use actively." (1002:136)*



- However, if a client has a sense of control, the medical condition and treatment for that medical condition can help them in their recovery.

*“I mean it varies. I mean, if the folks who are taking medication and have some sense of control over their health conditions, I think that helps in their recovery; and again vice and versa, you get some sense of recovery, the principles of recovery and focus on what you can do and what you can’t, what you need to work on, those folks are better all-around too.” (1002:132)*

**Description Theme #6: A counselor’s role includes case management (access to resources) and therapy to assist in instilling hope that life can get better and build client self-efficacy.**

- Role: Staying hopeful and helping the client see that life can get better. The challenge of instilling hope is when you have a client, you encourage them and motivate them, but then services may not be accessible.

*“Catching them while they’re in that mode to look at that and it’s our job I think, as clinicians, to motivate them, help them to find the motivation and the willingness and to believe that it **can** (emphasis added by participant) get better. That’s the tough part. It doesn’t have to be like this. That just bring me, when I say about clients that a piece where you also got to have staff believe that too. Because we get so mired down in so few successes, whatever you want to define as, stories where somebody actually does move on. We have them, but compared to the number who just come in because probation made me and I got to do this and I don’t want to change anything, it’s real different and so keeping staff immersed in the idea that really people do get better and they can and there are some things they have some control over and it’s our job to help them identify it and work on it.” (1002:140)*

*“I just read a study, I tried to send it to somebody at work, it’s too big; that looked at the benefits of recovery versus the cost of addiction which we are well versed in. This showed, it was really neat, the stuff we know, but that when somebody’s been in recovery, an active recovery for three years, you see more paying taxes, they got a job, their doing this and they’re connected and they’re, they’re, and this many years, they go do this and it’s like WOW! I mean that, we really, that’s the kind of data I want to be giving clients versus here’s you know, showing them honestly, if you can rather than, well you’re drinking all these years has done this, this, this, you know, it just like there is hope.” (1002:140)*

- Counselors work to help clients find the power to take control over their lives again.

*“To find the power within themselves to do the things they need to do to feel better.” (1002:140)*

- Counselors also build self-efficacy by demonstrating respect for the person and honoring the work the client does.

*“That being respectful, asking permission, trusting. They truly do know what they need to be doing. And my role is to help them, if they want, bring that out. And I do trust that and honestly people aren’t going to do anything they don’t want to do anyway.” (1002:144)*

*“I don’t have any control over what my clients decide, unless it’s a crisis situation. And if you are working in this field, be prepared for not a lot of big, big successes. That it’s a success when so and so comes in and tells me, ‘hey I’ve been sober for a week’ or ‘I’ve been sober for two months’ or ‘I’ve been...’, and then the next day they might go out, but you don’t take that two months away from them. You know, honoring the work they do and how difficult it is.” (1002:144)*

*“Again, I have the deepest respect for somebody who can come in there and I don’t care if it’s two days sober, but can come in there and try that. And again and look at all aspects of their life that have to change if I’m going to give up drinking because that might mean, I’m going to have a problem with my boyfriend or my husband or; so it’s not as simple as thinking I’m just stopping. You got to look at the whole picture and the impacts.” (1002:144)*

- Counselor identification with having a medical conditions.

*“But I’m a big advocate of finding, I myself have (health condition omitted) and when I started doing yoga, you know I suddenly was able to walk better and my hips improved, so I can say it really does, when you start applying some of these other things, whether it’s the mindfulness, these are things I know work, mindfulness, yoga, gentle exercise, what you’re eating, what you’re putting in your body impacts it, so again, all that holistic stuff.” (1002:104)*

**Description Theme #7: Substance abuse education can assist training counselors to work with clients with co-occurring medical conditions by providing more information on counselor self-care and trauma, as well as encouraging greater practical experience and immersion into the field.**

- Recognizing that substance abuse counseling extends beyond therapy, but also includes a lot of case management.

*“That the job is going to entail a heck of a lot more case management than you think it will. Most of us signed up to be therapists, but because of the nature of the work now a days (site identifying information removed), its case management, helping people access services and linking with this, that and the other because again, nobody comes in most of the time with a simple little thing.” (1002:152)*

- Clients benefit from a substance abuse counselor who stays hopeful.

*“To take care of yourself. Know, teach about burn out long before they ever start because you are dealing with folks that don’t often, at least in substance abuse, where*

*you may not see a lot of folks get sober and stay sober. It's cyclical to people, they come in and out of that. And don't do it if they (the counselor) can't stay hopeful." (1002:152)*

- For new substance abuse counselors and students to immerse themselves in the community, know the resources and the community and get as much practical experience as possible.

*"The more you can get out there and actually work with folks, get exposed to some good placements and go out especially if you are going to do SA. Don't try and go out into SA without some exposure. You don't have to be an addict or an alcoholic, but you know, go to some AA meetings, get out there and immerse yourself in some of the things." (1002:152)*

- With the high prevalence of trauma exposure, learn more about trauma and trauma informed services.

*"Knowing, I think more teaching about trauma and trauma informed services and how many people, that's a real gap in terms of not recognizing the effect it has not only in a woman, but in the rest of the life, if that's not addressed." (1002:156)*

**Interview Summary**  
**Interviewee: 1003 “Nicole”**  
**Interview date: June 20, 2013**  
**Summary date: July 12, 2013**

**Description: Counselor Characteristics**

(Deleted to protect identity)

**Description: Client Demographics**

Nicole provides outpatient substance abuse counseling to men 18 years of age and older, with most of the clients clustering around the ages of 30-55. She describes her clients as being mostly Caucasian (80%) and non-Caucasian (20%). She states the clients the site serves are “fairly resource limited,” unemployed and looking for work. The substances most often used by the clients are (in order from highest prevalence): alcohol, marijuana followed by heroin and other opiates, and cocaine.

Nicole describes the medical conditions she has observed among clients as including chronic pain conditions, pancreatitis, diabetes, cancer and some conditions that have somehow limited a client’s ability to function (e.g. remain employed, mobility). Some clients are on disability. She states that some clients have considered applying for disability because of their inability to find to work. “Lately, we’ve also had a lot of people who have not found work, that have thought about applying for disability, not really understanding that disability is not because you can’t find work, it’s more because you are unable to work.” (1003:064)

She describes “a whole other type of client who we see would be clients who are referred after hospitalization.” Sometimes those who are referred after hospitalization have insurance and possibly more access to resources. Individuals who enter treatment at the site after hospitalization include follow-up treatment for either mental health or substance abuse issue. Mental health issues include being suicidal or homicidal, and severe depression. Substance use issues usually involve alcohol either related to accidents or other health condition or being referred after detox. Clients that do not have health insurance who are referred from the hospital may or may not have resources or have been hooked up with any services yet. Other referral sources include self-referral or referral by employer.

She states the clients are usually involved in some sort of labor type of employment (e.g. construction type jobs). The physical work that many clients do put them at risk for work related accidents and wear and tear on the body leading to chronic pain conditions. In addition, they are at risk because of their substance use and/or alcohol use.

**Client Characteristic Quotes**

*“That doesn’t describe all the folks who are hospital..some folks who are hospitalized are people without resources and they end up being TDO’d (Temporary Detention Order) or some use of the hospital if they are in an emergency situation; especially if they are not hooked up with services yet. They just present, you know, they present at the ER and they may or may not have resources.” (1003:048)*

*“Lately, we’ve also had a lot of people who have not found work; that have thought about applying for disability, not really understanding that disability is not because you can’t find work, it’s more because you are unable to work.” (1003:064)*

## **Description: Main Themes**

**Description Theme #1: It is very rare that clients come into treatment with a simple thing to be resolved. Mental health, physical health, substance use and other predisposing factors interact and affect one another.**

- Discuss the prevalence of mental health and physical health issues that co-occur among clients coming for treatment.

*“I’d start by saying it’s, it’s fairly rare for us to have somebody, in the particular unit that I’m in, who has substance abuse issues without other either mental health or medical conditions. And, one that is particularly difficult is when people have a legitimate pain situation and are taking prescribed pain killers. It’s, it’s very hard for them if they have been addicted; it’s very hard for them to kind of hold the line with taking things that are prescribed as prescribed.” (1003:80)*

- Medical situations can affect other areas of their life, especially if it keeps them from working.

*“Especially if it is something that prevents their ability to work; those, those kind of medical situations can create or can worsen situations that are already going on with depression or anxiety or that, or that type of thing. So I think, I think just being sensitive to the fact that you know, in the unit where I work you are also going to be dealing not only with the problems created by their substance use, but also problems that are created from the physical issue or the mental health issue.” (1003:84)*

- One strategy for this counselor is to gain a better understanding of physical health issues affecting the client providing a more holistic view of the client.

*“I guess I’ve just developed a better understanding of how the physical condition kind of interacts with other problems that people are having. I think about chronic pain, when people are in chronic pain they are often irritable, they often don’t sleep well, and I think as I’ve, you know, as I’ve been a counselor longer and longer, I start hearing from them a little more about how a physical condition affects a lot of aspects of their lives that I wouldn’t have really known about and I probably ask more questions about things I’m not familiar with.” (1003:124)*

*“I think just in terms of, in terms of kind of the whole person concept that recognizing how important somebody’s health is to their general well-being and maybe, and maybe, because I’ve obviously been there 25 years, so I’ve aged as I’ve been there, and so maybe that’s something that’s a little more, that I’m tuned into a little bit more than when I first started and was very young and didn’t, and really didn’t have any, not many ways*

to relate to physical problems that people were having. The aging process helps you to kind of get a little more in touch.” (1003:162)

“So I think just being aware of how important people’s health is for their, for their general well-being and I mean that gets, when that gets messed with, when that gets disrupted, it just, to recognize how, how far reaching it is in terms of how they function in terms of how they interact with other people, in terms of how they see themselves.” (1003:162)

- When a client faces a physical health condition, combined with depression and substance use, medical decisions are difficult to make.

“I think especially for clients who have depression going on, that, that makes taking care of any medical condition or pain condition more difficult and what brought that to mind is a client I saw quite, quite a while ago whose divorced, who sort of felt like he had lost his family and had kidney disease and was approaching a point where he needed to make a decision pretty quickly about whether to start undergoing dialysis. And I think in part because, I think that it was hard for him to make a good clear headed decision because he was depressed, he was sort of like, “What’s the point? Who needs me? It’s going to be difficult.” And so that was a real clear connection for me between the depression and his, his interest in doing something to help, to help the medical condition.” (1003:154)

“I mean if someone is, if someone is depressed and has a medical condition, they are just less likely to take care of it. I mean, either lacking the energy or lacking the hopefulness that if they do something to take care of it, it can improve. And then in terms of the anxiety end of things, having a medical condition usually just jacks that up especially if it’s something, you know, that is not likely to shift, or improve very much.” (1003:154)

## **Description Theme #2: Access issues are affected by not only geographic location, but the overall health of the economy and policies.**

- Discuss the challenges of finding medical care and limited resources.

“The biggest, the biggest one is, is helping them to find medical care. There are not, I think that...I think that the few resources that are available for people who are uninsured are just really flooded right now...But things, resources like that, I think are just so flooded because there are so many people, due to the economy who are applying for those things that it’s taking a very, very long time; much longer than some of our clients really have the patience for.” (1003:88)

- Effect of changing policies on access issues (providers taking less Medicaid patients) and the impact it has on treatment.

“Some co-workers and I were talking recently about just the difficulty finding Medicaid providers who are, who are taking, who are taking new clients. And if their medical issue isn’t being treated, then obviously their medical condition isn’t going to improve, their



*mental health condition isn't going to improve and their likely to keep using as a way to manage pain or just kind of forget about it.” (1003:88)*

**Description Theme #3: The counselor utilizes strategies such as “thinking small” and educating on self-care to help clients manage multiple issues in their life.**

- Discuss the importance of assisting the clients in identifying and achieving smaller goals to build up successes and give encouragement.

*“My, my newest catch phrase is “think small.” Which is, a kind of against the grain for, I don't know, for our culture in general. You know we are kind of taught to think big, think big. But getting them to focus on something very small and manageable is sometimes helpful because if you make it small enough and if they carry it out and accomplish it, then it helps to build some feeling of confidence that they can, you know do something a little bit bigger. (1003:92)*

*“Well I know one thing that I do is to help them think about what it is that they want to get out of maybe the next appointment, for those that have a doctor. You know, writing down questions that they might have, having somebody go with them if there is somebody whose, available to accompany them to an appointment. So I'm not really providing the medical information, but I'm helping them to come up with strategies for how they can get information that's needed.” (1003:116)*

- However, thinking small is often a challenge.

*“But a lot of times they, their version of thinking small is still something pretty big. So getting them to kind of think about just the next thing they can do in terms of a phone call, you know, asking, asking friends if they have a physician they can recommend or that type of thing. It's, it's hard for people to think small apparently when they are so used to thinking, you know, in much bigger terms.” (1003:92)*

**Description Theme #4: Treating clients with chronic pain or other health conditions that is treated through potentially habit forming medications, is challenging because of a multitude of factors.**

- Clients with pain conditions often feel stigmatized and discriminated against.

*“So it's, I think, clients with the pain conditions who are taking pain killers for example, often feel they're either, either with or without justification, often feel very sort of discriminated against. If they've had a pain condition for a long time and they've, you know, gone around to several hospitals or doctors in the course of their condition. If they truly get in pain and they go to a hospital, we've had clients say they were, that they were sort of labeled as med seeking and so I think's there's more, I think there's more stigma attached sometimes to people who have pain conditions if they are in a substance abuse sort of setting especially.” (1003:96)*

- Having health condition that is being treated with potentially habit forming medications, reduces the substance abuse treatment options a person has.

*“And, another big issue if they’re in need of residential treatment, often what they’re taking rules them out in terms of eligibility for residential programs. And that holds true for, you know, other potentially habit forming medications that they might be taking for anxiety....So it makes it, it kind of rules out a whole avenue of treatment for those clients who might really benefit from 28 day treatment. So we’ve talked before how it would be great if there was a 28 day program for treating substance abuse and people who had those kinds of chronic medical issues, but at this point we don’t.” (1003:96)*

- The counselor utilizes multiple strategies to assist clients who are taking prescriptions for chronic health conditions.

*“The most frequent thing that I use is just, is just, just reflective listening...sometimes having people do some kind of rating is helpful as far as how important a goal is or the difference between how important it is and how ready they feel to take the next step. As far as the mindfulness piece, I think, I think sometimes to help people learn that for many people, even pain can pass if you don’t latch on to it quite so much. And not having a chronic pain situation, I don’t have any way to know how easy or difficult that is to actually put into practice.” (1003:108)*

*“But the physical relaxation kinds of things we do, sometimes people who have pain situations will say, you know, they felt a little bit more comfortable while we were doing some kind of mindfulness kind of meditation activity. So you know it might just a little glimmer of hope that there might be some things that can just provide some respite. I mean for people that, I guess some people’s pain is constant and some people kind of have episodes, but especially for people who have that constant pain to just, to know that there’s anything that they can do to just have a little break from it, I think can be something that provides a little bit, a little glimmer of hope.” (1003:108)*

**Description Theme #5: When talking about clients with co-occurring medical conditions, there are several things to consider including medical conditions that require habit forming medications and definition of abstinence/recovery, clients facing acute medical conditions verses chronic conditions, and those that find themselves in a role as a caregiver for someone with a medical issue.**

- Differences exist between clients that have conditions that require potentially habit forming medications and those that do not.

*“Again, I feel like you have to kind of eye between the medical conditions that are treated with habit forming medications and the medical conditions that are not. If somebody has a medical condition that doesn’t involve, you know, habit forming medications, I think it’s a lot easier for them to achieve abstinence and it really also kind of boils down to what definition do you use for abstinence?” (1003:112)*



- It's important to define abstinence.

*"I mean, we have recovery groups and people in those recovery groups who are taking prescribed pain killers and yet they are in a recovery group. So for me a lot of what you have to start with is what is considered abstinence? Are you talking about not taking anything that is habit forming or taking it as prescribed? How do you know if it's being taken as prescribed?" (1003:112)*

- Difference between clients who face chronic conditions versus acute conditions.

*"I think the other thing is, you know, for chronic conditions that aren't likely to improve, which most chronic conditions don't, there's, there's a certain level of acceptance that it's helpful for people to reach and so that might be, that might be an issue that, that we might work on. If it's, it's someone that, you know, isn't quite in a place where they realize that, you know, the goal is really going to be adaptation as opposed to something suddenly getting better." (1003:116)*

*"And if on the other hand if it's a medical condition that they can do something to improve, then just helping to, you know, to support them and help keep them motivated to do whatever, whatever next small thing they can do to improve their condition." (1003:116)*

- Working with clients to adapt to a condition or motivate them to continue on the road to recovery is similar to substance use treatment strategies.

*"It's, it's not, it's not totally unlike the substance abuse work in a lot of ways because you're just helping them figure out what, what's within their control to do and helping to support them, taking a step and kind of checking in with them and providing feedback, if that's appropriate about, you know, that they did a great job, that you know, there might be something else that they might want to keep in mind whenever they kind of take the next step." (1003:116)*

- Another view of the issue is the client as caregiver. Many folks are finding because of their substance use, they are living back home with parents or family who themselves, need assistance and the client is now in a caregiver role.

*"I mean, sometimes what, on an individual basis what seems to be happening a lot is that we have clients in that age range who are often, as a result of their substance use, are living at home and are starting to take care of aging parents. So that's, that's, that's kind of brought up some, you know, some different issues as far as how they manage their time, as far as whether they seek employment, some of have had parents that have passed away, so then you get into grief issues." (1003:136)*

*(Effect on outcome) "So maybe it's a function of the demographics that with the older population increasing that it's coming up more often. But it very much affects them and often can affect their ability to work towards abstinence because if it's a parent they are*

*connected with they often feel pretty depressed when they see the parent going downhill.” (1003:144)*

**Description Theme #6: The counselor’s perception of roles and responsibilities has expanded beyond just providing SA therapy.**

- Balancing between the role of substance use counselor and medical provider.
- The counselor feels the expectation of her role and responsibility with regards to her client expanding because there are many factors affecting the client’s life to consider and assist with.

*“I feel like it has changed. I think in my agency as time goes on, I feel responsible for a larger portion of people’s welfare. Anything that I’m not able to provide, I feel like there’s an expectation that I know where to direct them and especially when there aren’t many resources to direct them to, that, that’s stressful. And I’m thinking of things like medical care. I’m thinking of things like shelters in the particular county (omitted because of identification). I’m thinking of transportation. So, I think when I first started, you know, the substance use was sort of, it was a specific target and I think as time goes on, it feels like the target is much more, is much more far reaching. It’s not only treating the substance use, it’s also helping them to access resources at a time that it feels like there are fewer resources than when I first started the work.” (1003:166)*

*“I think that the, the therapist and the setting that I’m in is really expecting to be looking out for a whole lot of things besides just, you know, the substance abuse piece.” (1003:166)*

**Description Theme #7: Based on the counselor’s experience, substance use education could benefit from expanding beyond the target of substance use into the whole person perspective by including more education on things like pain conditions and utilizing the assessment as a guide to identifying multiple factors affecting the client’s life.**

- To see substance use counseling as a general practitioner and expanding knowledge and awareness beyond substance use.

*“I think paying attention to things beyond your own little area of focus. So it’s sort of like being the, the, in a mental health sense, a substance abuse sense, being more like the general practitioner than the specialist. So asking about things like do you have any medical conditions? Are you in pain very often? Do you sleep? So maybe broadening what you ask people instead of just the, what do you use and how often, how long has it been going on? I think that’s important to find out how, how people’s bodies are cooperating or not.” (1003:170)*

*“I think to have some, to have some information or during your educational process to, to, to, learn some things about pain, in terms of how it affects people. Not to become a pain specialist, but to, but to just appreciate how, how that shifts a lot of things for people*

*from like the time they wake up to the time they go to bed. And maybe, maybe at the time they go, you know is when it's actually when it's worse for them so. You see them at 9 in the morning, they may not be very cheerful.” (1003:170)*

- Include information in the assessment and use the assessment as a guide.
- Environmental accommodation is important.

*“The other thing I just thought of that we do when people, when we know that somebody is in pain, although people don't often feel free to do this, we, I always tell them, please stand up if you feel like you need to stand up. Feel free to walk around. We've had a few people in groups that we've said that if you need to, if you need to leave and walk up and down the hall or do you need a different chair or just doing whatever you can to accommodate them just in the little, just in the amount of time they're with you. And also to communicate that, that you respect the fact that they may have a different need during the course of the hour than people who are just sitting there comfortably, relatively comfortably.” (1003:174)*

*“You know having something as simple as having a decent chair for them to sit in. So some of that is more environmental accommodation I guess, than it really related to your counseling, but it's kind of important too.” (1003:178)*

- Because clients have many different types of losses, especially those with co-occurring medical conditions, to provide additional education on grief and loss.

*“I think about providing some information about grief and loss. I think, I think that ties in because I think medical conditions are, a lot of them represent a type of loss to clients. Yea, when people think of grief and loss, they think of people usually passing away, but for someone who's worked for 20-30 years and has become disabled or has had an injury or something who can't work, that sort of sets in motion a whole series of losses. The loss of the job. The loss of their identity as working person. Maybe the loss of their ability to do certain things, you know, as leisure activities because they may not have the money to do that.” (1003:194)*

- Educators and counselors have an opportunity to bring their experiences working with clients with co-occurring medical conditions to policy makers.

*“Maybe something even like educating policy makers about the need for additional, medical resources, additional dental. I didn't even get into the dental thing, additional dental resources. I mean I think educators are probably in a pretty good position to do that, especially if they are in the field themselves, if they are teaching students who are, who are in the field because you are hearing about that and so I think that puts them in a good position to, to try to impact policy making.” (1003:186)*

**Interview Summary**  
**Interviewee: 1004 “Don”**  
**Interview date: June 20, 2013**  
**Summary date: July 14, 2013**

**Description: Counselor Characteristics**  
(Deleted to protect identity)

**Description: Client Demographics**

Don describes the clients he primarily works with at the publically funded agency as male, uninsured and from lower socio-economic backgrounds. He states that most clients often have a high school education, GED or less. A lot of his clients work blue collar jobs and trades. Don states the he works with people who have both mental health and substance abuse problems and co-occurring health issues.

Don has observed the following health conditions including: diabetes, injuries such as serious back injury, high blood pressure, neuropathy, serious head injury, HIV/AIDS, clients with gastric bypass surgeries, and liver damage. Don states that is not unusual for clients to have multiple health issues. Don states “that’s a little bit of challenge because you know, some of the clients we see are older and so it’s kind of hard to say exactly what’s causing their problem, you know their health problem and we get some younger people who have had a accidents and so the accidents may have been substance related.” (1004:043)

**Description: Main Themes**

**Description Theme #1: Clients presenting with serious head injuries present unique challenges to providing substance abuse counseling.**

- Discuss the challenges of working with clients with head injuries (lack of information, neuro psych testing, etc).

*“I’ve had many clients with, well many; I’ve had a number of clients with head injuries in the past. Those are a bit challenging for us because we don’t get a lot of information about how the head injury’s impacting them. So we never get neurological studies or anything like that typically. So, even if we request them, it’s hard to get that information for some reason.” (1004:035)*

- Describe how sometimes you have people who may have Asperger’s, other intellectual disabilities or something related to a head trauma that makes treatment difficult.

*“And sometimes we’re wondering what’s going on with this client, why can’t we seem to be impacting them. It would be nice to have some neuropsych testing for those kind of clients. And then maybe integration of, it would be nice if we had a PCP down the hallway who could see our clients or consult with or whatever.” (1004:208)*

**Description Theme #2: Health conditions affect multiple areas of a client’s life and ability to function.**

- Discuss the connection between employment, health condition, insurance, substance use and mental health.

*“Well, a lot of them don’t have health insurance. Many of them are unemployed and because a lot of them do physical labor type of jobs, you know, if they got a serious health problem, then they become unable to work and they may not have any means of supporting themselves, often being supported by someone else.” (1004:047)*

*“Sometimes they’re connected, sometimes they’re not, and they interact or interplay in that, you know, you know, substance use can cause accidents and health problems; and the health problems can cause people to drink because they’re unable to do things that they were before that become isolated, depressed or whatever. They’re limited in, in their abilities, they might become dependent on someone else because now their health isn’t good enough for them to manage on their own financially.” (1004:087)*

*“Ok, I’ll give you one example, just kind of in my mind right now and this is the client that had the hip replacement. Is that he came in very depressed and thinking suicidal. Drinking is not his issue, but he had significant alcohol problem in the past and used, you know, poly-substance kind of person. Used everything, so, but not using currently, but, you know, the hip injury as a roofer prevented him from doing his job. One of the great joys of his life was participating (omitted to avoid identification) “social functions.” Caused him to be very socially isolated and then that spirals into the depression, which could have let him to relapse, but didn’t in his case.” (1004:123)*

### **Description Theme #3: Resources to address client health conditions are limited and have reduced over time.**

- Discuss limited resources.

*“And so I think not having the health insurance, not having consistent health care, preventative health care and those sorts of things, or ongoing PCP kind of care is a problem. And some of the resources around here have dried up for that. The options have shrunk a little bit in the area. (Health clinic name) is still a good option. But that takes some time for them to go through the financial process, have them assigned to a PCP and then if they need testing or anything, particularly if they have to go downtown, transportation is always an issue.” (1004:047)*

- Discuss how medical care is not connected to SA treatment and how it relates to getting people into other SA services such as detox and residential.

*“...And it becomes an issue for us sometimes when we are assessing for detox or referring people for detox. You know, I mean I can take a client blood pressure. I can probably get their pulse reading. I used to have to do it (at another facility) when I used to work there. But you know, it’s not easy for me to assess, you know exactly how serious their withdrawal might be. If they have a history of DTs or something, those sorts of things, but we have to refer people, it takes us some time and some of the facilities won’t, they won’t*

*touch them. The kind of places we refer, until they've been detoxed. So you have this thing of you got to arrange the detox, you got to arrange residential treatment, you got to coordinate all that and get the timing set up. And in the meantime the client might or might not be drinking more, might end up in the hospital anyway. It's always kind of, it's a real challenge." (1004:091)*

**Description Theme #4: Strategies to assist clients with co-occurring medical conditions vary depending on the clients need and situation.**

- Discuss how medical conditions can be a concern to the client and different ways it can affect them during treatment (e.g. standing up, visible pain) and how it draws attention to those issues.
- Describe how the counselor matches different strategies to the need of the client.

*"My favorite approach is the CBT approach. I think about things in terms of, you know, not awfulizing, creating, you know, the worst out of situations. Trying to see things in perspective, I guess. Maybe thinking about a time when things were better and what their strengths were like then and how those might apply to the future. I mean I've done a lot of, you know, I mean, some clients I do sleep problems and stuff, done meditation, progressive relaxation training." (1004:147)*

- Discuss the role of client motivation.

*"Well motivation is always an issue. You know, I mean, the client has to want to get, you know, you can encourage and encourage, but if they aren't willing to address it, it's not, if they don't see it as an issue, then that's going to interfere with their ability to follow-thru. And the harder you make it, you know, the more their motivation comes into play. Like if I have to call (hospital name), get down there, fill out a financial paperwork form, you know, to qualify financially and then wait months for my PCP to be assigned, so I can get a card so that I can go see the doctor on a regular basis and then I can access testing and health care that I need through the whole system, that takes a sustained level of motivation to do that. So it sometimes requires repeated encouragement at each step and lots of praise and affirmation when they do things that, you know, might benefit them." (1004:167)*

- Discuss the importance of counselor background.

*"Well I try to be empathetic and understanding about health problems. I'm, just from an individual perspective, I'm a person who had a lot of serious health problems at a young age. So can identify with what it's like to be, you know, how valuable your health is and how difficult it is when you're not able to do things you want to do or not capable at that moment to do the things you want to do and stuff. So I think I bring a level of understanding and empathy." (1004:163)*



*“You know my training is in rehab counseling so I’m kind of glad about that in some ways. Because one of the things we had to take is a lot of medical information and to understand the impact of chronic health problems in someone’s life. So I think I may have gotten more of that than some of, maybe someone who went through the MSW program or something or any other kind of counseling program.” “So in a way, I, I, I am maybe sensitized I guess to that and so I mean, you know, I think from my perspective that again I’m a whole health kind of person that, you know, you’ve got to address all the issues in order for someone to have the best quality of life that they can have. And so, if people aren’t seeing the doctor regularly, if their diet is shit, if they are chronically obese or whatever the problem is, if they are not at least seeing the doctor on a regular basis, you know, for an evaluation, checkup or whatever, then they may not be as healthy as they could be and that might affect them down the road.” (1004:171)*

**Description Theme #5: Treating clients with chronic pain or other health condition that may require a potentially habit forming medication, is challenging.**

- Discuss the relationship between substance use and chronic pain and habit forming medication.

*“But we have a lot of folks who, you know, have significant pain problems and so they have to sometimes be on medication and it’s always a challenge knowing how to address that with someone who has a substance use history. And then we see a lot of clients who have had pain problems ended up addicted and then they come in for treatment and because of pain pill addiction.” (1004:059)*

*“So you see people who, you know, may have gone in for medical condition and they start taking pain pills, they end up addicted to them. Now they’re doing heroin because now they can’t get the pain pills.” (1004:063)*

*“Yea, and it’s hard for us to know what’s legitimate and what’s not. I mean that’s probably true for the pain specialists too to some degree. But I’m sure that they are much more adept at it than I am and they probably have some medical training. They can look at their x-ray’s or their, you know, and understand how they are being impacted by whatever the physical injury is in terms of pain. (1004:107) (discuss here about the difficulty of identifying what is legitimate and what is not related to not having medical training, x-rays or other means of identifying the impact that their physical injury has had on the client).*

- Discuss strategies that the counselor uses to address chronic pain issues.

*“You know, these are some, actually some of the hardest issues we deal with because we don’t have a lot of resources for health. I don’t know if that is the right way to say it, but you know, we don’t work directly with a doctor in our agency and we’re not medical professionals so we don’t have complete understanding and training, what’s appropriate, what’s not appropriate and what their health conditions are and what’s...I mean, you know if you got to work with their motivation, so you start there. And you try and*

*encourage them to take their medication as prescribed first, and to discuss with their doctor any addiction issues they might have or might have had in the past so their doctors are informed. If they have, you know kind of, what might be an addiction concern and we might refer them to methadone. On some patients we've talked to them about seeing a pain management specialist." (1004:071)*

- Discuss the new challenge of medicinal marijuana. Describe the client that was using medicinal marijuana in another state and the limitation of services.

*"And apparently he had some pretty significant injuries to his back; lots of health problems over the course of his life and he smoked pot for a long time before he was willing to address it. So now he's not on pot and he's actually, his pain doesn't seem to be as great as he imagined it was. For what that's worth. So, but he wasn't willing to give up pot immediately, but I encouraged him to get evaluated, you know and see. Catch-22. Someone's on pain meds and they're automatically ruled out for residential treatment. This client wanted some services that his marijuana use ruled him out for and so, the question was could he go to residential treatment. Could he function without pain meds? I can't answer, I can't answer that question because I'm not a pain management specialist. So if you've taken him off the marijuana and you send him to residential treatment, is he going to be in dire pain and not going to be able to be maintained. And some of the treatment facilities are better than others about managing those health conditions and stuff." (1004:071)*

- Health conditions that require potentially habit forming medications limits the treatments available to a client.

*"And so they're different in that they have less services maybe available to them, less options." (1004:099)*

### **Description Theme #6: Some clients are more successful than others in managing medical conditions and recovery.**

- Discuss the impact of health conditions that utilize potentially habit forming medications on recovery.

*"I'm thinking of one specific person who had some health issues, injured his back, his mother was doling it (prescription meds) out to him. He ended up relapsing, taking pain medicine, getting worse and ended up incarcerated (information omitted because it was potentially identifying). So this guy was doing real well, really stable for a period of time and had a really ugly relapse which was kind of sad. It seemed to be tied in with some combination of pain, chaotic lifestyle, and you know, so I don't know." (1004:111)*

*"I hate to say it, but it kind of depends. It seems like every individual is a little bit different. So you know, I've had clients I've worked with for a long time who've complained about pain and struggle, with, with an on-going basis and have had to take med, pain medication, at least as far as I know. And struggled to achieving abstinence or*



*achieve consistent abstinence. And I think maybe to some degree they're related because I think chronic pain is an issue that if I had an ongoing, I'd probably, you know, fuck it I want to drink, too much pain today." (1004:119)*

- On the other hand, there are clients, that for some reason, can manage their health condition and maintain recovery.

(Discuss client with hip replacement, who because of the type of work he did, was unable to continue working because of his injury and also took him out of the recreational things he enjoyed with his friends.) *"It caused him to be very socially isolated and then that spirals to the depression, which could have let him to relapse, but didn't in his case." (1004:123).*

*"The one's that seem to be the most resilient are the ones that have had some serious struggles in their lives and older. Trying to think of some younger ones that have had some chronic health issues that (pause). The clients I'm thinking about are older and it may just be that I have more older clients with chronic health conditions. Yea, I think life experience." (1004:139)*

#### **Description Theme #7: Counseling students may want to redefine "success" to be more focused on quality of life improvement.**

- Discuss the counselor's strategy of building on interventions with more interventions to build more tools for the client.

*"I was telling someone I was providing some supervision to today that sometimes when I'm counseling, I'm not thinking about how this intervention is impacting the person today, I'm thinking about how this is going to impact them 3 years from now, 5 years from now. That a lot of times, you know, you can only work with where the person is, but you're hoping that, you know, that this intervention is a stepping stone to the next intervention, to the next intervention, to the next intervention, that if you think about substance abuse as a chronic on-going problem with, there are going to be many interventions, then you know, if I think about myself preparing someone for the next one and the next one, not that I'm trying to cop out of this intervention, but just that I'm trying to raise people's awareness so when they come back the next time they have more tools, more skills, more understanding to take more advantage of maybe more intensive or more disease focused, more action oriented level of treatment. That's a good way to look at it because I don't feel like I'm failing as much." (1004:179)*

*"So to think about it, you know, what you're doing is part of a larger continuum and that success isn't measured in whether people are sober today necessarily, but if they're quality of life is improving, if they're doing some things better, if they are doing less harm to themselves, that's a successful intervention as well." (1004:179)*

- Discuss the meaning of abstinence and recovery in terms of counselor burnout.

*“Then, I mean, I think if you see everything in terms of whether they’re completely sober and clean or not, that would make, could make for a pretty depressing career because the majority of people that I see are not going to stay sober forever and ever and ever from the day they walk in my door for the first time they’ve had substance abuse treatment. And you know if they can get off the heroin, but they’re still smoking some pot, well I’m glad that they are off the heroin, you know. Ideally, I want them off the pot too, but I’m glad they’re off the heroin. You know what I’m saying.” (1004:183)*

**Description Theme #8: Having a diverse education and continuing education are valuable tools to assist the counselor in staying up to date.**

- Discuss the counselor’s experience of having classes across disciplines and the benefit to having that diversity.

*“So I’m thinking that sometimes taking classes across departments is kind of a cool thing...overlap those resources and may get people to think how in rehab counseling, you know, you might benefit from some information from pharmacology and vice versa and sharing information back and forth.” (1004:200)*

- Discuss the importance of having continuing education that makes resources readily available.

*“I’m really sad that the ATTC isn’t located here in (area omitted) anymore. I just feel like something has slipped a little bit as a result of that. But, I think that the trainings that they offer and some of the resources that are available, like those CSAT TIPS and stuff are a pretty cool idea.” (1004:192)*

*“I mean, I think one of the challenges I have a been doing this for a while is maybe keeping current about what is going on. So I think the ATTC is pretty good about doing that.” (1004:192)*

**Interview Summary**  
**Interviewee: 1005 “Laura”**  
**Interview date: June 24, 2013**  
**Summary date: July 18, 2013**

**Description: Counselor Characteristics**  
(Deleted to protect identity)

**Description: Client Demographics**

Laura describes her clients as men ranging in age from 18 on up with her oldest in his 60's. She states that about 90% of the men she sees have a history of trauma, with a lot having complex trauma (not just one incident, but multiple traumatic events). Most of the men also have co-occurring mental health disorders such as depression, anxiety, and PTSD. She states, “rarely do I see someone who kind of just presents with substance abuse.” (2005:213) Laura describes that the younger clients (18-22 years old) are often there for some legal charge and to fulfill a probation requirement. Clients that are older often are there more voluntarily. Laura describes the health conditions she has observed on her case load to include: hepatitis C, pancreatitis, high blood pressure, diabetes, traumatic brain injuries, HIV/AIDS (1), gout, and diverticulitis. Health conditions are usually identified during the assessment process.

**Description: Main Themes**

**Description Theme #1: Treating chronic pain patients is very challenging in the substance abuse treatment setting.**

- Describe the bidirectional relationship between substance use and use of prescription medications used to treat chronic pain medications.

*“It’s, it’s definitely a lot more complex because what I found, and as far as people coming in, typically they will have an issue with one, one substance and then they’ll have some legitimate pain issues and they’ll be using, you know, opiates to treat that condition.” (1005:055)*

- Discuss the importance and challenges around medical releases.

*“Just framing it terms of wanting to collaborate and you know, really needing, needing for all of us to collaborate for the best treatment to occur. And I mean usually there’s a reason if a client doesn’t want a release signed. Usually, there may be some hesitation about not getting their medication anymore because they are abusing it or, or just not seeing it to be helpful. And the other piece is actually when you do get a release signed is trying to get in touch with the doctor. That’s, that’s, once kind of that hurdle gets, gets crossed, it’s usually pretty difficult to get the doctor on the phone.” (1005:067)*

- Discuss strategies the counselor uses to assist clients with chronic pain conditions including education and having a good physician.

*“So it’s, it’s really about having a good doctor which has been an issue for a lot of clients, sort of having someone who, who understands their addiction, but also educating the client about, about being extremely, you know, extremely, just careful about treating their pain condition.” (1005:055)*

**Description Theme #2: The mind, body and spirit are all connected and affect the overall health of the client.**

- Discuss how clients do not often see the connection between their health condition and their addiction.

*“One of the biggest things, I think, that still kind of surprises me is that people don't see the, the clients don't see the connection between, for example, treating their diabetes and their addiction. So people will, you know, I've had a client who would, would stop drinking, but would stop, you know, and start eating a lot of sweets after they stopped drinking. Obviously, you know, affects their diabetes and, and really kind of just those simply things as far as educating the connection between how all of that is really important. And, and that really still surprises me sometimes to hear people not be aware of that.” (1005:071)*

*“That a lot of, a lot of people with, with histories of trauma and complex trauma have a lot of sort of pain issues and it sort of manifests itself a lot of times in different parts of their bodies. So like I know people say fibromyalgia, you know, has a lot to do with or some people that's, I guess, hypothesis that fibromyalgia is really kind of untreated trauma and stuff like that. But I see a lot of people who have health issues that are connected to their trauma and once kind of their trauma gets resolved or they work on those emotional issues, the pain kind of lessens.” (1005:173)*

- Discuss how the counselor uses a holistic way of counseling to assist clients in recognizing the connection.

*“Well I'm a big believer in sort of the mind, body, and spirit connection. And, so you know, I think once again, everything is connected, and for whatever it is that we are putting in our body is going to affect how we are feeling. And so, I try to approach, and health conditions kind of, manifest themselves when there's an imbalance in any of those things. And so, that's kind of how I approach it is really looking at all those different pieces.” (1005:083)*

*“I mean there's, and that's kind of the sad part is people, people really do try and they'll come in sometimes sneezing and really sick and it's like, no it's really better to go home. So you know, you just have to kind of gauge it. But sort of when I'm sitting there thinking about it, just, I mean this has got me thinking a little about the fact that a lot of times I think my clients are not feeling good physically anyway and so, I don't know, the work we ask them to do (sigh), it's just amazing that they even do it.” (1005:115)*

*“Well, I do a lot of sort of body work, and so the mindfulness and the music and the art, and the EMDR and all that stuff you know, when we're working on something and someone has something come up for them physically that's what we do, we, we work on it right there.” (1005:177)*

*“I think we look at things in this society sort of in a Band-Aid way. You know, something's wrong and we put a Band-Aid on it as opposed to prevention. And in that, you know, when you talk about substance use, even though we, I think we've done some great strides forward as far as how we treat substance abuse, I still think we have a long way to go in that, there's still isn't a focus on, you know, how are physical mental, emotional, spiritual health kind of is all connected.” (1005:123)*

- Discuss how the connection between the body, mind and spirit affect counseling and the need for more research on complementary and alternative therapies.

*“The clients we see are not, generally are not healthy, and so when you're struggling with a health condition, you can't be fully present to, to address emotional issues. And so even though there's times where people will come in and say 'I'm just not up for it,' you know, 'I didn't sleep well' and so we'll have short session. But even in a more subtle way, it's difficult to address emotional wounds when physically you're not, you're not feeling good, or you're not healthy. So even on the days where it's not so over, when someone comes in and says 'I'm sick and I can't do this today,' um, I think it does affect it even probably more than, even more than we think.” (1005:107)*

### **Description Theme #3: Treating clients with traumatic brain injury is a complex issue.**

- Discuss the impact a lack of information about the brain injury affects counseling.

*“Well, with traumatic brain injuries, I certainly don't know as much as I would like to know and it's just so complex because we don't know what part of the brain was affected when it was injured and exactly how it's manifesting itself. It's really hard to tell whether someone had a deficit to begin with or is it the brain injury that's causing some deficit. So I feel like traumatic brain injuries I approach a little bit differently in that they seem a lot more complicated and you're sort of always have to, you always have to kind of pose that question, you know, where's, can this be something related to the traumatic brain injury? Was this present before? Is it something new.” (1005:087)*

*“I find, I'm thinking of one particular client, I find that you sort of end up kind of going over the same things sometimes. You know, you sort of you, you, pace things differently. Always kind of keeping in mind that, I mean and that's with anyone, you would pace things for sure. Bu you kind of pace things according to how much the person can absorb.” (1005:091)*

**Description Theme #4: Barriers such as access to medical care and resources can affect client motivation.**

- Discuss limited access to health care and how it affects motivation.

*“Most of the clients that I see want to take care of this stuff. They want to be able to take care of their health, but they don’t because they don’t have the access to health care. And so they, they sort of what a lot of them end up doing is going on an emergency basis only when things get bad enough.” (1005:095)*

- Discuss the affects this has on the counselor.

*“There are times where I want to pull my hair out and, or someone else’s hair. I mean, it’s, it’s, yea, I mean you end up sort of just being a witness to their pain and that’s, and that’s one of the most difficult things is when you just have to witness it and, and sit with it and there’s, you know, nothing you can do.” (1005:099)*

**Description Theme #5: Health conditions can either increase or decrease a client’s success in recovery.**

- Health conditions can both increase and decrease a client’s motivation to abstain drugs.

*“But once again they don’t see the connection between, you know, my stress level was high this week or you know, I didn’t take good care myself this week and so I had this flare up. So it’s, it’s about sort of educating and it’s a lot of sort of back and forth. So yea, it could, it could delay people meeting their goals. It could sometimes, you know, it pushes people to get sober if they have a scary experience and they get hepatitis or something like that, it can push them forward.” (1005:135)*

*“But now that I’m kind of thinking about it, it’s usually, you know, it kind of scares them. Doesn’t mean they are going to maintain sobriety, it just kind of, you know, it adds to their motivation but sometimes, sometimes it doesn’t. Sometimes it just scares them to the point where they end up drinking more because it’s so scary.” (1005:139)*

*“A couple of them, I’m thinking their confidence in being able to stay sober. I have one client I’m thinking about in particular has had a really difficult time staying completely sober. He’s you know, he’s moderated and he’s definitely cut down, but then he found out he got some test results with his blood. He had some test results come back and it was, he really needs to stop or he’ll you know, he’ll die. And it scared him to the point where he was able to stay sober for a few weeks. But now he’s back to drinking and it’s sort of like, he gets discouraged. It’s another reason why he knows he needs to stop, but doesn’t necessarily mean that’s it going to do it long term.” (1005:143)*

- The counselor uses several different strategies to assist clients.



**Description Theme #6: Counselor responsibilities include identifying their limitations and training needs.**

- Discuss how the counselor sees her responsibility.

*“I take my responsibilities pretty, pretty seriously. You know, it’s, it takes a lot of courage to be in counseling and address some of these things, and so I don’t take things lightly. And, you know, if someone’s working on their issues, it, it’s an honor for me to be there for them. And so definitely, and when I say I don’t take things lightly, I recognize my own limitations and I recognize where I still need training and I recognize my strengths. And so, you know, knowing when to, when to ask for, when to consult with someone else, knowing sort of, knowing my strengths and limitations is really important.” (1005:195)*

**Description Theme #7: New clinicians and students interested in becoming substance abuse counselors would benefit from doing their own work as a way to limit burn out.**

- Discuss the importance of a counselor doing their own work and experiencing what it is like to be in counseling and work through issues.

*“Do your own work. Do your own personal work. There’s no way that I could be a good counselor or I believe that no one can be a good counselor until they’ve done their own work. It’s so, it’s so emotional and it’s so heavy at times that it takes work to stay, you know, grounded, to stay clear, to know your own issues and having moved past them.”  
“I think it should be a requirement for people going into this profession to be in their own counseling process, to be doing whether its counseling or something else, you know, to do your own work.” (1005:203)*

## Appendix H

### Super-Ordinate Themes and Themes from the Project

#### Super-Ordinated Theme #1 (Research Aims 1, 2, and 3)

*Substance abuse clients with co-occurring medical conditions experience multiple layers of factors interacting with one another affecting client motivation and outcomes.*

Themes	Quotes	Referenced Theme in Interview
<b>Sub-Theme 1a: There is a multi-faceted relationship between substance use, medical conditions, mental health and other factors affecting motivation and outcomes.</b>		
Defining co-occurring medical conditions (chronic versus acute, caregiver).	1003:112; 1003:116; 1003:136; 1003:140; 1003:144; 1004:047	1003 - #5 1004 - #2
Counselors experiences describe the multiple layers of problems including unemployment, underemployment and loss of resources.	1001:092; 1003:080; 1003:084; 1004:087	1001 - #1 1003 - #1 1004 - #2
Clients are often not aware of the connection between their substance use and medical condition.	1005:071; 1005:173;	1005 - #2
Health conditions directly impact a client's motivation to obtain goals.	1005:135; 1005:139; 1005:143 1003:154; 1003:154	1003 - #1 1005 - #5
<b>Sub-Theme 1b: Clients and counselors face a host of challenges needing to be managed concurrently.</b>		
There is complex relationship of factors interacting with one another.	1001:156; 1001:156; 1001:140	1001 - #3
Resources for health care are shrinking and the process is difficult and discouraging for clients.	1004:047; 1004:091; 1003:088; 1003:088; 1002: 084; 1002:088; 1001:148; 1005:095; 1005:099	1001 - #3 1002 - #4 1003 - #2 1004 - #3 1005 - #4



There is a level of fear and apathy that may affect client's engaging in the health care system.	1002:092; 1002:092; 1001:180; 1001:168; 1001:168; 1001:176	1001 - #1, #5 1002 - #1, #3, #5
Some clients exhibit certain strengths in their ability to achieve their goals.	1001:148; 1002:040; 1002: 044; 1002:048; 1002:48; 1002: 048; 1002:052; 1004:123; 1004:139	1001 - #3 1002 - #1 1004 - #2, #6

### **Super-Ordinate Theme #2 (Research Aims 1 and 3)**

***Medical conditions including those that utilize potentially habit forming medications and traumatic brain injuries, present unique challenges to substance abuse treatment.***

<b>Note</b>	<b>Quotes</b>	<b>Referenced Theme</b>
<b>Sub-Theme 2a: Prescription drug use is prevalent among SUD treatment clients and includes unique challenges to treatment.</b>		
There is a high prevalence of prescription drug use among SUDs treatment clients.	1001:124; 1001:120; 1001:124; 1002:104; 1004:059; 1004:063; 1005:055	1001 - #2 1002 - #5 1004 - #5 1005 - #1
Legitimacy of prescription medication use is a challenge, especially if there is no coordination with the doctor.	1001:132; 1002:112; 1002:104; 1004:107	1001 - #2 1002 - #5 1004 - #5
There is a lack of resources for clients using potentially habit forming medication.	1002:104; 1004:071	1002 - #5 1004 - #5
Chronic pain patients feel stigmatized and discriminated against because they also have a substance use issue.	1003:096; 1002:104; 1002:112	1002 - #5 1003 - #4
Clients using prescription drugs find limited substance use treatment options.	1003:096; 1004:071; 1004:099;	1003 - #4 1004 - #5
When working with clients who utilize potentially habit forming medications, one questions the definitions of recovery and abstinence.	1003:112; 1002:072; 1002:076; 1002:076	1002 - #2 1003 - #5
Outcomes may not be as successful for clients utilizing prescription medications.	1002:132; 1002:136; 1002:132; 1004:111; 1004:119; 1004:119	1002 - #5 1003 - #6

Counselors utilize a variety of strategies to assist clients who utilize potentially habit forming medications.	1001:116; 1001:132; 1001:136; 1002:104; 1002:116; 1002:136; 1003:108; 1003:108; 1003:104; 1005:055; 1005:067	1001 - #2 1002 - #5, #6 1003 - #4 1005 - #1
<b>Sub-Theme 2b: Traumatic brain injury and other cognitive disorders are challenging to work with due to the lack of information.</b>		
Challenges include the lack of information and neuropsych testing.	1004:035; 1004:208; 1004:208; 1005:087; 1005:091	1004 - #1 1005 - #3

### Super-Ordinate Theme #3 (Research Aims 1 and 4)

*Counselor roles and responsibilities have expanded and adapted to incorporate a host of strategies building a more holistic view of treatment.*

Note	Quotes	Referenced Theme
<b>Sub-Theme 3a: Counselor roles and responsibilities have expanded over the years as counselors take on more responsibility for client well-being.</b>		
Counselors take their responsibilities seriously and appreciate the courage it takes to be in the profession.	1005:195; 1005:195; 1003:166, 1003:166; 1002:152; 1001:160; 1001:194; 1002:140; 1002:140; 1002:144; 1002:140; 1002:144; 1002:144; 1002:152	1001 - #4 1002 - #3, #6, #7 1003 - #6 1005 - #6
<b>Sub-Theme 3b: The key to providing SUD treatment counseling is the development of a healthy relationship between the counselor and client.</b>		
Counselors work to get the client engaged and develop a relationship this includes figuring out the client and focusing on developing a trusting relationship.	1001:168; 1001:188; 1001:194; 1001:206; 1002:140	1001 - #5 1002 - #6
Counselors utilize smaller goals to build client confidence in reaching the larger goal.	1003:092; 1003:092; 1003:116; 1004:167	1003 - #3 1004 - #4
Counselors have immense empathy for clients with co-occurring medical conditions.	1003:162; 1003:162; 1003:124; 1003:174; 1003:178; 1004:163; 1004:171; 1005:115; 1005:107	1003 - #1 1004 - #4 1005 - #2
Counselors utilize the relationship to assist clients in making lifestyle changes.	1002:056; 1002:056; 1002:072; 1002:076; 1002:076; 1003:116; 1005: 123; 1005:083	1002 - #2 1003 - 116 1005 - #2

<b>Sub-Theme 3c: Counselors utilize a mix of holistic and evidence based strategies to treat the client holistically.</b>		
Counselors utilize a number of holistic and evidence based strategies to assist client with co-occurring medical conditions.	1002:056; 1002:064; 1002:124; 1002:064; 1004:147; 1005:177	1002 - #3 1004 - #4 1005 - #2

#### **Super-Ordinate Theme #4 (Research Aims 1 and 4)**

*SUD treatment counselors' experiences shed light on where additional education and experience can increase the readiness of future SA counselors.*

<b>Note</b>	<b>Quotes</b>	<b>Referenced Theme</b>
<b>Sub-Theme 4a: Counselors need to remain hopeful and take care of themselves to avoid burnout.</b>		
Important for a counselor to go through a therapeutic process and remain hopeful.	1001:224; 1001:206; 1002:152; 1004:183; 1004:179; 1004:179; 1005:203	1001 - #6, #7 1002 - #7 1004 - #7 1005 - #7
<b>Sub-Theme 4b: The assessment is a living document growing and changing over time.</b>		
The assessment is a living document that assist in building the relationship with the client.	1001:220; 1002:231; 1002:152; 1003:170	1001 - #7 1002 - #7 1003 - #7
<b>Sub-Theme 4c: There are multiple topics counselors would appreciate more education and training in, including trauma, pain, and grief and loss.</b>		
Counselors recommend additional education on trauma, pain conditions, and grief and loss, and encourage cross discipline experiences.	1002:156; 1003:194; 1003:170; 1003:186; 1004:200; 1004:192; 1004:199	1002 - #7 1003 - #7 1004 - #7

## **Vita**

Lauretta Anne Cathers was born on April 12, 1972 in Riverside, California and is an American citizen. She graduated from Norco High School, Norco, CA in 1990. She received her Bachelor of Arts in Media Communications from Webster University, St. Louis, MO in 1993. She received her Master of Social Work from Virginia Commonwealth University in 2000. She has been employed with Virginia Commonwealth University as a Research Associate for 13 years. Currently, she is a Research Associate for VCU Institute for Drug and Alcohol Studies. Her research areas of interest include HIV/AIDS (prevention and linkage to care), substance abuse (treatment), health system navigation and integration of physical and behavioral health.