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# Does Counselor Type Affect a Manualized Treatment?

Cynthia C. Kay
*Walden University*

# Walden University

College of Social and Behavioral Sciences

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Cynthia Kay

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Abstract

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MA, University of Houston, Clear-Lake, 2004

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Dissertation Submitted in Partial Fulfillment

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Abstract

This quantitative study was to determine whether there are differences in client treatment outcomes based upon the type of counselor who conducted an empirically supported treatment called Seeking Safety for persons diagnosed with posttraumatic stress disorder and substance use disorder. Many studies show that counselors' personal attributes impact treatment; however, this study added to the literature by focusing on a standardized treatment for the co-occurrence disorder of substance use and posttraumatic stress disorder. Archival data from an outpatient treatment facility was used. Clients were provided integrated services, which included psychological and substance use treatment. The participants/clients were men and women who voluntarily agreed to 6 to 12 months of treatment. Descriptive statistics were used to describe the 445 participant/clients who received service during 2016. Hotelling's $T^2$, a special case of the one-way MANOVA, and the test of 2 proportions, also known as a chi-square test for homogeneity, were used determine the differences in treatment outcomes based upon type of counselor. Findings in the study showed significant differences in changes in clients' scores on mental health scores, in their length of stay, and on clients' substance use scores, based upon whether they received treatment from a mental health counselor or a substance abuse counselor. The results may be used by counselors to understand that their beliefs and emotions may be predictors of treatment outcomes and can be used to match clients to effective treatment.

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# Chapter 1: Introduction to the Study

## Introduction

Seeking Safety is a present-focused empirically supported manualized therapy designed for the integrated treatment of posttraumatic stress disorder (PTSD) and substance use disorder (SUD; Najavits, 2002b). It was specifically developed so that both disorders could be treated simultaneously, by the same counselor, in the same modality, and in a standardized format. However, it had been demonstrated that when implementing Seeking Safety, counselors' subjective characteristics were more important to outcome measures than counselors' traditional objective characteristics (Najavits, 2004b). Yet, little clinical research has been done to examine if a specific counselor's subjective characteristics affected client outcomes after delivering a manualized treatment such as Seeking Safety. Subjective characteristics differed when comparing two type of counselors, specifically, mental health counselors and substance abuse counselors (Najavits, Kivlahan, & Kosten, 2011; Oser, Biebel, Pullen, & Harp, 2011). Although the goal of manualized treatment is to hold constant the impact of counselors' characteristics, we know that standardization does not remove all therapists' nonspecific traits (Nissen-Lie et al., 2016).

Knowing whether differences among type of counselors could influence the effectiveness of manualized treatment is important when considering the uniqueness of the co-occurring relationship between PTSD and SUD. Studies have revealed that types of counselors held distinct beliefs (Mericle, Martin, Carise & Love, 2012; Nissen-Lie et al., 2016) and distinctive emotional reactions when working with clients with PTSD and

SUD (Moyers & Miller, 2013; Najavits, 2001). Manualized treatments reducing counselors' variance to a level where treatment outcomes were not affected seems unlikely when considering the special treatment dynamics found between PTSD and SUD.

This study is important because in clinical settings, and more specifically in substance abuse facilities, providers are increasingly required by third-party payers to adopt empirically supported treatments (ESTs; Gone, 2013; Hartzler & Rabun, 2014). Najavits et al. (2011) pointed out that the use of ESTs was "alive and well" in Veteran Affairs facilities because in their study, over 200 clinicians had used at least one EST (p.144). However, these same authors stated that the "quality" of use of ESTs had yet to be determined in practical clinical and substance use treatment settings (Najavits et al., 2011). Mental health providers may incorrectly assume that by adopting required manualized treatments, effective service is being provided to clients and treatment outcomes are predictable and stable. This is a fair expectation; however, given that treatments such as Seeking Safety specifically purports to be efficacious without regard to counselors' specific characteristics such as type of counselor. However, even with ESTs, Najavits et al. (2011) stated that if the treatment "does not fit", this could be a barrier to recovery (p. 144). Goodness of fit may be influenced by unsuspecting counselors' subjective characteristics, such as beliefs and emotionality, which differ between type of counselors (Smith & Manfredo, 2011). Yet to date, no studies have focused on whether differences in subjective characteristics based on type of counselor have an impact on the effectiveness of manualized integrated treatments.

Clinically, the social change implication for this study is to ensure effective services to clients who are more likely to receive manualized integrated treatment from mental health and substance abuse professionals. Practically, providers will be able to match counselors with treatment models based upon the counselors' subjective characteristics, which could be related to type of counselor, thus improving treatment outcomes and decreasing symptoms related to the effects of PTSD and SUD. Results can also help providers evaluate methods for selecting and training counselors, who are more at risk for burnout when serving clients with co-occurring disorders (Goldsmith, Dunn, Bentall, Lewis & Wearden, 2015; Mericle et al., 2012, Najavits, 2007). Given the chronic course of both PTSD and SUD (Meewisse, Olff, Kleber, Kitchiner, & Gersons, 2011) and the continued likely exposure to trauma, social implications are far-reaching.

The following sections of this chapter begin with the background, which provided an understanding of what had accounted for the emergence of mandated integrated manualized treatments and why subjective characteristics of counselors delivering the therapy, which are associated with type of counselor, must be considered. After the historical context, I define the research problem and provide reasons why this study is important to the mental health and substance abuse profession in the current climate. I explain the type of study, its methodology, the independent and dependent variables, and the research questions and hypotheses. Next I highlighted the psychological theories, which provide the foundation for the nature of the study. This section ends by providing definitions of key terms, acknowledging the assumptions, scope, and limitations, and then stipulating the significance of the study.

## Background

A review of the literature related to the emergence of integrated treatment can be traced back to the last 40 years when professionals in the mental health and substance abuse field became aware of the high prevalence of SUDs coexisting with other chronic mental health illnesses (Gotham, Brown, Comaty, McGovern & Claus, 2013). Specific to this study is the research, which has demonstrated a strong positive relationship between PTSD and SUD (Killeen, Back, & Brady, 2015; McGovern et al., 2015). According to McCauley, Killeen, Gros, Brady, and Back (2012), 12% to 59% of women in substance abuse treatment had histories of trauma and high rates of current PTSD. Yet, traditional treatment had been marked by a separation between mental health counselors who typically believed that they could not treat SUD, and addiction counselors who believed that they could not treat PTSD (Fisher, McCleary, Dimock & Rohovit, 2014). However, studies have found that clients overwhelming preferred an integrated approach to their treatment because they recognized the relationship between their symptoms of PTSD and SUD (McKee, Harris & Comier, 2013). Further, with decreased resources for mental health and substance abuse treatment, clients and service providers are interested in treatment that is effective and can be used across different settings, by different counselors, with different clients, and for co-occurring disorders (Mericle et al., 2012). Pressure is not limited to requiring an integrated treatment model; providers are increasingly encouraged to adopt ESTs.

A review of the research has shown that ESTs have gained considerable popularity due to the demands for short-term interventions and for measurable results by

third-party payers and government agencies (Hartzler & Rabun, 2014). Spett (2005), stated that conflict between EST and treatments-as-usual could be traced back to 1958 when behavioral therapists came up with an antidote to Freud's long-term psychoanalytical therapy. Unlike Freud's therapy, which required a lot of training for the analyst, ESTs do not require specific, specialized training because counselors are able to deliver treatment using a manual. Presently, most ESTs were developed with a cognitive-behavioral framework (Gyani, Shafran, Myles & Rose, 2014; Muller, 2009), which is the design for Seeking Safety. What is problematic is that manuals do not reduce therapists' differences to zero (Escudero, 2012; Wampold, 2001). Therefore, unexplained variance still exists. Connor and Callahan (2015) found that the therapist effect accounted for 5% variance in outcomes and 7.5% variance in client retention. These unexplained differences among therapists may be what Najavits (2007) referred to in stating that counselors held divergent beliefs, emotions, and attitudes when working with clients who suffered from PTSD and SUD. Najavits (2007) stated that one counselor may be "too nice" while the other counselor may be "too harsh." Najavits (2007) found the differences aligned with type of counselors, with mental health counselors tending to be "nice" and substance abuse counselors tending to be "harsh." Connor and Callahan (2015) also found that counselors' high expectations or beliefs related to a client's improvement significantly predicted successful outcomes.

Literature related to the impact counselors' subjective characteristics had on treatment, according to Sharf and Bishop (1979) can be traced back to the 1960s with the work of Traux and Carkhuff who investigated therapists' feelings toward clients.

However, as early as 1950, researchers have been concerned about how counselors' measurable behaviors influenced case outcomes (Barrington, 1961). Najavits (2011b) stated that clinicians' subjective characteristics, specifically as related to working with co-occurring disorders, had been understudied. In a review of several studies that was conducted by Crits-Christoph et al. (2011), they found that counselors were not homogenous, which was implied in ESTs. Because we know that manuals do not rule out differences between counselors, it was worthwhile to address the gap in knowledge regarding whether the effectiveness of standardized treatment varies when comparing counselors based on their subjective characteristics, specifically the type of counselor.

An initial review of the literature has not answered the question of whether there are differences in clients' outcomes based upon the subjective characteristic-type of counselors after delivering a manualized treatment developed for PTSD and SUD. Studies need to be done to understand whether differences in effectiveness (as measured by client's outcomes) could be influenced by type of counselor. More specifically, it was necessary to determine whether mental health counselors and substance abuse counselors have different client outcomes when treating individuals for PTSD and SUD, which could: (a) increase the counselors' capacity to help clients (Crits-Christoph et al. 2011; Najavits, Crits-Christoph, Dierberger, 2000), (b) provide a means of assessment for selecting and training counselors to help them avoid burnout (Moyers & Miller, 2013; Crits-Christoph et al. 2011), (c) enable providers to reach their organizational and agency goals, and (d) avert harm to clients (Moyers & Miller, 2013).

## Problem Statement

Subjective characteristics, which differ between types of counselors, have been shown to be more important than traditional "easy to measure" objective characteristics (Najavits, 2003; Rek & Dinger, 2016). Moreover, treatment providers' reliance on manualized treatments could create a false sense of assurance that subjective characteristics or type of counselors would not affect the effectiveness of treatment (Wampold, Ollendick, & King, 2006; Wampold, 2001). This is troublesome because research has shown that manualized treatments do not render counselors' characteristic differences null (Wampold et al., 2006; Wampold, 2001). In addition, a mismatch between counselors and treatment manuals could have an adverse effect on client treatment outcomes. Hence, the differences not accounted for by objective characteristics of counselors and not reduced by manuals should be explained. The problem is that more treatment providers and counselors are compelled to adopt ESTs for cost savings and best practices. Further, with the enactment of the Patient Protection and Affordable Care Act of 2010, the problem is current and relevant because many insurance companies must now offer mental health treatment on par with medical health treatment. The problem is significant because threats to clients' outcomes because of unmeasured subjective characteristics of counselors may go unnoticed, which means effective treatment may be thwarted. The problem is also significant because the risk to outcomes is further increased when EST such as Seeking Safety purports that its therapy can be conducted without regard to counselors' characteristics or counselors' type, and without the need for cross training (Najavits, 2002a).

Given that research has identified variant beliefs about addiction (Bond & Croasdas, 2014; Shearer & King, 2001) and different emotional reactions toward clients (Hofsess, & Tracey, 2010) between type of counselors when providing treatment to clients with PTSD and SUD, it makes sense to examine differences in treatment outcomes of clients when delivered by different counselors. The problem is that divergent beliefs and emotional responses to clients between types of counselors may interfere with optimal client outcomes even when relying on manualized treatment. At worst, these differences in types of counselor may result in countertherapeutic results. In addition, manualized treatments may be required in certain settings without identifying the type of counselor who may be best suited to conduct them. This lack of understanding of how differences between counselors affect client outcomes could frustrate staff and contribute to burn out. Seeking Safety has provided empirical studies based upon counselors' objective characteristics (Seeking Safety, n.d.), but not as it relates to subjective characteristics such as beliefs and emotional responses to clients, which differ between type of counselor. This study addressed the gap in research related to whether there are differences in client treatment outcome based upon whether the EST was delivered by either mental health counselors or substance use counselors.

The adoption of manualized treatments across agencies based on the premise that they can be implemented without regard to counselors' characteristics may have a deleterious effect on clients, treatment professionals, and treatment facilities. The most important reason to analyze how type of counselor influences effectiveness (as measured by client outcomes) is to reduce suffering related to PTSD and SUD. This examination

can also provide assessment criteria for selecting the best counselor for a treatment protocol. In addition, the result of this investigation can be used to advocate for cross-training of staff in an organization or agency. Lastly, providers in clinical and substance abuse settings can enhance the quality of their services if they are able to identify counselors who are most effective in delivering a manualized therapy.

## Purpose of the Study

The purpose of this quantitative study was to determine if differences in treatment outcomes, as measured by client outcomes and length of stay, existed between mental health counselors compared to substance abuse counselors after they had delivered a manualized treatment called Seeking Safety. I expected that clients' outcomes and their length of stay, which were the dependent variables, would differ based upon the type of counselor, the independent variable, after receiving therapy using Seeking Safety, - manualized treatment program. Specifically, I expected that clients' outcomes and their length of stay would be influenced by whether the manualized treatment, Seeking Safety, was delivered by mental health counselors or substance abuse counselors.

## Research Questions and Hypotheses

RQ1: After receiving Seeking Safety therapy, do clients' scores differ on the BDI and on length of stay when comparing mental health counselors to substance abuse counselors?

$H_0$1: There are no significant differences on clients' scores of the BDI and on clients' length of stay between mental health counselors and substance abuse counselors.

$H_a1$: There are significant differences on clients' scores of the BDI and clients' length of stay between mental health counselors and substance abuse counselors.

RQ2: After receiving Seeking Safety therapy, do client's scores differ on substance use outcomes when comparing mental health counselors to substance abuse counselors?

$H_0 2$: There are no significant differences on clients' scores of substance use outcomes between mental health counselors and substance abuse counselors.

$H_a 2$: There are significant differences on clients' scores of substance use outcomes between mental health counselors and substance abuse counselors.

The study's research questions and hypotheses were grounded in theories in the field of social psychology in general and specifically in psychological and counseling theories.

## Theoretical Framework

Understanding the theoretical framework related to differences between type of counselors, which may influence the effectiveness of providing manualized treatment for PTSD and SUD, is important. There are several theoretical perspectives that offered an understanding of how counselors' characteristics influence therapeutic processes, client outcome measures and client length of stay in treatment. Clinical practices, for example, offered intuitive and anecdotal support for the influence of counselor type or characteristics. However, empirical support was deemed sparse in this area because as Najavits et al. (2000) stated, counselors' influence was seldom used as an independent variable or as the focus of study. According to these authors, clinical studies were

typically designed to evaluate treatment rather than evaluating counselors. Even if there were findings that supported counselors' differences, they were generally interpreted as "surprising" or "serendipitous" conclusions (Najavits et al., 2000, p. 2163). Although Najavits et al.(2000) speculated that clinical research was beginning to catch up in this area wherein subjective characteristics of counselors were analyzed, they declared that much has yet to been done. This study relied primarily on social psychology, the attribution theory, the countertransference theory, and counseling theories specifically to gain insight into how differences between counselors may influence client outcomes (Nissen-Lie et al., 2016).

Social psychology explains how the mere presence of others influences behaviors. This theory can be used to understand how the type of counselor, which is a covert presence during therapy, may directly or indirectly influence the treatment and recovery behaviors of clients. Even without an individual explicitly stating their beliefs or outwardly expressing their feelings, social psychology illustrates how counselors' factors may play a role in affecting a client's behavior simply because of the interactions that take place in the therapeutic relationship. Social influence can be brought on by: (a) conformity, people changing their own behaviors to match that of another person to whom they are relating; (b) compliance, people changing their own behavior because another person asked them to; or (c) obedience, people changing their own behavior because another person with authority asked them to (Ciccarelli & White, 2009; McCarthy & Frieze, 1999; Senour, 1982). Additional theories that specifically informed

this study were the attribution theory, the countertransference theory, and counseling theories.

Attribution theory explains the specific cognitive processes, which counselors hold regarding the cause and effect of behaviors in their interpersonal relationships with clients (Lewis, 2009). As originally developed by Heider in 1958, this theory describes how people explain what caused the behaviors of others, as well as what caused their own behaviors (Lewis, 2009). More salient to this study, I used the attribution theory to explain how counselors could have divergent beliefs about what caused behaviors associated with PTSD or trauma versus what caused behaviors associated with SUDs. For trauma or PTSD, the causal attribution was primarily interpreted as situational, whereas substance use was often seen as a dispositional cause. What someone viewed as causal factors could affect the behavior of others as well as their own behavior. Lewis (2009) stated that the attribution theory was acceptable to professionals in the EST community because its precepts were based upon a medical model. Therefore, this theory was appropriate for this study, where the focus was on manualized treatment. However, Lewis contended that the attribution theory spoke of only one aspect of how a counselor's subjective characteristics could influence clients. The theories of countertransference explain another way. Lewis stated that attribution processes worked simultaneously with processes of countertransference in the therapeutic relationship.

Countertransference theory, historically derived from Freud's psychoanalytical perspective, describes the range of emotions therapists might feel towards clients, which could be negative or positive (Stefana, 2015). As it related to countertransference,

Najavits et al. (1995) found that clients with a single diagnosis of SUD elicited heightened countertransference because they were typically perceived as difficult clients. Moreover, clients with co-occurring disorders, specifically PTSD and SUD, were found to be more impaired than clients) with substance abuse disorder alone (Mericle et al., 2012; Saxon & Simpson, 2015). Increased countertransference would be expected when working with a population who have co-occurring disorders. Finally, Najavits et al. (2000) posited the idea of the "paradox of countertransference theory" when working with people diagnosed with co-occurring PTSD and SUD (p.7). According to Najavits et al. (2000), counselors who identified with clients diagnosed with PTSD tended to be "too nice," and counselors who identified with clients diagnosed with SUD tended to be "too harsh." What was important to this study was that counselors do experience countertransference, which may differ based upon the type of counselor or who the counselor most identified with personally. Notwithstanding the valence of the emotion, it was significant for this study to recognize that counselors were not devoid of unconscious impulses and feelings toward clients, which could influence the therapeutic process and subsequently clients' outcomes.

Although Seeking Safety was developed so that it could be conducted without regard to counselors' characteristics or training, it was rare to have equivalent expertise in both the treatment of PTSD and SUD (Najavits et al., 2000). Hence, the theories of counseling also informed this study because differences in type of counselor could also be rooted in training. For example, substance abuse counselors were more likely to be trained in the disease or biological model when conceptualizing addiction (Silver Wolf

[Adelv Unegv Waya], Maguin, Ramsey, & Stringfellow, 2014). However, mental health counselors were more inclined to receive training from a biopsychosocial perspective (Silver Wolf [Adelv Unegv Waya] et al., 2014). According to Shearer and King (2001), counselors could be categorized along a theoretical continuum, with extreme markers of powerlessness versus empowerment. Shearer and King found that these two extremes were opposing constructs. Substance use counselors typically held that "powerless" beliefs related to how people change; whereas, mental health counselors were more likely to endorse an empowerment idea for change (Shearer & King, 2001; Silver Wolf [Adelv Unegv Waya] et al., 2014). Because research on manualized treatment is relatively new, there is a dearth of studies identifying differences between counselors in general and particularly while conducting Seeking Safety. In this study I examined differences as measured by clients' outcomes between counselors after delivering Seeking Safety. Because it has been supported that counselor's beliefs about how people change and their emotional reactions to clients differ based on their training, clients' outcomes may subsequently differ, even when using a manualized treatment approach (Smith & Manfredo, 2011). Manuals by definition were purported to reduce therapist variance (Wampold & Bolt, 2006). However, the question remains whether differences in type of counselors could be controlled so that equivalent outcomes were produced.

In short, the theoretical foundation grounded in social psychology, the attribution theory, the countertransference theory, and counseling theories provided support for how differences between type of counselors could influence client's outcomes. Chapter 2 provides more detail regarding how these theoretical propositions relate to the question of

whether the differences between counselors could affect outcomes after using a manualized treatment. Specifically, the theories provided support for addressing if after receiving Seeking Safety therapy, clients' treatment outcomes differed when comparing treatment from mental health counselors to treatment from substance use counselors. Social psychology explained how clients can be influenced by counselors. The attribution theory and the countertransference theory illuminated how beliefs and emotions, which differed with counselor type, were the catalyst for counselors' behaviors (both verbal behaviors and nonverbal behaviors). Lastly the counseling theories supported the idea that counselors held different perspectives about how people change.

## Nature of the Study

The treatment used in this study, Seeking Safety, was for clients suffering from co-occurring PTSD or a trauma-related disorder and SUD. It was chosen from several EST options because it conformed to insurance and governmental requirements. Another reason for choosing Seeking Safety was its involvement in the Substance Abuse and Mental Health Service Administration (SAMHSA) women's study (Najavits, 2001), which focused on women in substance use programs. Further, because clients in substance abuse treatment were highly likely to suffer from trauma and/or PTSD (Saxon & Simpson, 2015), best practices meant assessing and treating both disorders. Seeking Safety is a program that addresses issues of trauma/PTSD by first teaching safety from consequences associated with the disorders and by replacing maladaptive coping skills with life sustaining skills (Najavits, 2002b). The idea is to reduce symptoms of trauma/PTSD, which in turn would reduce substance use and relapses (Najavits, 2002b).

Seeking Safety was chosen for this study because the treatment is manualized and can be effectively implemented without regard to type of counselors.

The research method for this study was a quantitative, archival design using existing data. Using this type of research plan meant analyses were drawn from data, which were gathered at a time prior to the beginning of the current study (Bem & Lord, 1979). This nonexperimental design allowed for the testing of hypotheses to identify differences between groups when experimental studies were impractical (Bem & Lord, 1979). Hence, the design used for this study was chosen because it provided a way to compare type of counselors based upon outcome measures where a manualized treatment was used using existing data. This design helped to overcome the limitations of resources required if a different design had been used.

The independent measures for this study were type of counselors who facilitated Seeking Safety in a outpatient treatment center. The counselors were either mental health counselors or substance use counselors who may vary with regard to their beliefs and emotional responses to clients.

The dependent or outcome measures used for this study were changes in mental health scores, changes in substance use scores and length of stay for each client. The outcome measures were collected from records of clients in an outpatient treatment facility for substance use and mental health treatment. The clients participated in the Seeking Safety therapy as a part of their individual treatment plan. The primary diagnoses were SUD with other co-occurring disorders; chief among them was PTSD or a trauma-

related disorder. I chose an outpatient treatment facility because many who received governmental funding in the State of Texas were required to use EST.

In this study I examined differences between mental health counselors and substance use counselors as it related to clients' outcomes after delivering a manualized treatment protocol. Although PTSD and SUD symptoms were similar in some of their manifestations, counselors' emotional reactions and what they believed about each disorder differed. These characteristics could affect whether the effectiveness of a manualized treatment was generalized. Trauma, PTSD, and SUD symptoms become progressively worse if left untreated or not treated appropriately, which could increase morbidity and mortality for the sufferer.

## Definitions of Terms

*Alcoholics Anonymous (AA):* A nonprofit, self-supporting, entirely independent fellowship of men and women whose primary goal is to remain sober and to help others do the same (Alcoholics Anonymous, n.d.). AA's method for achieving and maintaining sobriety is through members sharing their own stories and their hopes for recovery. AA is a voluntary, total abstinence-based program (Alcoholics Anonymous, n.d.). Their motto for members is to refrain from drinking alcohol one day at a time (Alcoholics Anonymous, n.d.). AA is not affiliated with any organization or institution, and although it welcomes collaborating with professionals, the fellowship is specifically made up of members (Alcoholics Anonymous, n.d.).

*Emotional reactions:* A term used interchangeably with the psychoanalytic concept of countertransference, which refers to responses by therapists evoked by the

interpersonal patterns, projections, and life experiences of their clients (Holmqvist & Armelius, 2006)

*EST:* A restrictive integration of clinical research trials and clinical expertise in the context of clients' characteristics for the treatment of mental health disorders (Hagemoser, 2009). EST normally requires the use of standardized procedures promulgated in manuals with a heavy reliance on evidence-based medical literature (Hagemoser, 2009). A therapist adherence and allegiance are important to the effectiveness of the treatment (Wampold, 2001).

*Length of stay:* Measures of the period of time in weeks clients remained in outpatient treatment.

*Mental health counselors:* Counselors whose education and training were obtained in human and health services, specifically in the clinical, counseling, social work, and marriage and family programs accredited from a college and/or university. Counselors may be in different stages of their practical training, which include internships for educational programs and/or for state licensure. Some counselors may have obtained full licensure, and all are at minimum master's level students.

*Objective characteristics of counselors:* Descriptors or qualities of a counselor that are easily measurable and are not unique to one person (Najavits, 2003). Examples include gender, years of training, length of experience, licensure or certification, education, and theoretical orientation (Najavits, 2006b).

*Posttraumatic stress disorder (PTSD):* "[T]he development of characteristic symptoms following exposure to an extreme traumatic stressor" (American Psychiatric

Association [APA], 2013, p. 463). The traumatic stressor can be acute as evidenced in combat or natural disasters or it can be chronic, which could be the result of childhood sexual abuse. Some of the PTSD symptoms prevalent across types of trauma include (a) re-experiencing the traumatic event, (b) avoidance of the stimuli related to the trauma, and (c) an autonomic hyper arousal response (APA, 2013). Researchers have found that PTSD is the most common co-occurring diagnosis in clients with a substance abuse disorder (Najavits, 2001).

*Seeking Safety treatment:* Seeking Safety is a present-focused empirically supported manualized therapy designed for the treatment of PTSD and SUD (Najavits, 2005). The treatment is noted for its flexibility because it can be conducted in different modalities (groups or individuals), with variant disorders (PTSD or trauma, substance abuse or substance dependence), in different settings (inpatient, outpatient, residential, prison), across different populations (women, men, veterans, adolescents), and across different counselors (substance abuse, mental health, psychiatry, social worker). The therapy specifically addresses the first stage of trauma and substance use, which includes helping the client obtain safety from consequences of their problems and to provide them with adaptable coping skills (Seeking Safety, n.d.). According to, Seeking Safety's website, it is the most studied therapy for the combined treatment of PTSD and SUD.

*Subjective characteristics of counselors:* Descriptors or qualities of a counselor that are not easily measurable and are unique to a specific person (Najavits, 2003). Examples include counselors' beliefs, their unique countertransference or emotional

reactions, their implicit theory, their personality traits, their propensity for burnout, their recovery status, and their interpersonal skills (Moyers & Miller, 2013; Najavits, 2006b).

*Substance use:* Characterized by a maladaptive pattern of continued use of a substance despite the cognitive, behavioral, emotional and interpersonal consequences (APA, 2013). One or more of the following must occur in a 12-month period to be clinically diagnosed with a substance abuse disorder: (a) recurrent substance use despite the inability to fulfill roles in major parts of life, such as work, school, or home; (b) recurrent substance use in situations of danger, such as driving, operating a machine, or a pattern of legal problems; and (c) recurrent substance use despite social or interpersonal problems caused by the effects of using, such as marital conflicts and conflicts with peers (APA, 2013). Substance abuse is considered a lesser form of the SUD (Najavits, 2007). The person must not meet criteria for substance dependence disorder.

*Substance use counselor:* Counselors whose education and training were obtained in general studies with specific training in the addiction field. Some may not have a college degree. Others may endorse a recovery status. All, however, are fully licensed in the State of Texas, which has the designation of licensed chemical dependency counselor.

*Substance dependence:* Characterized by a maladaptive pattern of continued use of a substance despite the serious consequences leading to clinically significant impairment or distress, as described by three (or more) of the following, occurring at any time in the same 12-month period: (a) tolerance, as defined by a need for an increased amount of the substance to achieve the desired effect or a markedly diminished effect with continued use of the same amount of the substance; (b) withdrawal, as defined by

characteristic withdrawal syndrome for the specific substance or the same substance is taken to relieve or avoid the withdrawal symptoms; (c) the substance is often taken for longer amounts or over a longer period than intended; (d) there is a persistent desire or unsuccessful effort to cut down or control substance use; (e) a great deal of time is spent in activities necessary to obtain the substance; (f) important social, occupational, or recreational activities are given up or reduced because of substance use; and (g) the substance use is continued despite knowledge of having a persistent or recurrent physical or mental health problem that is likely to have been caused or worsened by the substance (APA, 2013, p. 197). Substance dependence is considered a severe form of SUD (Najavits, 2007).

*Trauma:* As defined by the *Diagnostic Statistical Manual of Mental Disorders - IV-Text Revised* (APA[DSM-V], 2013), and as one of the criteria for PTSD, an event in which both of the following are present: (a) the person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and (b) the person's response involved intense fear, helplessness, or horror (APA, 2013). Although, trauma can be the result of combat, natural disasters, accidents and physical assaults, Seeking Safety was specifically developed for trauma as a consequence of sexual abuse in childhood or through experiences in adulthood (Najavits, 2002b).

## Assumptions

The basic assumptions for this study were during treatment, (a) clients answered all questions on the psychosocial intakes and assessments honestly, which included the

BDI, their Individual Treatment Plan (ITP); and their Discharge Summary; (b) clients' urine analysis were unadulterated, (c) all clients answered questions from their own perspective and as they applied to their own lives, (d) counselors met the minimum educational and/or training requirements for a mental health or substance use counselor as described in the definition section and (e) clients had a SUD and had experienced a traumatic event in their lives. These basic assumptions were necessary in the content of this study because the independent variables measured differences in mental health and substance use counselors, which according to research differed in measurable ways (Najavits, 2005; Nissen-Lie et al., 2016; Shearer & King, 2001). Further, these assumptions provided support for the dependent variables, which were changes in treatment outcomes measured by changes in mental health scores, length of stay in outpatient treatment and substance use scores. Outcome measures were derived from clients' self-reports and from independent urine analysis report.

## Scope and Delimitations

This study addressed the research problem of how differences in type of counselor impacted clients' outcomes after receiving a manualized treatment since traditionally, this had not been a focus of research (Najavits, 2003; Nissen-Lie et al., 2016). According to Najavits (2003), many studies have used objective characteristics to investigate counselors' influence on therapy. For example, Alessi, Dillion and Mi-Sung Kim (2015) used years of training to measure therapist's attitudes toward sexual minority individuals. However, counselors' emotional reactions and their beliefs could enhance or impede the therapeutic process (Moyers & Miller, 2013; Najavits, 2002b). Najavits (2002b) and

Shearer and King (2001) both found that counselors beliefs and response differ along type of counselors, specifically mental health counselors contrasted with substance use counselors. de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found that counselors' attitudes regarding using a feedback questionnaire, affected clients' progress in therapy. This was made more significant since these subjective characteristics could be so different depending on whether the treatment was conducted by a mental health counselor or a substance abuse counselor (Moyers & Miller, 2013, Najavits, 2002b & Shearer and King, 2001).

The scope of the study was purposefully limited to individuals in a outpatient treatment facility where treatment providers included mental health and substance use counselors. Rates for co-occurring PTSD and SUD range from 33-59% among clients in substance abuse facilities (Saxon & Simpson, 2015). The treatment was delivered using Seeking Safety since it was originally designed for people with co-occurring posttraumatic stress and substance use disorders (Najavits, 2002b). The clients in this study were assumed to be representative of the population in a large urban southwestern geographical area of Texas.

Seeking Safety was conducted in group format, which is the common method in outpatient treatment facilities. The study's emphasizes was on manualized treatment versus treatments as usual since providers are being mandated to use ESTs and there are some misconceptions that manuals can obtain the same results despite the type of counselor administering the treatment (Wampold & Bolt, 2006). Further, Seeking Safety

was the focus since the effects related to counselors' subjective characteristics to date has not been tested with this manualized therapy.

All conclusions derived from this study should be limited to the population examined, which were individuals in an outpatient treatment facility. Although, it may be reasonable to surmise that the results would generalize to other populations and other types of mental health and substance use centers; however, age, socioeconomic conditions of communities, and the focus of treatment might influence these assumption. The results of this study could serve as a guide for future research but should not necessarily be used as representative of other clients and at other outpatient facilities.

## Limitations

The limitations for this study included (a) a sample of convenience, (b) there were no adolescents' participants, thus the results may not generalize across age; (c) the data collected for outcome measure were from archival data derived from the records of clients who were in an outpatient treatment facility; hence the results cannot be use to show casual relationships.

## Significance

The current study contributes to the mental health and addiction field by identifying that the type of counselor could affect treatment outcomes, even when using a manualized protocol. Providers of mental health and substance abuse treatment have been increasingly mandated to use empirically support treatment. There is a body of research, which already exist regarding the influence of objective characteristics on manualized therapy. This study offered an opportunity to understand if the type of counselor, which

have been relatively ignored, may have an influence on the treatment of the co-occurring presentation of PTSD and SUD. Further, this study validated and provided additional evidence for previous studies related to the Seeking Safety treatment program, which have confirmed benefits for different patients despite no differences in a counselor's objective characteristics (Lenz, Henesy & Callender, 2014; Cook et al., 2006; Zlotnick, Najavits, & Rohsenow, 2003).

The clinical significance of this study was that if a relationship between type of counselor and treatment outcomes were supported, then providers could assess, screen and train counselors to obtain "goodness of fit" for clients. Matching type of counselor with the client's characteristics can lead to an increase in the therapeutic alliance, which favors increases in outcome measures. The ultimate significance of the study was the potential to avoid a diminishing outcome effect or harm because of incongruence between therapist and client (Moyers & Miller, 2013).

The implication for social change is that by identifying certain type of counselor that may influence outcome measures, treatment providers can lessen the cost and suffering related to the effects of PTSD and SUD. In addition, this study's findings could be used to prevent burnout since treatment providers would be able to screen and train staff based upon the type of counselor who would be conducting the treatment.

## Summary

This study provided support for the idea that the type of counselor could influence the effectiveness of a manualized treatment program. Because of the increased pressure for providers to adopt empirically support treatment and because there may be factors,

which enhance or impede standardized outcomes, there was a need to identify if type of counselor had an impact. Research has shown that counselors' characteristics may be more important than their professional credentials (Najavits, 2004b; Rek & Dinger, 2016). Further there is a body of evidence that subjective characteristics of counselors were notably different when considering the treatment of PTSD and SUD concurrently. This study offered additional information to the body of research on Seeking Safety by identifying influences that would have on an effect on its manualized treatment program.

Beginning with Chapter 2, current and historical research related to counselors' characteristics and their relative impact on treatment outcomes is discussed. After the review of the literature, the quantitative methodology, the process of analyses and a discussion of the results is explained. Specifically, Chapter 3 includes in details, the method, procedures, and testing instruments used. Chapter 4 provides specifics regarding the results of the research, which includes numerical and graphical data, as well as contrasting and comparison analyses. All research questions and hypotheses are addressed in this chapter. The study culminated in Chapter 5, where all findings are confirmed or denied based on the original assumptions. In this chapter I also offer recommendations for future research, discuss the clinical and social implications, and explain limitations of the study. Confirmation of the study's assumptions supported the need for a thorough assessment of counselors' subjective characteristics before requiring the use of manualized treatment protocols, specifically with clients suffering from PTSD and SUD.

# Chapter 2: Literature Review

## Introduction

This literature review delineates the importance for inquiry into how characteristics of counselors may affect the effectiveness of manualized treatments. Interest in this area is growing because insurance companies and governmental agencies are requiring providers to use ESTs. How the type of counselor affects ESTs has not been examined in the addiction and psychological research. Studies over the last 30 years have examined client characteristics and treatment types in regard to the effectiveness of EST, but counselor characteristics have been assumed to be neutral (Najavits, 2001). This is problematic because research has also documented that manualized treatments do not reduce the counselor's effects to zero (Wampold, 2001). The purpose of this study was to examine whether differences in the type of counselor had a significant influence on manualized treatment outcomes.

Current studies that analyzed differences in counselors' characteristics as independent variables were limited (Najavits, 2001). This may be an important point of inquiry because Wampold (2001) found that variances between different counselors were greater than variances between different treatments, even when using manualized protocols. Najavits (2003) questioned the general consensus common in the literature, which assumed equivalence among counselors in their delivery of treatment. This assumption led to studies that focused on treatment types and/or client characteristics as independent variables while ignoring the impact counselor's characteristics had on outcomes (Michael, Seltzer, Miller & Wampold, 2012; Najavits, 2003). Even when

studies were conducted using characteristics of counselors, Najavits (2003) stated that much attention had been paid to objective characteristics as opposed to subjective characteristics.

The gap in the literature is whether subjective characteristics of mental health counselors and substance abuse counselors affect treatment outcomes using a manualized psychosocial treatment for co-occurring disorders. Najavits (2003) stated that the most neglected area in outcome research was the lack of consideration for counselors' subjective characteristics. Michael et al. (2012) contended that research that examined counselors' effects such as their ability to empathize with clients would be instructive to other disciplines. In fact, interest in this area is growing because health management organizations are looking for the best providers to be included on their provider networks (Berwick, Nolan & Whittington, 2008). Researchers are also interested in counselors' effects because the outcome of treatment may not be based entirely on differences in treatment or differences in client characteristics (Michael et al., 2012). Najavits (2003) questioned the general consensus common in the literature that assumed equivalence among counselors in their delivery of manualized treatments. This assumption led to studies that focused on treatment types and/or client characteristics as independent variables while ignoring the impact counselor characteristics had on outcomes (Michael et al., 2012; Najavits, 2003). Even when studies were conducted using characteristics of counselors, Najavits (2003) stated that much attention had been paid to professional characteristics as opposed to subjective characteristics. In this study I sought to focus on the impact subjective characteristics of mental health counselors and substance abuse

counselors had on a manualized treatment designed for co-occurring disorders. Specifically, differences between type of counselors were compared to determine if treatment outcomes were affected.

This literature review is organized in sections. First, I discuss the theoretical framework of this dissertation that was rooted in social psychology theories, which describe in general how the presence of others (e.g., counselors) can influence treatment behaviors of clients. Specifically, Allport's social psychology theory, Fishbein's theory of reasoned action and role theory, as conceptualized in 1979 by Deutsch and Krauss, provided the theoretical framework for this dissertation. Second, empirical research in the fields of psychology and addiction, provided rationale for how substance abuse counselors and mental health counselors held distinct beliefs and attitudes, which may influence treatment outcomes. Particularly, the attribution theory, the belief and attitude theory, and the countertransference theory supported the idea that thoughts and emotions influenced our appraisal and reactions to others, which in turn influenced how others behave. Third, current research about the treatment of PTSD and SUD by different counselors is established (Najavits, 2003), as well as the background for this study in terms of the limited research done on treating these conditions simultaneously by the same counselor. Lastly, this literature review provides information on research methods and research participants that supported this study. In the final section, I discuss instrument measures used in empirical research to assess characteristics of counselors and treatment outcomes for clients.

I conducted an extensive review of the literature to examine the impact counselor characteristics had on outcomes measures when using a manualized psychosocial treatment. The review was done utilizing the EBSCO Research database system (Academic Search Premier, PsycARTICLES, and PsycINFO), Seeking Safety's website, and Alcohol Anonymous website (Alcoholics Anonymous, n.d.)

Search terms included *objective characteristics of counselors, subjective characteristics of counselors, therapist's impact on outcomes, accurate empathy, therapist effects, interpersonal skills, positive countertransference, negative countertransference, emotional reactions and therapy, training, powerlessness, empowerment, beliefs related to addiction, attitudes related to addiction, manualized psychosocial treatments, Seeking Safety treatment, posttraumatic stress disorder, substance use disorder, attribution theory,* and *Alcohol Anonymous (AA).*

The scope of this literature review in terms of years spanned from the early 1920s through 2017. I derived the sources of peer-reviewed articles and vital statistics for this study primarily from digital media. However, I obtained some peer-reviewed articles through printed versions of professional journals. I used multiple hard cover books, which provided information on decades of research for the treatment of PTSD and SUD.

## Social Psychology Theories

While it may be generally acknowledged that counselor characteristics influence treatment, Montaño-Fidalgo, Ruiz, Calero-Elvira, & Froján-Parga (2015) found few studies that explained "how" this occurred. Alcoholic Anonymous was described by Kingree & Thompson (2011) as the most effective treatment in influencing members to

abstain from substance use. AA's longstanding effectiveness may be due to the influence of the 12-step program, the influence of sponsors, or the influence of its members helping one another. However, the specific factors that facilitated AA's influence have not been systematically tested (Zemore, Subbaraman & Tonigan, 2013). Senour (1982) referred to London's (1964) contention that psychotherapy, by its own definition, depended on the ability to "influence" people's behavior. Yet there was a dearth of studies in the counseling field that identified specific processes of this influence. Wampold (2001) suggested that this is made even more difficult because "common factors" in therapeutic interventions were important ingredients for improvement in clients' lives. Social psychology literature can be used as a framework for understanding the dynamics of social influence, which may then be used to understand the influence counselors and support groups have on individual treatment outcomes.

**Allport's Social Psychology Theory**

Allport has been described as the father of social psychology and his seminal work has been described as the catalyst for the scientific understanding of how people's behaviors were influenced by the actual, imagined or implied "presence" of others (as cited in Thoits, 1995). Allport's 1925 book *Social Psychology* (as cited in Thoits, 1995) linked the theories of those times with applied psychology and provided classic experiments on group influence. One of Allport's famous studies was "the bystander's intervention," which provided the foundation for understanding counselors' influences on treatment outcomes. According to Allport's theory, clients' behaviors could be influenced by the actual "presence" of their respective counselors' subjective characteristics. For

example, in the famous bystander's intervention, the mere presence of another bystander would affect whether a co-bystander provided aid to someone in need (as cited in Thoits, 1995). Scaife et al. (2009) used Allport's theories of social psychology to highlight how adolescence peer groups influenced substance abuse among their cohorts. Hence, social psychology can be used to provide an understanding of how a counselor's beliefs about addiction and the counselor's emotional responses, which are "present" in therapeutic relationships, can influence how clients behave.

**Fishbein and Ajzen Theory of Reasoned Action**

Fishbein and Ajzen theory of reasoned action supported Allport's theory by postulating two key determinants of human behavior, which included attitudes and beliefs. The theory of reasoned action was first developed by Fishbein and Ajzen in 1967 as a model of psychology to explain the relationships between attitudes and behaviors. According to this theory, attitudes and beliefs about a particular behavior, such as substance use behaviors, could determine what actions would be taken (Hurtado, Crain, Simon-Arndt, & Highfill-McRoy, 2012). The theory of reasoned action was used in a study by Roberto, Shafer and Marmo (2014) to predict whether substance use treatment providers would communicate to their clients the benefits of medication assistance treatment. Their study found that substance use treatment providers had positive attitudes and somewhat positive intentions toward recommending medication assistance treatment as part of their client's treatment plan. Although the theory of reasoned action has been heavily studied in the literature as it relates to health-related behaviors (Manstead, 2011), it is also useful in studying the behaviors of mental health profession (Roberto et al.,

2014). Substance use counselors' attitudes and beliefs predicted whether they would screen military personnel for mental health issues (Hurtado et al., 2012). Hence, the rationale for applying the theory of reasoned action for this study was that it could help explain how counselor attitudes might influence their behaviors and subsequently their clients' treatment behaviors.

**Role Theory**

Role theory, as conceptualized in 1965 by Deutsch and Krauss, added to the literature by describing the mutuality of influence in relationships. In other words, just as physicians' and counselors' attitudes and beliefs might influence their clients' behavior, their clients' own attitudes, beliefs and perceptions might ultimately influence how the counselor behaved. Barnett, Spruijt-Metz, Moyers, Smith, Rohrbach, Sun and Sussman (2014) investigated the bidirectional effect of counselors and clients. They found that clients influenced which skills counselors would use when conducting motivational interviewing. For example, if a client perceived a mental health counselors' role as an advocate, the client could perform behaviors, which "elicited" aid from that counselor, which resulted in favorable outcomes (Barnett, Spruijt-Metz, Moyers, Smith, Rohrbach, Sun & Sussman (2014). However, if a substance use counselors' role was perceived as the arbiter of discipline, the clients' response may be hostile or an overt display of mistrust of authority, which could "elicit" rejection or unfavorable outcomes (Barnett, Spruijt-Metz, Moyers, Smith, Rohrbach, Sun & Sussman (2014). What was clear from Barnett, Spruijt-Metz, Moyers, Smith, Rohrbach, Sun and Sussman's study was that clients' perceptions influenced counselors' behaviors and that the therapeutic relationship

was mutual. Galanter (2014) used role theory to describe the mutuality aspect of the Alcoholic Anonymous (AA) fellowship. He contended that mutuality of relationship, rather than the self-help, was the central tenant of the AA movement (Galanter, 2014). In his study, he illuminated how members in AA had a bidirectional relationship that explained the brain processes associated with psychological functions, which ultimately motivated members to improve their substance use (Galanter, 2014). Role theory or the concept of mutuality informed this study by providing information about how characteristics such as beliefs and perceptions might influence counselors and clients in a bidirectional manner even though treatment was being conducted using a manualized treatment approach.

Although, psychology and the addiction field may be limited in studying the effects counselor's subjective characteristics, such as their beliefs about addiction and their emotional reactions have on treatment outcomes, social psychology, specifically the theories on social influences provided a broad framework for this study. Despite the challenges in the literature as it related to specifically describing how subjective counselors' characteristics affected outcomes, the attribution theory, the belief and attitude theory and the countertransference theory could provide some insight into understanding the relationship.

**Attribution Theory**

Attribution theory states that cognitive-emotional processes are the major determinant of behaviors (Reiland, Lauterbach, Harrington & Palmieri , 2014). This theory originated in the work of Fritz Heider during the 1960s (Reiland, Lauterbach,

Harrington and Palmieri, 2014) and described what processes counselors might use to understand behaviors associated with PTSD and SUDs. How counselors understand clients' pre-therapy behaviors could influence their own therapeutic interventions, which ultimately affect client's improvements in treatment. Reiland, Lauterbach, Harrington and Palmieri (2014) attribution model described causal attributions, which mediated factors of personal responsibility and controllability.

Reiland, Lauterbach, Harrington and Palmieri (2014) used the attribution of causation to describe how counselors could conceptualize causes of PTSD and SUD. According to these authors, causality could vary along four dimensions: (a) where the locus of control was believed to reside; (b) the stability of the event; (c) the controllability of the event; and (d) the generalizability of the event. According to these authors, what counselors attributed to behaviors was governed by the counselors' worldviews and ideologies. Different counselors might make different assumptions regarding their clients' SUD (Klingemann, Schläfli, Eggli, & Stutz, 2013). For example, Tolfrey, Fox & Jeffcote (2011) suggested that substance use counselors working in a medical paradigm might hold beliefs that substance use disorder is an involuntary disease with voluntary behaviors. When considering the attribution model proposed by (Reiland, Lauterbach, Harrington and Palmieri, 2014), substance use counselor may conceptualize substance use by the client as residing with that person, as a persistent state of being, as uncontrollable by that person and as having a global affect across that person's life. Whereas, when using the attribution model, mental health counselors may view SUD by the client as residing from external and internal sources, as being transient while the

person learns coping or receives treatment, as being controllable and as being specific to areas of a person's life most impacted. For example, Tolfrey, Fox and Jeffcote (2011) pointed out that drug use should be conceptualized as the result of what happened in the environment, which influences people, such as parents, peers, and the larger community. It is important to understand casual attributions held by counselors since Sorsdahl, Stein and Myers (2012) stated that counselors' beliefs about addiction could predict their helping behavior and their suggested treatment decisions. Sorsdahl, Stein and Myers (2012) found that women with alcohol use disorders were more likely to be offered help than were men with alcohol use disorder. Based upon the type of intervention, clients' may or may not benefit from therapy, which would be reflected in outcome measures.

Klingemann, Schläfli, Eggli and Stutz (2013) found that when attribution about the cause of mental illness was believed to be under one's control, such as in drug use, counselors were more inclined to withhold help, and endorsed coercive treatment. Philip, Chadee, and Yearwood's (2014) study showed that when social service providers attributed their client's HIV/AIDS status to their own behavior, their reactions toward their clients were hostile, anger and they express less willingness to help. However, when attribution about the cause of an illness was believed not to be under one's control, such as in a blood transfusion, trauma or PTSD, providers were willing to help, showed pity, and displayed less anger (Phillip, Chadee & Yearwood, 2014). Reiland, Lauterbach, Harrington and Palmieri (2014) stated that attribution theory was useful in understanding how beliefs about the causation of behaviors influenced decisions. The rationale for using the attribution theory in this study was to provide an understanding of how subjective

characteristics such as counselors' beliefs about addiction and their beliefs about mental health could influence their treatment of clients, which in turn could influence client's outcomes, even though counselors were guided by a manualized protocol. Still another theory, which can provide a framework for understanding counselor's subjective characteristics in relationship to clients' treatment outcomes, is the attitude and belief theory.

**Attitude and Belief Theory**

Ajzen and Fishbein's attitude and belief theory, unlike the attribution theory, distinguished the term "belief" from "attitudes" with the former defined as a cognitive construct and the latter as a positive or negative feeling toward an object (Ajzen & Fishbein, 1977). These authors stated that there were two requirements necessary to predict behaviors from attitudes. First, there must be a high correspondence between the target and the action elements (Ajzen & Fishbein, 1977). In addition, Ajzen and Fishbein noted that investigators must also use the appropriate measurements when defining and assigning the labels "attitudes" and "behaviors". Without a high correspondence between the target and action and appropriate procedures to measure attitudes and behaviors, the predictive value will be zero at worst or inconsistent at best (Ajzen & Fishbein, 1977). Haines-Saah, Moffat, Jenkins, and Johnson (2014) distinguished between attitudes and beliefs to predict marijuana behavior use in adolescents. These authors studied how the attitudes and beliefs of adolescents affected their subsequent intention of smoking marijuana and the perceptions about its harmfulness when compared to cigarettes. They found that both the attitudes and beliefs about marijuana were good predicators of the

intention to perform the behavior of smoking marijuana and whether adolescents found it more harmful than smoking cigarettes (Haines-Saah, Moffat, Jenkins & Johnson, 2014). Although, Ajzen and Fishbein's theory of attitude and behavior may be useful in explaining how counselor's subjective attitudes about addictions might predict ultimate behaviors in implementing a manualized therapy, caution must be taken by the investigator in terms of the high correspondence of the target and action and the measurement of variables.

## Psychological Theories

### Countertransference Theory

Countertransference theory can also be used to explain the impact subjective characteristics, such as an emotional response, had on clients and ultimately on treatment outcomes. Countertransference origins reside in psychoanalytical theories as developed by Freud (Stefana, 2015). Although the definition has evolved over time, countertransference was originally conceptualized as an expression of an analyst's personal or even neurotic unresolved conflicts, which could be triggered during the therapeutic relationship (Stefana, 2015). In its infancy, countertransference was considered harmful to the therapeutic relationship. Goode-Cross (2011) contended the countertransference was amplified in the dyad-relationship between Black therapist and Black clients. Liebman and Burnette (2013) study supported the ideal that clients with a borderline personality disorder elicited a negative countertransference response from therapist. These authors acknowledged that treatment providers in their study viewed the clients with BPD as less ill, and they displayed less empathy (Liebman & Burnette,

2013). They found that more experienced clinicians were less prone for over-identification, which could have led to heighten anxiety, potential burnout and negative outcomes to clients (Liebman & Burnette, 2013). However, Connolly and Cain (2010) explored positive countertransference in psychotherapy with psychotic patients and how it could be used to strengthen the therapeutic relationship. In addition to previous studied positive countertransference response, what was new in Connolly and Cain's study is how the countertransference could facilitate therapist's self-care, enhance the relationship and serve as a container for the working alliance. In the psychoanalytic framework, countertransference had been viewed as an emotional reaction by therapists triggered by the interpersonal patterns and projections of their clients (Stefana, 2015). However, Stefana noted that countertransference was not only reflected in a client's distorted perceptions of their therapists but also in accurate perceptions that clients had access to during the therapeutic relationship.

Outside of the psychoanalytic perspectives, constructivists defined countertransference as an interactional dynamic between clients and therapists as they co-create their therapeutic relationship. Constructivism focused more narrowly on the highly subjective characteristics of countertransference. Even though the operational definition of countertransference was varied and could be subjectively or objectively construed, Ponton and Sauerheber (2014) stated that countertransference needed to be recognized, understood, managed and taught to counselors in educational programs. Their article provided field placement supervisors and counselors educators a model to help interns and supervisee address countertransference in a manner that would facilitate the

therapeutic relationships. Schwing, Lafollette, Steinfeldt, and Wong (2011) also stressed that working with countertransference was crucial in training counselors. They proposed that counselors must process their countertransference through being aware and understanding their reactions to their clients and the importance of supervision. Tishby and Wiseman (2014) found that therapists' countertransference impeded the therapeutic alliance and resulted in weaker outcomes. Tishby and Wiseman (2014) article revealed that negative influence of countertransference on outcomes were due to fixed patterns of the counselor's feeling and reaction style and it related to their own parents. Hence, research indicates that countertransference, which for this study was considered a subjective characteristic, not only has an influence on the therapeutic alliance, but it could ultimately affect outcomes.

**Counselors' Professional Characteristics Differences**

Studies have shown differences related to the construct counselors' professional and counselors' personal characteristics. Much of the literature has focused on objective professional characteristics such as sex/gender, years of training, length of experience, licensing, education and theoretical orientation. Few studies examined subjective personal characteristics such as counselors' beliefs, attitudes, implicit theories, emotional reactions, interpersonal skills and type of counselor. Literature in the mental health and the addiction field support the importance of counselor's characteristics on therapeutic alliance, on outcome measures and as a focus of study (Anderson & Levitt, 2015; Crits-Christoph et al., 2011; Smith & Manfredo, 2011; Sommers-Flanagan 2015; Wampold & Bolt, 2006). However, one study by Goldsmith et al. (2015) found no relationship

between therapeutic alliance and treatment effect. These authors, moreover, stated that the lack of significant therapist effect on outcome might have resulted from the trial's rigorous quality control.

Some researchers have approached the influence characteristics of counselors have on outcomes by investigating gender differences. For example, Bhati (2014) stated that studies, which showed whether a counselor's biological sex (defined as male or female) influenced treatment outcomes were mixed. This study found that female therapists with female or male clients had a comparatively stronger working alliance than male therapist with male therapist (Bhati, 2014). Staczan, and et al. (2017) also found that females as opposed to male therapists had higher satisfaction ratings when their clients completed measurements assessing the working alliance and the overall therapy. Williams, Farquharson, Palmer, Bassett, Clarke, Clark and Crawford (2016) also found a small preference for matching clients based upon the sex of the counselor. Najavits (2006a) found differences between males and females when investigating counselors' preferences for PTSD treatment. Significantly more females believed that exposure therapy for the treatment of PTSD was outside of their professional training that their male counterparts (Najavits, 2006b). Staczan, and et al. (2017) detected differences between male and female therapists related to what factors influenced ten different types of psychotherapy. These authors' investigation looked at the role of sex or gender of therapists and patients with regard to treatment outcome, as well as, other nonspecific therapeutic factors. The results showed that there were substantial differences among therapists due to their gender -most notably as it related to the intervention they used.

However, Gaume, Magill, Longabaugh, Betholet, Gmel and Daeppen (2014) found the opposite in that male counselors compared to female counselors showed better outcomes when conducting a brief motivational intervention for alcohol use. In addition, Anderson and Levitt (2015) found that biological sex was not a significant predicator of a quality working alliance when it was the only variable under study. Landes, Burton, King and Sullivan (2013) found differences in gender as it related to preferences of clients. Their research findings stated that women preferred working with women when giving an option. Hence, studies supporting matching clients with counselor based on biological sex/gender had mixed finding. Owen, Duncan, Reese, Anker and Sparks (2014) in the study with various therapists, found that gender did not significantly account for variance in outcomes. Owen, Duncan, Reese, Anker and Sparks (2014) contended that since gender was not a predictive variable, these authors removed it from their model of analyses.

Researchers have approached the problem of how counselors' professional characteristics related to their credentials may have on client's treatment outcome. Najavits (2003) stated that professional characteristics, such as length of clinical experience, years of training, licensing, and education have been extensively used in outcome studies because they were conceptualized as "easy to measure" factors. Hundt, Harik, Barrera, Cully, and Stanley (2016) found that therapists' years of experience were related to their preferences in choosing an evidence-based treatment for clients with PTSD. Therapist with fewer years of experience selected evidence-based protocol more often than more experienced therapist (Hundt, Harik, Barrera, Cully, & 2016). However,

Satir (2013) noted that fewer years of experiences was related to burnout when treating patients with chronic mental health issues. This author stated that less experienced therapists often had the tendency to "work harder than the client" thus increasing burnout risk. Further, Alessi, Dillon and Mi-Sung Kim (2015) showed that training and years was associated with more affirmative attitudes, higher levels of affirmative counseling self-efficacy, and most positive beliefs.

Education is another professional characteristic used to distinguish counselors, which researchers have approached in variant ways. However, Oser et al.'s (2011) review of substance use counselors found that both rural and urban counselors agreed that although education was important, it was not more important than experience. In fact, Sperry (2012) stated that a paradigm shift has occurred in counseling programs, wherein the traditional way of input-based training had given way to an experimental based training. In a study conducted by Nissen-Lie et al. (2016) professional credentials did not explain therapists' variance. In fact, these authors found that therapists' idiosyncrasies better explained variances in outcomes (Nissen-Lie et al., 2016). Alessi, Dillon and Mi-Sung Kim (2015) found that professional identification did not predict outcome when controlling for years of practice experience and age. Norton, Little & Waterneck (2014) found that therapist's experience was unrelated to improvements in a cognitive-behavioral group therapy for anxiety. However, Sias, Lambie & Foster (2006) found that counselors' education was a predictive variable in positive treatment outcomes. Campbell, Buti, Fussell, Srikanth, McCarty, D., and Guydish (2013) found that education was a predictive variable in that therapist with graduate degrees had higher performance

in sessions and higher adherence when conducting evidence-based treatment. Nissen-Lie et al. (2016) found that the relationship between objective professional characteristics and treatment outcomes were less important than common factors located with the subjective personal characteristics of counselors.

Theoretical orientation, also an objective characteristic, is frequently identified in research as a single descriptor for therapists' variance. However, Castonguay (2013) stated that theoretical orientation was limited in its capacity to predict outcomes for treatment. Particularly, Castonguay (2013) added, theoretical orientations per se had lost its "purity" because many therapists endorsed an eclectic or integrated treatment approach. Hence a counselors' theoretical orientation influence on therapy maybe more obscured than it had been in the past when counselors adhered more closely to one perspective (Castonguay, 2013). However, Mcaleavey, Castonguay, and Xiao (2014) found that outcomes in some cases may depend upon the theoretical orientation of therapists. In using multilinear modeling analysis, their data showed that cognitive behavioral therapy outcomes were stronger when the therapist shared a cognitive behavioral orientation (Mcaleavey, Castonguay & Xiao, 2014). Simotis, Jacobucci and Houston (2006) found that theoretical orientation predicated favorability of EST among therapists as well. Their study found that therapists with a behavioral orientation favored EST higher than therapists who held a client-centered approach (Simotis, Jacobucci & Houston, 2006). Simotis, Jacobucci and Houston (2006) study examined substance use counselors whereas as Mcaleavey, Castonguay, and Xiao (2014) study examined mental health counselors.

Although objective professional characteristics, such as gender, years of training, length of experience, licensing, education and theoretical orientation were extensively researched, they were not strongly related to outcome measures used in substance use studies nor do they fully account for therapist's variance in psychotherapy in a consistent, manner (Nissen-Lie et al. (2016)). Hence, justification for examining personal characteristics of counselors is a reasonable variable of research interest.

**Counselors' Personal Characteristics Differences**

Few studies were found in the literature which focused on the subjective personal characteristics of counselors and their influence on therapy outcome measures. The sparse research available approached the problem by examining counselors' beliefs and attitudes, emotional responses of counselor, countertransference, counselors' implicit theories, counselors' personality characteristics, counselors' propensity for burnout, counselors' recovery status and counselors' interpersonal skills.

Counselors' interpersonal skills have been identified as a predictor of client outcomes (Anderson, McClintock, Himawan, Song, & Patterson, 2016; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). Recovery statuses have been an important subjective characteristic of counselors in the addiction field (Perkins & Sprang, 2013). These authors, found that counselors who were in recovery were at higher risk for compassion fatigue and thus recovery status could be a disadvantage. Ham, LeMasson, & Hayes (2013) also stated some disadvantages for disclosing recovery status, such as the risk of taking the focus of the client and placing it on the therapist. Oser et al. (2011) reported two possible disadvantages of counselors in recovery disclosing their

status to clients. The authors suggested that when counselors are not in recovery then clients could use this as an excuse to be disengaged in their own recovery. (Oser et al., 2011). Further this study pointed out that differences in counselor's recovery status on a treatment team could be used by clients to discriminate among which staff member garnered respect and which staff member did not. Najavits (2006a) found advantages in that counselors with personal histories of substance use and histories of trauma, compared to those without, were more gratified with their work, experienced less burnout and were open to using exposure therapy for individuals with PTSD. Findings for importance of recovery status on outcomes are mixed. Some studies find that counselors with personal histories similar to diagnoses or problems of their client could result in favorable treatment outcomes. However, recovery status could be used in a narrow, limited and opposing manner whereby counselors rely more on their own experiences than on empirical data. For example, Simotis, Jacobucci, and Houston (2006) found that recovering counselors viewed EST less favorable stating that manuals impeded flexibility, autonomy and their creativity.

Researchers also address counselor's subjective characteristics on outcomes by examining the construct of burnout. The degree to which counselors felt burned out in their work has been used as measures of personal characteristics (Najavits, 2006b). This author found that the more burnout clinicians were the less willing they were to work with PTSD or SUD clients and the more likely they were to refer clients to another professional (Najavits, 2006b). Best, Savic, and Daley (2016) study revealed that alcohol and drug counselor's burnout rates were associated with physical fatigue and cognitive

weariness. Further, burnout was related to how confident clinicians believed that could conduct a past-focused PTSD treatment and how important they felt the treatment was to the recovery process (Najavits, 2006b). Finally, counselors who were burnout were less gratified in their work and found it more difficult to do (Best, Savic & Daley, 2016; Najavits, 2006b). Thus, studies support a relationship between the subjective characteristic of burnout among counselors and its effects on treatment and the treatment team.

Although researchers in counseling and addiction fields did not focus specifically on counselor's personality traits, literature in social psychology on the topic of similarity and attraction provides a framework for investigating relationships between counselors' personality characteristics and outcome measures. Saarnio (2010) research, using an A/B typology model for alcoholism, supported an association between substance abuse therapists with and without personal recovery status and personality traits. This study found significant differences between therapist's score on two factors on the Five Factor Model. Counselors in recovery were less conscientious and scored lower on emotional stability than those who were not in recovery. However, this same study did not support any significant differences between counselors when analyzing their interpersonal functioning (Saarnio, 2010). Oluwatoyin (2016) described the expected personality traits for therapist, also using the Five-Factor model. He suggested that professional counseling programs use personality traits as one measurement in evaluating students for admission (Oluwatoyin, 2016). He stated that regardless of theoretical orientation that the personality of the therapist is related to the therapeutic alliance, which is related to

positive treatment outcomes. Lent and Schwartz (2012) found that counselors who scored high on extraversion, agreeableness and conscientiousness on the Myers-Briggs inventory were more likely to find job satisfaction when working with clients. Hence, the relationship between counselor's personality characteristics –a subjective factor and treatment outcomes are mixed.

Researchers also examined the effects counselor's implicit theory had on outcome measures. Vossler and Moller (2014) suggested that implicit theories of counselors (another subjective characteristic studied in the literature) may impact outcome measures to a greater extent than the objective characteristics called explicit theoretical orientation. For example, counselors' personal strategies related to what to do during therapy, their views about what processes were occurring during therapy and their philosophies about what NOT to do during therapy may enhance or hinder treatment (Vossler & Moller, 2014). Implicit theories are private beliefs and assumptions that counselors may hold about a particular therapy as opposed to "extra therapy" personal beliefs (e.g. social or political beliefs) (Vossler & Moller, 2014). Implicit theories are by definition distinct from formal theoretical orientation, where more attention is paid to abstractions and less attention to practical problems (Vossler & Moller, 2014). In these author's study they found that a counselors implicit theory relating to their private beliefs about infidelity in a couple, could influence the counselor's treatment interventions. Hence the practicalities of what a counselor believes about therapy maybe a subjective characteristic, which influences outcomes. Although not heavily researched, Najavits made a case for future inquiry.

Subjective characteristics such as “extra therapy” beliefs and values are also important factors in therapy and examined by researchers. Orozco, Nievar and Middlemiss (2012) study revealed that counselor’s perceptions about factors, which contributed to domestic violence were important to treatment outcomes. Dollarhide (2013) stated that counselor’s values were the core of counseling and could be innate or learned. Moreover, Korcet and Herlihy (2014) provided a decision-making model to aid counselors in determining when their personal values may infringe on the values of their clients. Najavits (2006a) measured the effects clinicians’ beliefs had on their preference for using a present-focused or a past-focused therapy when providing treatment for PTSD and substance abuse disorders simultaneously. Najavits findings revealed a relationship between clinician beliefs and their ratings on the assessment. Mental health counselors’preferred both present and past focused therapies whereas substance abuse counselor’s favored present-focused therapy only stating that past-focused was outside of their areas of training (Najavits, 2006a). Lassiter and Chang (2006) study measured substance abuse counselor’s beliefs as it related to their multicultural competency. They found that substance abuse counselors perceived themselves to be less knowledgeable about multicultural issues. The beliefs, values and attitudes of a counselor may impact outcome measures, and they can be a deciding factor on whether clients will be referred out (Korcet & Herlihy, 2014). Smith and Manfredo (2011) measure practitioner beliefs and how they were associated with treatment approach. They found that counselors’ beliefs underscored the challenge in implementing evidence-based treatment techniques in community settings.

Lastly, the subjective characteristics of a counselor's emotional response to a client has been sparingly approached by researchers. Rek and Dinger (2016) showed interpersonal values (a nonspecific subjective characteristic) was an important predictor of good client outcomes. Degnan, Seymour-Hyde, Harris & Berry (2016) found evidence that counselor's attachment style contributes to alliance and treatment outcomes. Connor and Callahan (2015) supported differences in therapist's expectations wherein, high expectancy was associated with positive client outcome and retention in therapy. Although researchers have described how subjective characteristics, such as an emotional response, attitudes and beliefs, implicit theories, personality traits and recovery status differences impact treatment, the question remains whether subjective characteristics differ based on the type of counselor.

**Characteristics Differences Between Mental Health and Substance Abuse Counselors**

Counselors vary and should not be considered monolithic, which Chris-Christoph et al. (1998) stated was the presumption made by early researchers. Najavits (2006b) stated concerns about differences she found between mental health and substance abuse counselors. She recommended that characteristics of counselors be the focus of studies to ascertain which clinicians were best suited for which treatment and how these characteristics influenced client outcomes (Najavits, 2006b).

Differences found between mental health and substance abuse counselors, included beliefs about addiction (Shearer & King, 2001). These beliefs varied among counselors along an opposing construct of powerlessness versus empowerment in terms

of how to conceptualize approaches to addiction. Mental health and substance abuse counselors also differed in their counseling style, which could be viewed along a continuum from corroborative to a directive-action approach. Other differences between these counselors included whether they adopted a medical versus a strength-based model, whether they purported abstinence versus harm-reduction, and how they emotionally reacted to clients. Mental Health counselors differed from substance abuse counselors as it related to the type of interventions they adopted. For example, substance abuse counselors adopted 12-step models, whereas mental health counselors relied on cognitive-behavioral or psychodynamics approaches.

As it relates to differences in philosophies, Herman's (1998) findings suggested that recovery from psychological trauma was based on empowerment since disempowerment was at the core of what was experienced by victims. However, the powerlessness paradigm, advocated by the percepts of AA and traditionally adopted by substance abuse counselor, differed (Shearer & King, 2001) from Herman's (1998) view. Recovery under the powerless paradigm was predicated on helping clients surrender to a "power" outside of themselves (Alcoholic Anonymous, n.d.) [A.A]. Herman (1998) contended that no intervention, which took power away from trauma survivors, could foster recovery (no matter how effective it was with one another diagnosis, such as SUD). Reading and Rubin (2011) also emphasized the importance of empowerment and autonomy in healing complex trauma among LGBT asylum seekers.

However, this emphasis contradicts Alcoholic Anonymous' (AA) first step of recovery, which is admitting powerlessness over an addiction. Hence, some mental health

counselors (especially those who treat trauma and PTSD) may adopt an empowerment paradigm as suggested by Herman (1998), whereas substance abuse counselors may incorporate the traditions of AA, which advocates powerlessness.

Another notable difference between mental health counselors and substance abuse counselors was offered by Fisher et al. (2014). These authors stated that counselors in masters- level mental health programs received nondirective training found in client-centered and existential approaches. These theories fostered the belief that clients have an innate ability to solve their own problems and did not need to depend on external forces – thus advocating personal autonomy. On the other hand, cognitive-behavioral and relapse prevention approaches assumed counselors were authorities or experts in the counseling process; thus, adopting a directive-action style. Traditionally, mental health counselors adopted a client-centered approach, whereas, substance abuse counselor were trained in cognitive behavioral interventions (Fisher et al., 2014). For example, in AA, members must be willing to do what their sponsors "say" without question or deviation (Fisher et al., 2014). In this action-type, authoritarian counseling style, the idea was to structure the sessions to problem solve since time was of critical importance in crisis or brief counseling (Cuijpers, Driessen, Hollon, van Oppen, Barth, & Andersson, 2012). This approach is typically used with clients presenting to substance abuse treatment programs. However, clients who presented to mental health treatment with trauma and/or PTSD may necessitate a counseling style found in nondirective approaches (Gil, 2016). Hence, mental health and substance abuse counselors often differ in their counseling style based upon different theories regarding how people change. Should clients' "resistance" be

confronted or should clients' "resistance" be tolerated as part of the therapeutic process thus allowing client's opportunities to recognize their own problems? The answer to this question may depend on the type of counselor asked (i.e. a mental health versus a substance abuse counselor). Not only do counseling styles (nondirective versus directive) differ based upon the type of counselor, their conceptualizations about addiction may also be dissimilar.

Studies have examined the differences in how counselors conceptualized addiction and mental health diagnoses. Substance abuse counselor, especially those who endorse Alcoholic Anonymous philosophies, viewed addiction from a medical model. For example, AA website defines alcoholics as an illness of the body –an allergic reaction (Alcoholics Anonymous, n.d.). Even though mental health counselors were trained to rely on the DSM-V (APA, 2013) as a guide, many have embraced a more responsibility-based model (Johnson, Lukens, Kole, & Sisti, 2015). Theories of counseling, such as psychodynamic, humanistic, and client-centered approaches may focus on psychological mechanism such as early childhood experiences, coping styles, and environmental factors as causes for alcoholism rather than AA's idea that people were "allergic" to alcohol (Johnson, Lukens, Kole & Sisti, 2015). How counselors conceptualized what "caused" addiction is just another distinction between mental health and substance abuse counselors and this difference could influence treatment.

Studies have investigated differences in how mental health counselors and substance abuse counselors differ in their form of intervention. Silver Wolf [Adelv Unegv Waya] et al. (2014) study showed that mental health workers and addiction

workers differ in their attitudes toward ESTs. Substance abuse counselors were less likely to adopt EST unless they were mandated and intuitively appealing (Silver Wolf [Adelv Unegv Waya] et al., 2014). For example, Ham, LeMasson, & Hayes (2013) found that substance abuse counselors used self-disclosure as an intervention more frequently because they lack traditional counseling education and supervision. Mental health counselors through their formal education and supervision were taught the dangers and pitfalls in using self-disclosure in the therapeutic process (Ham, LeMasson & Hayes, 2013). In addition, substance abuse counselors who wholly held the AA view maintained that people cannot control their use of alcohol thus total abstinence was the purported form of intervention (Johnson, Lukens, Kole & Sisti, 2015). Some AA members (although not sanctioned by AA's literature) extend "abstaining" from drugs to the use of psychopharmacology interventions. This stance could be discouraging to people who also have a co-occurring mental health disorder in that they may not feel comfortable taking prescribed or over-the-counter medications. Harm-reduction, as a treatment intervention for SUD, may be offered by some counselors but not by others (Lee, Engstrom, & Petersen, 2011). These authors extensive review of AA's effectiveness resulted in findings, which supported the contention that harm reduction was not a recommendation made by substance abuse counselors. Sobell and Sobell (2016) on the other hand, mental health counselors taught control drinking to their participant pool. However, it is noteworthy that weaknesses in the study were that the participants were individuals who were "problem drinkers" as opposed to those deemed "alcoholics". Even though many mental health counselors advocate abstinence as a treatment goal, (especially when

physiological dependence was established), it is often the only option of intervention offered by substance abuse counselors. In addition to beliefs about addiction, and beliefs about treatment interventions, counselors differed in terms of other attitudes and beliefs, such as whether to use manualized treatments or not, which was the focus of this study (Smith & Manfredo, 2011).

Finley et al. (2017) found differences in attitudes between clinicians regarding how they used treatment manuals. Mental health clinicians endorsed significantly higher favorable ratings for use of manuals than did substance abuse clinicians (Finley et al., 2017). This finding was not surprising since an early study of (Smith & Manfredo, 2011) revealed that different forms of manuals were needed because counselors differed in their beliefs, intuition and inferences about how people change. Neukrug and Milliken (2011) found that counselors disagreed when considering whether it was unethical to use treatments, which were not evidenced- based. Mental health counselor's ratings were higher than substance abuse counselors (Neukrug & Milliken, 2011). In addition, studies reflected differences in the emotional responses of counselors to their clients.

Najavits (2001) postulated that counselors working with individuals who had been dually diagnosed with PTSD and SUD differed in their emotional response. Mental health counselors were described as being "too soft" while substance abuse counselors were deemed "too hard" (Najavits, 2001). Either emotional response could be helpful or hurtful to therapy and ultimately to treatment outcomes (Degnan, Seymour-Hyde, Harris & Berry, 2016; Najavits, 2001). Cramer (2004) described counselors working with trauma and substance abuse as having a desire to "rescue and desert" the client.

According to Nielsen, Ho, Bahl, Varma, Kellogg, Borg, and Kreek (2012) how counselors responded emotionally to their clients depended on value judgments related to character traits. For example, Nielsen, Ho, Bahl, Varma, Kellogg, Borg and Kreek study showed that if behaviors, such as committing acts of violence while in pursuit of getting drugs, were interpreted by counselors as dispositional or inherent in the client's character, then counselors' emotional responses were harsh, confrontational and punitive. On the other hand, these authors found that if behaviors by clients seemed to be caused by external factors, then counselors' emotional responses were empathic and understanding. Mental health counselors (especially those working with trauma and PTSD) were more likely to attribute external factors to client's problems whereas substance use counselors located the "problem" in the person (Nielsen, Ho, Bahl, Varma, Kellogg, Borg and Kreekm 2012). Carrick (2014) found that mental health counselor differed from substance abuse counselor in their work with clients in crisis. They found that client-centered therapist enjoyed crisis work and had a positive attitude (Carrick, 2014). Miville, Carlozzi, Gushue, Schara, and Ueda (2006) suggested that the counselor's emotional responses to clients were associated with their own emotional intelligence. The more counselors were able to identify their own emotions and feelings the greater the likelihood that they would be able to empathize with their clients (Miville, Carlozzi, Gushue, Schara & Uede, 2006).

Researchers have investigated how countertransference between mental health counselors and substance abuse counselors differ and affect therapeutic outcomes. Najavits (2001), supported a dual-countertransference concept where therapists differed

in their feelings based upon whether they viewed the individual as “a client” or “an offender”. When clients are viewed as sick people who needed treatment, counselors tended to be sympathetic (Kellogg & Tatarsky, 2012). On the other hand, when clients are viewed as bad people who deserved punishments, counselors tended to be display feelings of anger, fear, cruelty and other dysphoric emotions (Kellogg & Tatarsky, 2012). Rothrauff and Eby (2011) showed that counselors working in a correctional facility were less likely to implement smoking cessations programs, whereas counselors working in a harm reduction treatment center were more likely to facilitate the nonsmoking program, which reflected differences in counselors. This is interesting since both the mental health and addiction field could experience legal consequences because of their symptom-driven behaviors. In fact, SUD uniquely has criteria in the DSM-V (2013) specific to the present or absent of legal involvement. Hence, counselors are more likely to have clients with forensic matters, which means they must work with penal institutions who refer to individuals’ as “offenders”.

Other studies examined the independent variable of counselors as it related to countertransference. Najavits (2001) developed a typology of countertransference reactions which suggested that therapist expressed overtly avoidant, withdrawn and distant behaviors when working with clients who were processing traumatic events. In the substance abuse field, Beck, Liese and Najavits (2005) conceptualized how clients were viewed. According to their research, substance abuse clients were viewed as suspicious, manipulative or avoidant, which could make it difficult to develop good working relationships (Beck et al., 2005). Mental health counselors typically view clients

(especially those who have suffered from trauma and/or PTSD) more empathically (Beck et al., 2005). These authors stated that it was important to know how counselors expressed their emotions toward clients since irritation or dissatisfaction through verbal or nonverbal language could result in premature termination of treatment. Barrett and McWhirter (2002) also agreed that negative biases or countertransference toward clients led to negative consequences in treatment outcomes. Najavits (2001) suggested that a common reaction among counselors unfamiliar with substance abuse patient was likely negative. In her conclusion, Najavits said that some mental health counselors held on to ideas about clients with addiction history, which were limiting, such as "they can't get better" (p. 138). On the other hand, substance abuse counselors who were trained in confrontational approaches may be "too hard" and risk re-traumatizing clients with trauma histories or PTSD (Beck et al., 2005). Schwalbe and Maschi (2011) questioned the practice of using the confrontational approach even with substance dependent clients who were not motivated for treatment. These authors contended that the confronting or "breaking through" denial or resistance by directly convincing clients to abstain from use through intensive treatment may be countertherapeutic.

The literature supports the concept that mental health counselors and substance abuse counselors differ when considering subjective characteristics, specifically when working with clients with co-occurring diagnoses of PTSD and SUD. The study of how attitude, beliefs and countertransference influence others and by extension therapy has been studied extensively in social psychology but has not been specifically a focus in the mental health and addiction field, specifically for PTSD and SUD.

Given that counselor's subjective characteristics, in general, influence treatment, these factors may be more noteworthy when considering the treatment for co-occurring disorders, which was examined in this study. Traditionally, interventions used to help clients reduce symptoms of post-traumatic stress disorder substantially differ from interventions used to help clients reduce their SUD and thus may require different type of counselors for effective facilitation. This of particular concern since Seeking Safety suggested that the type of counselor does not affect the effectiveness of treatment it empirically support therapy designed for the simultaneous treatment of PTSD and SUD. Since studies so far have not examined the effect of counselors' characteristics on PTSD and SUD, these will necessarily by the dependent variables for this study.

**Posttraumatic Stress Disorder and Interventions**

PTSD is defined as "the development of characteristic symptoms following exposure to an extreme traumatic stressor" (APA, 2013, p. 463). The three primary symptoms include re-experiencing the traumatic event, avoidance of stimuli related to the trauma, and autonomic hyperarousal (APA, 2013). According to the APA, the lifetime prevalence among adults for PTSD is 8% in the United States. Although traditionally associated with men in combat, Najavits, Hyman, Ruglass, Hien & Read (2017) stated that PTSD is also more commonly associated with people who suffer from addictions. Mixed gender rates of PTSD in substance abuse treatments range from 12% to 34%; however, women have much higher rates ranging from 33% to 59% (Najavits, Hyman, Ruglass, Hien & Read (2017).

PTSD is uniquely different from other mental health disorders because counselors may be vulnerable to the effects of their clients' traumatic stories. Shannonhouse, Barden, Jones, Gonzalez, & Murphy (2016) referred to this phenomenon as secondary traumatic stress (STS). Treatments for other DSM-V disorders (e.g. phobias, depression, or schizophrenia) do not have this "occupational hazard" (Najavits, 2005, p. 120). Thus, Najavits suggested that this secondary risk lends credence to the need for specialized training and screening of counselors involved in trauma work. Some counselors may be more vulnerable because of their personal recovery status (Perkins & Sprang, 2013). Even though Seeking Safety focuses on the first phase of recovery, which deals with safety instead of traumatic histories per se, counselors must remain in the confines of the treatment protocol in order to avoid secondary traumatic stress (Najavits, 2005). This may pose a unique challenge for addiction counselors who were trained in emotionally processing their client's addiction histories. Najavits, Hyman, Ruglass, Hien and Read (2017) warned that re-telling stories of addiction could be re-traumatizing, if clients have a co-occurring diagnosis of PTSD. In addition, mental health counselors who are not familiar with exposure therapy may also inadvertently expose themselves and their clients to emotional material that may be addressed prematurely and consequently counter-therapeutic.

There are treatments, which when implemented effectively reduce symptoms of PTSD. Najavits, Hyman, Ruglass, Hien and Read (2017) described evidence-based psychotherapy for the treatment of PTSD as either present-day focused or past focus. Present-day focused models help improve functioning by teaching coping, and social

skills (Najavits, Hyman, Ruglass, Hien & Read (2017). In addition, present-day treatments offer cognitive restructuring techniques (Najavits, Hyman, Ruglass, Hien & Read (2017). Stress inoculation training, anger management training and grounding were described by Najavits as interventions where the focus was placed on present living situations. Cognitive-behavioral therapy has been the most promising approach use for PTSD and it directly meets the needs of the first-stage of therapy which is safety (Najavits, Hyman, Ruglass, Hien & Read, 2017).

In past-focused models, however, clients re-tell the details of the traumatic events. Some studies stated that the exploration of trauma was a major intervention in PTSD treatments (Najavits, Hyman, Ruglass, Hien & Read, 2017). However, Najavits (2002b) said the effectiveness of past-focused models was not well known when used with clients who were currently diagnosed with SUD. Najavits (2004a) provided examples of interventions where the focus was on the past, such as eye movement desensitization reprocessing, mourning, the counting or rewind method and exposure therapy. When working with clients suffering from PTSD and SUD, prior literature recommended a 10-month period of abstinence from substance use to protect the client from relapsing (Najavits, Hyman, Ruglass, Hien & Read, 2017). Hence exposure to traumatic material can be premature if clients have not been able to maintain a period of sobriety. Other forms of treatment for PTSD may be used interchangeably in a present-focused or a past-focused framework.

Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014) suggested different forms of therapy for helping clients with PTSD, which were

developed from a cognitive perspective. Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014) highlighted a treatment for PTSD, which was developed specifically for civilians who suffered from substance abuse that included understanding the contextual factors, looking for meaning in the clients' stories, aligning with the clients' values and helping clients establish a new identity that was life affirming. Dorrepaal, Thomaes, Smit, van Balkom, Veltman, Hoogendoorn, and Draijer (2012) stated that psycho-education could be helpful in decreasing the hyperarousal system associated with PTSD since it provided a means to educate and inform clients about trauma and the symptoms associated with it. The National Center for PTSD (2014) recommended psycho-pharmacology as an adjunct treatment, specifically, suggesting selective serotonin reuptake inhibitors (SSRIs), which are antidepressant medication helpful for PTSD symptoms.

Whether PTSD treatment is a mixture of present-focused or past-focused models, Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014) proposed that effective treatment for PTSD be conducted in three phases to include: (a) making sure clients were stable and felt safe; (b) helping the client retell the story of the traumatic event and (c) helping the client reconnect with others. A relative new therapy, Seeking Safety, addresses the first phase of PTSD treatment, which is to establish safety from the harmful effects of the co-occurring disorder. The second phase in the treatment of PTSD and/or trauma should is emotional processing, which is not recommended until after a period of stabilization has been achieved (Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014). Processing involves assisting clients in constructing

narratives through: (a) exploring the meaning of the trauma event that impaired functioning; (b) integrating the trauma with adaptive networks and (c) learning new meaning from the trauma (Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014). Counselors usually adopt past-focused cognitive behavior therapy (CBT) when helping clients process their trauma (Kaysen, Schumm, Pedersen, Seim, Bedard-Gilligan, and Chard, K. (2014).

Some CBT exposure therapies include having clients write about the traumatic event, having clients create images of the event, and exposing the client to the event through external cues or internal physical cues (Coffey, Schumacher, Nosen, Littlefield, Henslee, Lappen, and Stasiewicz, 2016). Exposure therapies are used to treat many anxiety disorders, however, eye movement desensitization and reprocessing (EMDR) was specifically designed for treating clients who had PTSD (Coffey, Schumacher, Nosen, Littlefield, Henslee, Lappen, and Stasiewicz, 2016). Even though both traditional exposure therapy and EMDR focus on memory, imagining, thoughts, emotions and bodily sensations, EDMR adds a simultaneous process called dual attention bilateral stimulation or exposure with tones or tapping (Coffey, Schumacher, Nosen, Littlefield, Henslee, Lappen, and Stasiewicz, 2016). Many of the recommended treatments in the second phase require specialized training and should not be facilitated by counselors not otherwise trained in this area. However, Najavits, Hyman, Ruglass, Hien and Read, 2017 contended that since Seeking Safety's treatment objective was specific to the first phase of treatment purportedly it could be conducted by counselors across disciplines without

specialized training in trauma or PTSD (i.e., rather than mental health or substance abuse counselor).

According to (Najavits, Hyman, Ruglass, Hien & Read, 2017), clients were subjected to split systems where mental health counselors focused on treating PTSD and substance abuse counselors focused on treating substance abuse disorders. Najavits, Hyman, Ruglass, Hien and Read, 2017) stated that federal funding had made the problem worse because they do not allow providers to comingle monies between mental health and substance abuse services. These policies made it hard to provide treatment to clients with co-occurring illnesses. However, clients, as well as researchers, indicated that an integrated treatment system was more desirable and most effective (Najavits, Hyman, Ruglass, Hien & Read, 2017). Specifically, the simultaneous treatment of PTSD and alcohol abuse was recommended by counselors because these disorders were uniquely interrelated (Expert Consensus Guidelines Series, 1999). Still, researchers stated that they often meet with resistance from treatment providers, which made it difficult to apply what has been learned from the data to practical settings (Najavits, Hyman, Ruglass, Hien & Read, 2017). In addition, Najavits, Hyman, Ruglass, Hien and Read (2017) warned that there was a danger in using split or separate systems in that treatment for one disorder may exacerbate the symptoms for the other. For example, benzodiazepines, which are used in the treatment of PTSD, may be problematic when used with clients who have addiction issues since this anti-anxiety medication was often misused or abused (Najavits, Hyman, Ruglass, Hien & Read, 2017). Najavits, Hyman, Ruglass, Hien and Read (2017) contended that even though simultaneous treatment was recommended, it

was also made difficult because different counselors held conflicting views about what constituted positive outcomes. For example, a mental health counselor might view a reduction in a clients' substance use as progress in treatment, whereas a substance abuse counselor may view success as total abstinence. Najavits, Hyman, Ruglass, Hien and Read (2017) suggested that segregated systems of treatment continued as the normal way of delivering services because professionals were more devoted to their own respective interest and training whether than stepping outside of their comfort zone.

Najavits, Hyman, Ruglass, Hien and Read (2017) highlighted common practices related to the co-occurring disorders in that mental health counselors required individuals to obtain some degree of sobriety before they received treatment for their PTSD. However, substance abuse counselors, required treatment of PTSD systems before treating drug and alcohol abuse (Najavits, Hyman, Ruglass, Hien & Read, 2017). In fact, Najavits (2005) found that these counselors differed in terms of how they viewed whether to use present or past focused therapies for the treatment of PTSD. Substance abuse counselors considered having clients focus on past events outside of their scope of training, but mental health counselors' views were different (Najavits, 2005). This was evidenced in Najavits' study where she found that substance abuse counselors referred PTSD clients out for treatment more than mental health counselors. According to Najavits (2005), clients with co-occurring not only were not receiving integrated treatment in clinical or substance abuse settings; they were not fully represented in research either. Ouimette, Brown and Najavits (2005) viewed not treating clients with co-occurring disorders in the same setting troublesome, especially when considering how

common this was for many clients. When examining research on the efficacy and effectiveness of PTSD treatments, according to Najavits (2006b) clients with co-occurring disorders were systematically excluded because the consensus was that front-line treatment would not be tolerated by such a "vulnerable" population. Mericle et al. (2012) explained barriers to PTSD treatment for clients with co-occurring disorders; some were client-driven and some were provider-driven. According to their research, clients were not initially or continuously screened for trauma and PTSD and even when assessed, providers did not address these issues in the client's treatment plan (Najavits, Hyman, Ruglass, Hien & Read, 2017). Further, these authors stated that clients might be unwilling to talk about their trauma and PTSD, which also impedes treatment.

Dual-diagnosis is a commonly used term to described individuals suffering from SUD s with a co-occurring mental health disorder (Najavits, Hyman, Ruglass, Hien & Read, 2017). According to Substance Abuse and Mental Health Services Administration (2008), over 10 million people in any given year in America suffered from two or more mental health disorders. Although, the mental health field in general and psychotherapy specifically, have ignored substance abuse, Najavits (2001), stated that more outcome research had begun to pay attention to treatment and training in this area and not simply relegated it to the addiction field.

**Substance Use Disorder**

SUD is defined as

"A) a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring

in a 12-month period: 1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household) 2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use) 3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct) 4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights) B. The symptoms have never met the criteria for substance dependence for this class of substance." (APA, 2013) [APA].

According the APA (2013), the lifetime prevalence among adults for substance dependence range from 9-13% in the United States and it constitute a major public health concern costing more than 400 billion dollars annually. SUDs are by far the most often co-occurring disorder, highly comorbid with many psychiatric disorders (APA, 2013). The guidelines cited lifetime prevalence estimates between 20-90% of individuals with SUDs to also have met criteria for a serious Axis I psychiatric disorder. Further, approximately 33% of hospitalized psychiatric patients had a co-occurring nonnicotine related SUD (APA, 2013). According to Najavits (2001), 12% to 34% of clients in a substance abuse treatment facility met criteria for a co-occurring PTSD diagnoses. She

stated that these PTSD rates were higher for women in substance abuse treatment programs ranging from 33% to 59% (Najavits, Hyman, Ruglass, Hien & Read, 2017).

Substance abuse treatment has been traditionally relegated to the addiction field; however, Najavits (2011) stated the mental health field have shown more interest over the last decade. In addition, the Affordable Care Act requires that medical health care field also integrate substance abuse treatment into their services (Fields, Blum & Roman, 2014). Psychosocial treatments are by far the most popular and essential component of the treatment for SUDs (APA, 2013). Twelve-step facilitations such as Alcoholic Anonymous and Narcotics Anonymous are often the most common interventions used in health care services. According to AA website, it is an international fellowship of people with drinking problems and is nonprofessional, self-supporting, multiracial, apolitical and open to everyone and available almost everywhere (Alcoholics Anonymous, n.d.). Narcotic Anonymous adopted many of the Alcoholic Anonymous tenants; however, it does not distinguish between drugs and alcohol (www.na.org). Membership is advertised as free, although there is an opportunity for members to contribute during the "passing of the hat" ritual. Unlike other psychosocial treatments for substance abuse disorder, the 12-step facilitation (TSF) groups are not lead by professionals and may differ in types and/or formats. The success rates for 12-step facilitation groups are hard to determine since many are anonymous and do not readily report outcomes. According to AA's website in 2014 that estimated that there were more than 2 million members who achieve successful recovery (ww.aa.org); however, many of these reports are anecdotal.

There are some research studies which have examined the success of 12-step groups. Kelly, Stout, Magill, Tonigan and Pagano (2010), found greater AA attendance was associated with better subsequent alcohol use outcomes and decreased depression.

Zemore et al. (2013) investigated the different interventions advocated in traditional AA programs and found a strong and consistent predictor between abstinence and attending meeting and having a sponsor. However other activities promoted by AA such as identifying a home group, becoming friends with other members, performing service work are reading the AA literature, did not predict abstinence among members (Zemore et al., 2013). McKellar, Stewart and Humphreys (2003) used a structural equation model to support Project Match (1999) assertion that AA affiliation predicted lower-alcohol related problems at 2-year follow-up, however, these authors admitted that questions still remained regards to what mechanism or mediational processes were involved in AA involvement. Despite studies, which reflected 12-step program's success, Cloud, Rowan, Wulff and Golder (2007) noted that there was a high percentage of members who dropout. They cited Project Match 1999 report, which stated that 26-38% of individuals dropped out of 12-step programs in a 6-month period. Their study attempted to evaluate factors, which may motivate members to maintain their involvement in 12-step programs. Cloud, Rowan, Wulff and Golder contended that treatment providers would benefit from investigating factors, which encourage continued recovery efforts.

Research related to 12-step facilitation and co-occurring disorders reflected outcomes differently. For example, Timko, Sutkowi and Moss (2010) studied revealed

that patients with dual diagnoses showed weaker outcomes than patients with a SUD as it related to 12-step group participation. In fact, Kelly, Kahler and Humphreys (2010) showed how the existence of a co-morbid psychiatric illness was one of the reason for early dropout in 12-step programs. When Brooks and Penn (2003) study compared treatments for dual diagnosis they found a worsening of conditions for patients who participated in a 12-step program versus those who participated in a cognitive behavioral program. Since SUD co-occurring with a mental health diagnoses, such as PTSD, may result in different treatment outcomes, this study addressed the gaps in identifying possible factors, which may attribute to these noted differences. Further, integrated treatment is the recommended guidelines for co-occurring disorders (APA, 2013).

**Integrated Treatments**

Beck, Liese and Najavits (2005) pointed out the importance of integrated treatment when clients have comorbid diagnoses. Mericle et al. (2012) reviewed empirical research noting that there were only a few treatment studies of PTSD-SUD comorbidity. Throughout their review, the objective was to highlight the treatment implication and to encourage developed of evidence-based practices for these co-occurring diagnoses. Rather than treating each disorder singularly, the recommendation was to treat them simultaneously (Beck, Liese & Najavits, 2005). Ouimette et al. (2005) review of the literature showed that short-term and long-term treatment yielded better outcomes when integrated with family treatment, teaching of coping skills, 12-step programs, and a carefully monitoring of client's substance use cognitions. These authors

suggested future research in investigating the benefit of psychotropic medication for the treatment of PTSD and SUD.

However, care must be taken in integrated treatments since unlike other dual-diagnoses (e.g. depression), PTSD symptoms may worsen with abstinence from substances (Najavits, 2005). Hence this author recommended stage-based integrated treatments. Ouimette et al. (2005) focused on posttraumatic stress and substance abuse disorders in a substance abuse setting while Bremmer, Southwick, Darnell and Charney (1996) focused on substance abuse disorders in mental health settings for trauma and PTSD. Despite the disciplines or settings, clients with two or more mental disorders had poorer outcomes in treatment, which intensified over time (Omimette, Brown and Najavits, 2005), which intensifies the demand for empirically supported standardized treatment, specifically for PTSD and SUD. Since these co-occurring disorders elicited different beliefs and attitudes among counselors, it is important to know what type of counselor will be most effective in conducting standardized treatment.

**Counselor's Characteristics on Treatment of Posttraumatic Stress Disorder/Substance Use Disorder**

Research, which studied the effect of counselor's characteristics on the co-occurring treatment of PTSD and SUD is sparse, specifically as it relates to an empirically support protocol. However, Back, Waldrop, and Brady (2009) study examined counselor's perspectives when treating substance use and PTSD. Clinicians varied in their training backgrounds and treatment settings. Their findings supported other research findings, which showed that clinicians found working with patients being

treated for PSTD/SUD challenging. Some of the concerns by clinicians were when and how to integrated the treatments for trauma, how to address severity of patient's symptoms and self-destructive behaviors and how to help patients abstain from substance use (Back, Waldrop, & Brady, 2009). Fahy (2007) described a substance abuse counselor's experience in working with clients affected by PTSD and substance us as compassion fatigue. Fahy contended that substance use counselors did not have adequate training and a foundation in evidenced support treatment for PTSD, which lead to "burnout" and poor outcome for clients. O'Hare and Sherrer examined the perceptions of staff support on the psychosocial outcome of clients as it related to their use of alcohol and on their PTSD symptom severity. They found that clients' who perceptions of staff support were positive showed substantial direct effects on their psychosocial well-being, their satisfaction with services and were likely to drink alcohol to cope with negative emotions (O'Hare & Sherrer, 2009). However, they found no effect on PTSD symptoms as it related to client's perception of staff support (O'Hare & Sherrer, 2009). Najavits, Norma, Kivlahan and Kosten (2011) examined staff's attitudes about treatment of PTSD/SUD including strengths and weaknesses of program of treatment. The found differences among staff in their attitudes and beliefs in terms of difficulty in treating PTSD/SUD as well as in gratification received from the work (Najavits, Norma, Kivlahan, & Kosten, 2010). These authors found that mental health professionals differed from substance abuse counselors on the separate constructs. Najavits, Kivlahan and Kosten (2011) also survey counselors and from that they held different view as it related to evidence-based therapies for PSTD and substance abuse. Their results showed

significantly different ratings by counseling of four key areas they addressed (Najavits, Kivlahan & Kosten (2011). Although, there are a few studies, which examined the effects of subjective characteristics of counselors as it related to the treatment of PTSD/SUD, none of them addressed the affects counselors' beliefs and attitudes may have on an EST.

There is vast amount of research in various disciplines, which supported the idea that the subjective characteristics of counselors conducting therapy will ultimately have an effect on client's treatment outcomes. Even though EST protocols are designed to reduce counselor's effects; there is evidenced that manuals do not reduce counselor's variance to zero. Furthermore, there are studies, which show that there are differences in how specific type of counselor response to clients who present with specific diagnoses as well as their beliefs and attitudes toward these clients. For example, mental health counselors vary on subjective characteristics from substance abuse counselor when treating clients with posttraumatic stress and substance abuse disorder. Seeking Safety is an empirically supported therapy for the co-occurring treatment of PTSD/SUD, which purports that differ counselors may implement it without affect clients' outcome. However, the developer also admits that subjective characteristics, which have yet to be studied, may have an effect. The current climate in health care services are mandating that providers adopt EST. Moreover, what is known is that integrated treatment is notable more desirable by clients. What is not known, is whether integrated treatment can be provided by the same provider without regard to their specific characteristics. This is important to clinical and substance abuse settings since clients who present with co-occurring disorders are often more difficult to treatment and have poor outcomes. If the

questions of how counselor's subjective characteristics may influence treatment is not answered, we risk increased deterioration of client's mental and emotional stability. Further, without knowing who is the best counselor to implement treatment protocols, we risk burnout among providers. Hence, this study sought to address the gap in research as it relates to the problem of whether or not there were differences in outcomes using an EST for PTSD/SUD based upon the type of counselor conducting the therapy. The method described in Chapter 3 will use archival data to examine client's outcome after mental health and substance abuse counselors have implemented an empirically supported therapy designed for the treatment of posttraumatic stress and SUD.

# Chapter 3: Research Method

## Introduction

The purpose of this quantitative study was to determine whether there are differences in client treatment outcomes based upon the type of counselor who conducted an EST for persons diagnosed with PTSD and SUD. An increased understanding of how differences in treatment outcomes, even when using a treatment manual, may be associated with the type of counselor will help to:(a) establish assessment criteria for choosing the best counselor for a particular treatment protocol;(b) cross-train staff in an organization, and (c) address concerns regarding negative effects of treatment such as relapses, early dropouts, and low success rates for clients with co-occurring disorders.

Mental health providers and substance abuse programs are mandated by third party funders to adopt ESTs. ESTs are preferred because they are usually developed with manuals and supposedly able to be used by different types of counselors while maintaining effectiveness. However, manuals do not reduce subtle characteristics of counselors, which may be a part of implicit theoretical orientations held by different types of counselors. For example, Najavits (2005) noted how different types of counselors varied in their responses when working with clients who had PTSD and SUD. Najavits (2005) stated mental health counselors were “too lenient” while substance abuse counselors were “too harsh”. Identifying counselors who are effective in conducting treatment for co-occurring disorders will add to the growing body of knowledge and understanding of EST and how it can be used effectively in clinical settings.

This chapter focused on the methodology and the rationale for conducting the study. Specifically, I discussed the study's design, the research questions, the hypotheses and variables, as well as, a description of the population and sample. Also included are procedures that I used to obtain and collect archival data along with a description of the analyses that I used for reaching conclusions. I provided a discussion of the self-report assessments and the intervention used in this study. Lastly, in this chapter I discuss the procedures that I implemented to ensure adherence to applicable ethical standards and confidentiality rules.

## Research Design and Rationale

The research method for this study was a quantitative archival design using existing data. Using this type of research plan means analyses are drawn from data that were gathered at a time prior to the beginning of a study (Lord, 1973). This nonexperimental design also allows for the testing of hypotheses to identify differences between groups when experimental studies are impractical (Lord, 1973). It is a popular design used in many studies in social sciences (Trochim & Donnelly, 2007). Examples of previous studies that employed a retrospective analysis include Mott, Graham, and Teng's (2012) examination of data collected from 1,740 veterans who had participated in assessments in prior years. These authors were able to use prior data to significantly predict variables, which were associated with veterans' reports of perceived threat during deployment. Mott et al.'s study was able to identify important relationships that would help improve preparation before deployment and facilitate adjustments during deployment, which had the potential of reducing troops' threat appraisals and mental

health issues (p. 594). Booth, Mengeling, Torner and Sadler (2011) used a retrospective design and examined records 5 years preceding their study to identify variables that were associated with changes in substance use among women veterans. Ouimette, Read, and Brown (2005) examined characteristics among civilians with SUD to enhance evidence-based interventions by using a retrospective research design. They focused on 120 participants who completed a follow-up assessment approximately 6 months after discharge.

A review of prior methodologies where earlier researchers used archival data in nonexperimental designs (Booth et al., 2011; Mott et al., 2012; Ouimette et al., 2005) supported this study's use of examining prior medical records to determine if there are differences among groups of counselors in treatment efficacy. There were several advantages in using an archival design as used this study. Firstly, the use of prior medical records allowed a 3-year analysis rather than confining me to a standard 3-month period for conducting a cost-effective experimental investigation. Secondly, this study's design eliminated the need to request adequate accommodation at the treatment facility for office space to conduct therapy sessions as well as the need for determining flexible hours and days for scheduling participants. Thirdly, access to medical records allowed data to be examined from a diverse population of individuals along various possible demographic influences such as age, ethnicity, gender, and education level. A shorter period typical of an experimental study would likely not have afforded the same diversity. Lastly, the use of medical records from a treatment facility in the State of Texas provided uniformity in documentation from a multidimensional approach, which included psychiatric diagnoses,

medical diagnoses, a presentation of social and family issues, and a general assessment of current and past functioning.

This archival quantitative study used information from medical records at a treatment facility that is part of a continuum of care contract funded by the U.S. Department of Justice. Because the program is associated with governmental agencies, data must be collected and maintained according to a documentation protocol for licensed mental health professionals and substance abuse professionals. There are also preestablished confidentiality protections and client rights that govern the facility.

## Study Variables

The purpose of this research was to ascertain whether differences in treatment outcomes exist between mental health counselors and substance abuse counselors after conducting a standardized therapy called Seeking Safety. The independent variable was counselors, which was identified as either a mental health counselor or substance use counselor based upon their educational training and/or license. Dependent variables that I used to define effectiveness of treatment were: (a) change in client's outcomes scores as measured on the BDI, (b) change in client's outcome scores as measured by whether they maintain sobriety or relapsed to substance use, and (c) a client's length of stay measured in weeks. Two scores were developed for dependent variable "outcomes" (i.e. mental health score and a substance use score) and one score was developed for "length of stay in treatment." Outcome referred to improvement or changes in clients' level of emotional stability (i.e. depression, sustained sobriety, and length of treatment) by the end of Seeking Safety therapy. There were two measures for the first dependent variable, which

included: (a) the BDI for depression symptoms, and (b) the Substance Use assessment score for reporting sobriety or return to substance use. There was one measure for the second dependent variable, which was length of treatment, which was the number of days the client remained in the Seeking Safety treatment program. Demographic factors used to check whether counselors' caseloads where similar before Seeking Safety treatment begun were: (a) client's demographic variables (age, race/ethnicity, education, (b) a measure of clients' suitability for therapy (based on scores from the Mental Status Exam), and (c) severity of clients' pathology (based on global assessment functioning score from the DSM-V (APA, 2013).

The study's design made it possible to answer research questions regarding whether differences in type of counselor exist after facilitating Seeking Safety treatment, which is a standardized protocol. The design built upon empirical studies for manualized treatments in general and Seeking Safety *s*pecifically in both the mental health and addiction field. Prior studies investigating counselors' influence generally used treatment models (as opposed to therapist) as independent variables because the assumption was that manualized treatment reduced therapist's variance to a level of insignificance (Najavits et al., 2000, p. 2163). According to Wampold (2001), however, therapist's variance should be considered in a study's analyses because manuals do not reduce differences among counselors to zero. To address Wampold's contention, this study isolated counselors as independent variables, thereby advancing knowledge in clinical and addiction research. For practitioners and policymakers, evidence provided from this

study using archival data in a clinical setting may encourage them to improve their current practices and carefully match counselors with the best treatment models.

Seeking Safety is used as the intervention at the treatment facility and subsequently in this study because: (a) it is an integrated therapy for the co-occurrence of PTSD and SUD, which is more likely to elicit different thoughts and feelings from counselors toward clients; (b) it is purported to be effective despite objective characteristics of counselors, although, the author acknowledged the need for further research (Lenz et al., 2016; Najavits et al., 2011; Najavits et al., 2000); (c) it is popular in the mental health and addiction field (Lenz et al., 2016; Najavits, Kivlahan & Kosten, 2011); (d) it has the most empirical supported studies (Lenz et al., 2016; Najavits et al., 2011); and (e) it has shown to be effective across different settings with different clients (Lenz et al., 2016; Najavits et al., 2011).

To test the hypotheses for the research questions, data analyses will consist of MANOVAs to compare mental health counselors with substance abuse counselors after facilitating Seeking Safety as determined by clients' outcome scores and their length of stay in treatment.

## Population

The source for this study's population is mental health and substance use records of adult men and women who received services at a treatment facility located in southeastern Texas in the city of Houston. Written approval was obtained to access the records of cases identified in this study's inclusionary criteria. Cases included clients who received treatment during the period of January 2016 through December 2018. The

specific criterion was that all cases must have participated in a Seeking Safety therapy group for a minimum of 6 sessions. In addition, each case must have either (a) PTSD or trauma-related symptoms, and (b) a SUD upon admission to the treatment facility.

The program's client population ranged in age from 16 to 65 years old. Men and women, who the program generally served, were predominately White Americans. This reflected the racial and ethical breakdown found in the United States statistical data regarding individuals who sought mental health and addiction treatment (National Institute of Mental Health, 1999). According to the facilities' published statistics, the demographics of the population they served was 65% White or Caucasian Americans, 26% Black or African Americans, 5% Hispanic or Latino/a Americans with the remaining clients representing other minority groups. However, the city where the facility was located was more divere than national statistics. According to the U. S. Census Bureau, (2017), the city's population was White or Caucasian (25.6%), Black or African American (23.1%), Hispanic or Latino/a (43.8%), Asian (5.9), Native Americans (0.2) and Pacific Islander (0.2). The differences in the cities's and the program's racial make up can be explained by research findings, which showed that minorities tended to be under represented in mental health services when compared to Whites (Ojeda & McGuire, 2006).

Some clients in the treatment program met the Federal Housing and Urban Development's definition of homelessness. Further, some clients entered the program as an alternative or diversion to incarceration. However, for the most part, cleints in this study's population entered the program voluntarily. Only a few clients entered

involuntarily or under the stipulations of the court systems, which could have be through probation, parole or child protective services.

Data collection came from the on-going course of a client's treatment plan, which normally required random urine analyses, relapse prevention groups, 12-step addiction groups, psychoeducational groups, and individual and family therapy. Clients' name and other identifiable personal information was not used in this study. Based upon the average census capacity at the residential facility the estimated size of the population served during the proposed chart reiview of January 2016 through December 2018 was approximately 450 clients.

## Sampling and Sampling Procedures

Since this study was a retrospective analysis conducted through chart reviews, the sample was drawn from approximately 450 closed client records from B&B, an outpatient treatment facility in southwestern part of the United States. Specifically, the sample was extracted from the population of women and men who participated in B&B's treatment program during the record collection period of January 2016 through December 2018. The sample was required to meet the inclusion and exclusion criteria for this study. Therefore, the results and conclusions were based on a subset of the larger population (Trochim & Donnelly, 2007).

The sampling frame will include men and women who during the chart review period were: (a) proficient in reading, writing, and speaking English at a 8th grade level, which ensured that they could independently complete self-assessment, questionnaires and homework assignments; (b) able to provide informed consent regarding participation

in B&B's treatment; (c) diagnosed with a PTSD or had trauma related symptoms and a SUD; and (d) able to participate in Seeking Safety therapy provided through B&B's program. These inclusionary criteria assured that clients had a co-occurring mental health and SUD, were engaged in treatment and were able to read, write and speak English in order to complete and understand the group's study material.

Exclusionary criteria were men and women who during the chart review period were: (a) identified as displaying severe signs of mental disorders, including danger to self and others, and (b) identified as having severe physical impairment, which prevented participate in the treatment program. These exclusionary criteria assured that clients were able to engage in therapy both mentally and physically.

As it related to the size of the proposed sample group, there was not much in the way of prior research to draw upon. No studies were found wherein the effectiveness of manualized treatments was examined while using type of counselor as independent or predictor variables. However, a few studies were found to be somewhat similar to this study. These studies provided background for determining a sample size necessary to detect statistically significance differences between type of counselors. Carise et al. (2009) compared counselors satisfaction with a toolkit developed to aid them in implementing an evidenced-based practice. These researchers compared counselors in recovery (n=13) to counselors not in recovery (n=11) (Carise et al., 2009). In this study, counselors' recovery status was the independent variable. These authors found significant differences between counselors based upon their recovery status and reported effect sizes

of $d$ = .87, .92 and 1.15 (Carise et al., 2009). The sample size as it related to the counselor's respective caseload was 210 in Carise et al. (2009).

In another study, Crits-Christoph et al. (2009), examined the effect of therapists' alliance on outcome measures using a manualized treatment for outpatients. These authors compared therapists who were trained using a substance abuse treatment ($n$ = 16) to therapist who conducted "treatment as usual" ($n$ = 14; Crits-Christoph et al., 2009). Between-therapist differences were significantly associated with outcomes with an effect size of $d$ = .39 at follow-up (Crist-Christoph et al., 2009). Therapist with low or high alliance had poorer average outcomes (effect size of $d$ = .44) than those with moderate alliance. These findings were based upon a sample size of 257 clients (Crits-Christoph et al., 2009).

Although these studies provided useful information, neither investigation compared types of counselors (i.e. mental health versus substance abuse) after treatment with a standardardized treatment protocol in a clinical setting. Therefore, this study relied on the recommended minimum effect size for social science data suggested in the literature to determine an approximate sample size. According to Ferguson (2009), following are the minimum effect sizes specific to the type of analysis: (a) $d$ =.41 is used for group differences; (b) $r$ = .2 is used for stength or associations; (c) $r^2$ = .04 for squared association indices; and d) $RR$ = 2.0 for risk estimates.

*G*Power,* a computerized statistical software (Faul, Erdfelder, Lang & Buchner, 2007) was used to run a priori power analysis in determining a sample size for this study. The following input parameters was entered into the *G*Power* program's distribution-

based approach: (a) two tail test, (b) effect size *d* = .41, (c) alpha error of probability = 0.05, and (d) 95% power (1-error of probability; Faul, Erdfelder, Lang & Buchner, 2007). According to a preliminary statistical calculation in *G*Power*, for linear multivariate multiple regression: fixed model, the recommended sample size should be 156 participants (Faul, Erdfelder, Lang & Buchner, 2007; see Figure 1). In social science research, the rule of thumb is alpha set at .05 and statistical power greater than 0.8 in value (Trochim & Donnelly, 2007). Alpha of .05 means there is a 95 percent chance of saying that there is a relationship when none exist (Trochim & Donnelly, 2007). Statistical power greater than 0.8 means that there are 80 chances out of 100 of finding a relationship that exist (Trochim & Donnelly, 2007). Below reflects the distribution for the priori power analysis as calculated by *G*Power*.

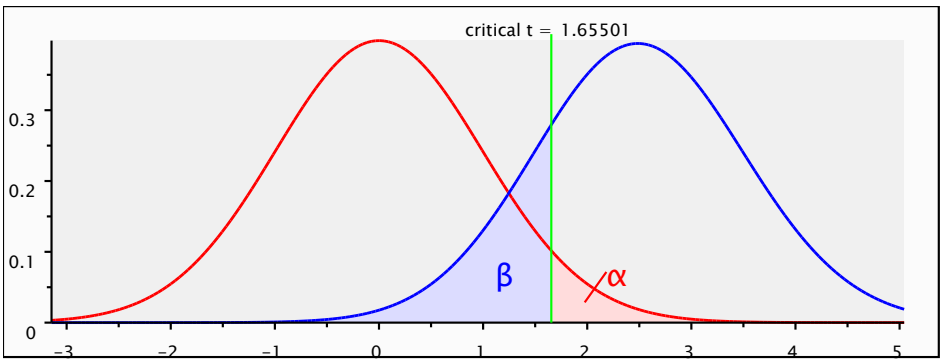


*Figure 1.* Sample size.

After a review of sample sizes in the literature of similar studies and using the *G*Power* statistical program calculations to estimate a sample size, the sample size of approximately 450 cases was adequate.

## Data Collection Procedures

Before beginning the study, approval from the Institutional Review Board (IRB) at Walden University was obtained. After permission, had been granted by the IRB, written approval from B&B's chief financial officer was secured. B&B is a teaching facility for master level students and there are established procedures for supporting research. Clients' records are maintained in paper form in individual folders. The records are locked behind two different doors at the building of B&B where treatment services are offered. The first step in the data collection process was to identify cases, which meet the inclusion and exclusion criteria. The primary criterion was that clients had participated in Seeking Safety therapy for at least 6 sessions, which is the minimum dosage recommended for effective treatment (Najavits, 2000b). Secondly, the client must have had a PTSD diagnosis or trauma-related symptoms, and a substance use-disorder (SUD). Seeking Safety has benefited clients who did not meet the criteria for PTSD or SUD (Najavits, 2000b). However, at B&B only clients diagnosed with either PTSD or displayed trauma-related symptoms and who were diagnosed with a SUD were assigned to the group. Clients, who were unable to complete therapy because of severe mental health issues (e.g. psychosis or harm to self or because of medical issues (e.g. cancer or HIV/Aids) were excluded from the sample.

A Participant Data Sheet was created to aid in facilitating the data collection process. The Participant Data Sheet was used by the investigator to collect data. The number of group sessions for Seeking Safety was documented on the sheet, and must have been a minimum of 6 sessions. Using the DSM-V codes on the data sheet, clients

with PTSD and a substance-related disorder was identified and their DSM-V code was circled. Further, clients who reported trauma-related symptoms, as assessed by their psychosocial assessment, were identified and included in the sample.

After all cases, which meet the study's criteria had been identified, each one was given a confidential seven-character code. The first two characters were used to identify the type of counselor who conducted the Seeking Safety therapy (e.g., MH = Mental Health Counselor and SU = Substance Abuse Counselor). The next two characters were digits used to specify the year that the client entered the program (e.g. for the year 2016, the next two digits were 16). The next three characters were digits to identify the chronological sequence of the client (e.g. first client for the year 2016, which met criteria for the study was 16001; the second client was 16002 and so forth). So, the first client in the year 2016 who met the study's criteria and who had a mental health counselor had an identifying case number, which read MH16001 The second in the year 2017 who met the study's criteria and who had a substance abuse counselor had an identifying case number, which read SU17002. This coding system was followed to protect confidentiality of both clients and counselors and it was used in data analyses to compare counselors for differences after conducting Seeking Safety therapy.

Counselors' designation of mental health counselor versus substance use counselor was determined by their educational training and/or their current licensure. B&B hired a permanent staff of professionals and they offered internships to students from different programs in their local colleges and universities. Staff members as well as interns (who are under supervision) conducted the Seeking Safety therapy group. All staff

members who provided Seeking Safety therapy were licensed by the State of Texas with the majority being either a Licensed Professional Counselor or a Licensed Chemical Dependency Counselor. All interns who provided Seeking Safety therapy were master-level students seeking degrees in either a clinical, counseling, social work or substance abuse program. For the purpose of this study, those in clinical, counseling or social work program were designated as mental health counselors. Counselors were assigned Seeking Safety groups on a rotation schedule. Once assigned to a therapist, clients remained with that therapist throughout their length of stay. Occasionally, clients were reassigned if their therapist left the facility or if there was an irreparable therapeutic rupture.

**Assessments**

The following assessments were used as a part of B&B program. Clients were vetted using a telephone screening form created by B&B. Eligibility requirements were: (a) between 16-65 years old, (b) participated in group and individual counseling, (c) had a minimum of 30 days sobriety from drugs and abstinence from harmful behaviours to self and others, and (f) be able and willing to function in a structured program.

After a telephone interview, and if potential clients, met the program's criteria, an in-person interview was scheduled by the admission's coordinator who was a licensed mental health professional. During this interview, a psychosocial assessment was given, which evaluated a client's mental health, social status and functioning capacity. A diagnosis, as delineated in the *Diagnostic and Statistical Manual of Mental Disorders-V,* (APA [DSM-V], 2013) culminated the psychosocial assessment. The DSM-V diagnoses guided the researcher in identifying charts where clients had both PTSD and SUD.

In addition to the psychosocial assessment, the Beck Depression Inventory II (BDI-II) was given at admission to obtain a baseline for depression symptoms. The BDI-II is a self-assessment that has 21 multiple choice questions, which can be administered and scored in 10-15 minutes (Beck, Steer, Ball, & Ranieri, 1996). It provides objective evidence as to the depth and breadth of depression (Beck et al., 1996). It is also the most popular and widely used instrument among mental health professionals and researchers (Beck et al., 1996). Revisions were made to the original BDI to accommodate diagnostic criteria changes for mood disorders, which were subsequently made to the DSM-V (APA, 2013; Beck et al., 1996). The BDI-II revisions included changes in body image, hypochondria difficulties in working, and adjustments for sleep and appetite losses (Beck et al., 1996). All but three of the 21 items from the original inventory were reworded (Beck et al., 1996). Another revision made to the original BDI was the time period individuals are asked to rate their symptoms. The period for assessment increased from one week, as found on the original BDI, to two weeks, which is reflected on the BDI-II (Beck et al., 1996). Cut-off scores were also modified, which are now:

(a) 0-13: minimal depression; (b) 14–19: mild depression; (c) 20–28: moderate depression; and (d) 29–63: severe depression (Beck et al., 1996).

The BDI-II's test-retest reliability is $r = .93$ over one week, which is relatively high and provides sensitivity to instabilities in mood (Beck et al., 1996). An internal consistency of $\alpha$=.91 is also high (Beck et al., 1886). The BDI-II's convergent validity of $r = .71$, when correlated with another popular depression assessment is strong (Beck et al., 1996). Since the BDI-II assesses the depth and breadth of depression, B&B used it in

its program to get a baseline, to observe changes over time, and to provide an objective way to determine treatment effectiveness (Beck et al., 1996). For this study, the BDI-II was used to capture the measure that would make up the dependent variable "mental health outcome".

The second assessment that was used to measure treatment outcomes for this study was the discharge summary to determine clients' length of stay in the program. This study used this assessment to ascertain the numbers of weeks clients remained in treatment. This measure was the dependent variable "length of stay."

The last assessment used in B&B's program was urine analyses, which measures changes in substance use while clients were in treatment. On the date of admission, new clients were asked to submit a urine analysis to assure that they had not taken nonprescription drugs, which included alcohol. A requirement of continued participation in B&B's program was that all clients (whether they were diagnosed with a substance-related disorder or not) must agree to refrain from drinking alcohol and using any mood-altering drug not prescribed by a medical doctor. Random urine analyses were requested throughout a clients' length of stay, which were used to monitor sobriety and detect relapses. Specifically, the purpose of the drug test was to obtain, objective evidence regarding substance use. B&B followed established procedures for identifying, collecting, storing and ensuring chain of custody for transporting urine specimens. All specimens were mailed through Federal Express to Alert Toxicology, a testing company, which provided results to the facility. To ensure the reliability and validity of urine testing, it was necessary to follow the industries' policies and procedures (SAMHSA,

n.d.). According to SAMHSA, there were three procedures that should be a part of all urine testing: (a) how it was actually collected; (b) how it was actually tested in the lab; and (c) how notification was given to the individual. The strict collection procedure required properly identifying the person giving and receiving the specimen, as well as making sure that there was protection of custody until the urine was submitted for testing (SAMHSA, n.d.) During collection, it was important to certify the proper temperature of the urine to make sure samples were not adulterate or substituted. An acceptable range of temperature for specimens was between 96 to 99 degrees Fahrenheit; although SAMHSA allowed for a wider limit (between 90 to 100 degrees) (SAMHSA, n.d).

Testing procedures also had specific requirements to confirm positive specimens, which could be done by using either the gas chromatography-mass spectrometry (GC/MS) or liquid chromatography-mass spectrometry (LC/MS; Lepowsky, Ghaderinezhad, Knowlton, & Tasogly, 2017). The objective was to reduce false positives (Lepowsky, Ghaderinezhad, Knowlton, & Tasogly, 2017) The two approaches to drug testing can be deemed as: (a) a cut-off test, which has limits that if not reach means a "no detection" result or (b) a limit of detection, which has zero tolerance so that a "no detection" result will *only* be made if no drug is found in the specimen (Lepowsky, Ghaderinezhad, Knowlton, & Tasogly, 2017) Although the most ideal testing approach is the limit of detection test, SAMHSA's certified laboratories are allowed to establish cutoff concentrations, which means a negative result can be obtained even though some level of the drug is present. B&B follows SAMHSA's minimum policies, where they

used the cutoff test. This approach was appropriate for B&B's since participation in the program was not contingent on "no tolerance" or abstinence methodology.

The last procedure important to drug testing was random call, which meant that individuals were unaware of when the request for a specimen may be made. Random call was important for the reliability of drug detection since notification beforehand may allow individuals to purge their systems of prior substance use. Detection depends on when the drug was taken and how much of it was ingested (Lepowsky, Ghaderinezhad, Knowlton, & Tasogly, 2017) For example, alcohol can be processed through the body in 3 to 4 hours. So, if clients were aware of when urine analyses might be required, they might have opportunities to avoid detection by manipulating the time period between ingesting and eliminating the drug in their bodies. Although every client at B&B submitted a urine specimen upon admission, random calls were just that –random. They could occur more frequently for one client than they did for another. Therefore, clients' medical records varied in terms of the number of urine analysis reports. In addition to using objective drug testing, drug use may be subjectively identified through staff observing emotional and behavioral changes.

Subjective evidence of drug use at B&B could also be obtained from self-reports, which could occur in group or individual sessions. *Seeking Safety* specifically prompts self-disclosure by including a standardized procedure in each therapy session, which required counselors to ask clients about recent substance use (see below in the Treatment Section). However, self-reports were not as reliable as random drug testing since a return to substance use could have negative consequences for clients at B&B. Though clients

could be able to remain in the program after a return to using prohibited substances, their treatment plan was modified to address one relapse. A discharge from the program was the consequence after a second relapse. Clients could apply for readmission after they had completed at least 30 days of intensive treatment at a higher level of care.

This study examined the objective urine analyses and subjective reporting to determine whether goals of sustained sobriety were achieved. Scores were computed as follows to assess sobriety: A code of 0 was used to indicate that the client relapsed – resulting in discharge [positive urine analysis and/or subjective report]; A code of 1 was used to indicate that the client sustained sobriety [negative urine analysis and/or no subjective report]. Urine analyses or subjective reports was used to capture the last measure, which made up the dependent variable "substance use outcome".

**Treatment**

The treatment, which was an integral part of B&B's program, is a present-focused therapy called Seeking Safety. It is designed so that individuals can attain safety from the consequences of trauma/PTSD and substance abuse (Seeking Safety, n.d.). Seeking Safety was used in this study to evaluate differences between mental health counselors and substance abuse counselors. Although, the treatment is outlined in a manual, it is hypothesized that implicit theories unique to mental health versus substance abuse counselors would influence the standardization of the protocol. To enhance standardization, *Seeking Safety's* manual contains handouts for both clients and counselors, which are used during treatment (Seeking Safety, n.d.). Counselors at B&B

were trained to follow Seeking Safety's protocol, which is discussed below under intervention section.

In addition, Seeking Safety provides an adherence scale, which is used to evaluate whether counselors are continuously following the manual. The lead counselor at B&B verified adherence by watching pre-taped videos of counselors conducting the treatment. Counselors were evaluated at the start of facilitating the group and at least once every 6 weeks thereafter. However, evaluations could occur more frequently if there were adherence concerns or constructive feedback from clients. Counselors were required to attend a formal training on conducting the Seeking Safety treatment, which was a two-day (12 hours) workshop. In addition, B&B provided videotapes available to counselors for continued training.

Seeking Safety (n.d.) is an EST, which is standardized and designed with flexibility. It can take place in individual or group sessions; in different settings (e.g. inpatient, outpatient, prison, residential treatment); with different populations (e.g. men, women, people who are homeless, in confinement, and adolescent) and with substance abuse or substance dependence disorder ( Seeking Safety, n.d.). It has also been used with individuals who have experienced trauma –yet not diagnosed with PTSD, and those with no history of trauma but only has a SUD (Seeking Safety, n.d.). The *Seeking Safety* manual has 25 topics, which are independent and can be implemented in any sequence. The list is as follows:

Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substance Control You, Honesty, Asking for Help, Setting Boundaries in Relationships,

Getting others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Healing from Anger, Creating meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding), Life Choices, and Termination (Najavits, 2002b).

B&B's program generally covered all 25 topics in group modalities; however random topics could be chosen in individual sessions. Clients, who were assigned to the Seeking Safety therapy, attended at least once per week for 50 minutes. The group usually had a set time (e.g. Mondays at 1:00 pm). As part of the individual rehabilitation plan, case counselors assigned clients to the Seeking Safety group based upon their respective diagnosis and their presenting issues. Normally clients with current or a history of PTSD along with SUD were placed in the Seeking Safety group. However, some clients were assigned to the group without meeting criteria for PTSD but who alternatively presented with trauma related symptoms. Clients may exit the Seeking Safety after completing a minimum of 6 group sessions but most remained in the group throughout their length of stay. Mental health counselors and substance abuse counselors conducted Seeking Safety groups at B&B.

*Seeking Safety's* treatment manual provided an "in session" outline, which was followed by each counselor in conducting the therapy at B&B. It was made available to counselors as a separate handout, which could be photocopied and referred to as needed (Najavits, 2002b). Each "in session" followed the following four step sequence: (a) check-in; (b) the quotation; (c) relating the material or topic in the manual to what was

going on in the client's present experiences and (d) check-out. The first step "check-in" was to gauge how clients were doing and it was done by asking them to report briefly (up to 5 minutes) on five questions, which were as follows:

Since the last session, (a) "How are you feeling?"; (b) "What good coping have you done?"; (c) "Any substance use or other unsafe behaviors?"; (d) "Did you complete your commitment?" and (e) Community Resource update (Najavits, 2002b)?

The second step "the quotation" was used to help engage clients emotionally in the session (Najavits, 2002b). Counselors asked clients to read out loud the quotation, which was listed on the handout of each topic. The counselor then asked the client, "What was the main point of the quotation?" and "How was the quote related to the topic to be discussed" (Najavits, 2002b)? This step usually took about 2 minutes to complete.

The third step was called the heart of the session and it involved relating the topic for discussion to the client's lived experiences (Najavits, 2002b). During this part of the session (30-40 minutes), counselors used examples from the client's lives, which offered an opportunity for rehearsal of the material (Najavits, 2002b). Clients were asked to review the topic before class so that it increased the likelihood that they were able to reflect on how it connected to their own lives.

The last step was the "closing" or "check-out" and tool up to 5 minutes of the session. This step was used to reinforce clients' progression in the treatment and to give the counselor feedback. Clients were asked to answer three questions in a 3 minute interval:

(a) Name one thing you got out of today's session (and any problems with the session); (b) What is your new commitment? (c) What community resource will you call? (Najavits, 2002b)

All sessions at B&B used the structured format, and there were additional options, which could enhance the richness of the treatment. Counselors had available to them: (a) The Safe Coping Sheet (a handout, which can be used to remind clients of coping skills); (b) The End-of-Session Questionnaire (a confidential written feedback sheet on counselors performance; (c) Commitment to Recovery Handout (a written documentation of recovery efforts) (d) a Certificate of Achievement award (given when the treatment ended). Although, not required by the Seeking Safety protocol, B&B required that counselors who conduct the group subsequently prepare progress notes for each member of the group.

The progress groups notes prepared by facilitators of Seeking Safety at B&B were standardized and the following information was used: (a) date of the group, (b) focus or topic of the group, (c) length of the group, (d) the client's affect and/or mood during the group, (e) the client's thought processes during the group, and (f) the client's progress in the group. In addition to the standardized categories on the group notes, counselors could add additional comments for atypical situations or areas of concerns. Examples of issues that should be monitored and/or followed-up on included suicidal ideations, unsafe behaviors, or a return to substance use. Group notes were signed by the respective counselor of the group and by a supervisor. The group notes for Seeking Safety was used

in this study to 1) verify that the client participated in therapy; 2) to identify the counselors who conducted the therapy and 3) to evaluate treatment goals and outcomes.

Along with Seeking Safety treatment, B&B provided a variety of other services, which included vocational and clinical programming. Specifically, clients at B&B, in combination with Seeking Safety participated in psychoeducational groups, 12-step self-help recovery groups, medication therapy, family counseling, case management, individual therapy, psychotherapy groups, vocational training and social skills training.

## Description of Study Variables

Counselors were the focus of this study, and they were differentiated by type of counselor along two categories: mental health counselor and substance abuse counselor. So, the independent variable is “type of counselor” with two levels.

The dependent variables was developed and consist of three scores: (a) mental health outcomes, (b) length of stay and (c) substance use outcomes. Table 1 outlines this study’s variables and the tools used to measure them.

Table 1

*Description of Study Variables*

| Variable | Description of variable |
|---|---|
| Independent<br>(Type of counselor) | Mental health counselor and substance abuse counselor<br>1 = Mental health and 2 = Substance use |
| Dependent 1<br>(Mental health outcome) | Depression score: Beck Depression Inventory II (BDI-II)<br>(21 items on a 0-63 scale); high scores = severity |
| Dependent 2<br>(Length of stay) | # of weeks in treatment: discharge summary |
| Dependent 3<br>(Substance use outcome) | Maintained sobriety = 1<br>Relapse = 0 |

**Instruction Procedures**

The investigator participated in three different 2-day Seeking Safety training where one was facilitated by the developer, Lisa Najavits. As a licensed professional counselor, as someone licensed to supervise other professional counselor, and as someone who have actually conducted the Seeking Safety therapy, the investigator was adequately qualified in understanding the variables that could influence treatment outcomes. Before analyzing retrospective medical records from B&B, counselors who had already conducted the Seeking Safety treatment for the period January 2016 through December 2018 were identified. B&B maintained folders, which keep account of group attendance sheets. The attendance sheets contained the group date, the topic of the group,

the group's facilitators and a list of clients who attended the group. Clients verified their attendance by signing the group's attendance sheet. For audit purposes these binders were stored for 7 years. Seeking Safety's group's attendance was reviewed for the period January 2016 through December 2018. Counselors who facilitated the group was categorized by type (i.e. mental health counselor or substance abuse counselor). Counselors were required by B&B to include their degrees, credentials and title on all documents. Hence, it was relatively easy to distinguish counselors by types. In the event, there was missing data, B&B maintained records of this information in separate individual files. The majority of counselors at B&B who facilitated the Seeking Safety group were master-level counselors with a concentration in mental health or substance abuse counseling. The group could also be facilitated by master-level interns who are being supervised by a staff member.

The Seeking Safety treatment was designed with specific suggestions for selecting and training clinicians, which were followed at B&B. Counselors were required to "try out" before facilitating the Seeking Safety group by conducting a session with actual clients while being observed by the lead supervisor. B&B was a training site with equipment necessary for observing and evaluating staff, students and volunteers. However, according to Najavits (2002b) the developer of the Seeking Safety, no "formal training" or "prior experience" of counselors was required. Still counselors, as described in the Seeking Safety selection criteria, are asked to read Chapters 1 and 2 in the *Seeking Safety* book (Seeking Safety, n.d.). Counselors select a sample topic from the book to use during their trial run (Seeking Safety, n.d.). After the trial group, clients were asked to

confidentially rate their counselor by using two scales provided by the developer: (a) "Selecting a Clinician Questionnaire"; and (b) "End of the Session Questionnaire" (Seeking Safety, n.d.). In addition to clients' rating, supervisors at B&B used the Adherence Scale, also provided by the developer of *Seeing Safety* to determine if counselors follow the treatment manual (Seeking Safety, n.d.). It was recommended that the Adherence Scale be completed by someone familiar with the treatment and who had conducted *Seeking Safety* before (Seeking Safety, n.d.). Supervisors at B&B, as part of their responsibilities, met this criteria. The Adherence Scale provided evidence of whether a counselor was a good match for conducting Seeking Safety treatment and was used as an ongoing evaluation tool (Seeking Safety, n.d.). The developer of Seeking Safety specifically stated that these procedures were better indicators regarding therapist-treatment match than the traditional criteria, such as years of training, professional degrees or experience (Seeking Safety, n.d.). This study assumes that the recommended selection process and training procedures were followed by B&B.

The following three topics were conducted more frequently at B&B than others because they were considered "core" to the treatment: (a) *Introduction to Treatment/Case Management*; (b) *Safety*, (c) *PTSD: Taking Back Your Power*, (d) *Detaching from Emotional Pain (Grounding),* one of the key skills in Seeking Safety; and (e) *Commitment,* addressing issues relevant to the commitment at each session's check-out (Seeking Safety, n.d.). Counselors at B&B adopted the format as outlined in Seeking Safety standardized procedures, which included 4 parts for each session: (a) A check-in; (b) A quotation; (c) Relating the topic to the client's life and (d) A check-out. For other

weeks of treatment, it was recommended that counselors allow clients to select the order of topics since they were motivated when they felt some sense of control (Seeking Safety, n.d.). The developer of the treatment recommended a simple process to facilitate this, which was followed at B&B (Seeking Safety, n.d.). Counselors normally handed clients a copy of the list of treatment topics and asked them to choose two topics they would like to cover in the next week. Counselors then provided the handouts for the two topics chosen by the clients so that they could read them prior to coming to therapy. Although a full treatment consisted of covering all 25 topics, the developer noted a minimum dosage of 6 sessions (Najavits, 2002b). B&B considered this as its minimum required dosage.

Counselors with education, training and/or licenses in clinical, counseling, or social work were categorized as mental health counselors. Counselor with education, training and/or licenses in substance abuse were categorized as substance abuse counselors.

After distinguishing between types of counselors, dependent variables were composed, which were used to assess outcomes after facilitating Seeking Safety therapy. Three scores were developed: “MH outcome”, “length of stay in treatment” and “SU outcome” The outcome scores were composite scores and they indicated improvements in clients’ level of mental and emotional stability, their sustained sobriety and how many weeks that stayed in the program, (a) changes in depressive symptoms, as assessed on the *BDI-II* (21 items on a 0 to 63 rating scale of a client’s rating of depression, (b) the length of stay in treatment dependent variable was the number of weeks, as assessed by discharge summaries and (c) changes in substance use or relapses, assessed from random

urine analysis or by information on IRPs in the substance use area (0 indicating relapse and 1 indicated maintained sobriety.

**Data Analysis**

IBM® Statistical Package for the Social Science (SPSS) ® Version 26 was used for the data analysis. Descriptive statistics was employed to describe client's demographics. Data were collected for the following variables of interest: gender, age, ethnicity, and education level. A coding scheme was designed to cover all possible responses.

Before conducting statistical analysis to address each of the research hypotheses, the investigator determined the type of distribution formed from the data. In order to use parametric tests, the assumption of normality and homogeneity of variance must be met (Trochim & Donnelly, 2007). If the distribution from the data did not met these assumptions, then nonparametric or distribution free tests had to be used (Trochim & Donnelly, 2007).

This study used a one-way analysis of variance (ANOVA) to address pretreatment characteristics and to assert that counselors' caseloads were equivalent before treatment began. ANOVAs are used to determine whether or not significant differences exist between the means of three or more unrelated independent groups. Specific to this study, the ANOVA compared counselors' caseload at pre-treatment on client's demographic variables (i.e. gender, age, race/ethnicity, education). Assuming all distributions met the assumptions necessary for parametric testing, this study used a multivariate analysis of variance (MANOVA). This type of statistical analysis allow testing of hypotheses

regarding the effect of an independent variable on more than one dependent variable. Specific to this study, the MANOVA examined whether there were mean differences between mental health counselors and substance abuse counselors in mental health outcomes and length of stay after conducting Seeking Safety therapy. The MANOVA examined whether mean differences were likely to have happened by chance among three dependent variables, "MH outcome" and "length of stay". MANOVAs are appropriate in two major situations, which applied in this study (Mitchell & Jolley, 2004). First there were several correlated dependent variables and the MANOVA allowed for one single statistical test rather than performing multiple individual tests and increasing Type I errors (Mitchell & Jolley, 2004). Secondly, the MANOVA will explored how the independent variable (i.e. type of counselor) influenced some pattering of responses on the dependent variables ("outcomes" and "length of stay") (Mitchell & Jolley, 2004).

A two-tailed region of rejection was used because while therapy is generally shown to be beneficial, there were still questions related to negative effects, such as high relapse rates, and low success rates with treatment resistant clients (Najavits & Strupp, 1994). Therefore, changes could result in either a positive improvement direction or a negative direction (i.e. deterioration). Consideration was given to using a one-tail versus a two tailed region of rejection, however given that there was a risk that psychological interventions could have counter-therapeutic effects, a two-tailed accounted for this incidence. Although, Seeking Safety therapy was the most clinically tested integrated treatment (Lenz et al., 2016), it had not isolated counselors as an independent variable.

This data analysis used a statistical significance level of $p \leq 0.05$ to reject the null hypotheses, which is the most popular level in social sciences (Mitchell & Jolley, 2004). There was no compelling reason known to this study, which would have supported deviation from conventional standards with regard to the significance level. A cut off point for clinically relevant change was inherent in each measurement tool. Established benchmarks were available for tools used in this study and were discussed in the section in this chapter covering assessment tools.

Given this study used archival data from medical records in a outpatient treatment facility, some thought was given to using hierarchical linear modeling (HLM) to address potential clustering of clients in treatment. For several reasons, the decision was made to use conventional statistics. First, Seeking Safety treatment services used in this study, although conducted in group settings, its outcomes were identified, measured and evaluated at a client level through individual rehabilitation plans. Secondly, Seeking Safety covers topics, which were not normally offered in B&B's standard treatment programs since it was specifically designed for clients with co-occurring PTSD/trauma and SUD. The underlying multivariate statistical models assumed individualized treatment or one level, and there was no reason to assume clients would interact in groups in systematic and meaningful ways while participating in treatment, which would have necessitate the consideration of additional levels. Although clustering (i.e. violation independence assumption) was possible because of client's similar histories, it did not necessarily occur in an outpatient treatment facility of varied backgrounds and diversities. One might argue that some clustering could still occur through group membership since

individual treatment outcomes correlated with other supportive systems. This was a reasonable stance; however, the treatment facilities used funding agencies requirements with no apparent efforts to track levels other than at the client-level. Therefore, diagnosing clustering at the facility program level by calculating intra-class correlations (nonzero correlations of this type would suggest a violation of independence assumption and these can inflate a Type I error rate) would probably yield values that have little to no meaning. However, if clients spent an appreciable time with the same groups throughout the day, this would been of some concern. Since clients have individualized treatment plans, different schedules, participated in different phases of the program, and had varied length of stays, an individual-client level and conventional analyses would best fit a test for this study.

A major goal of quantitative ex post facto designs was to allow for testing of hypotheses to identify causal or functional relationships between variables when experimental studies were impractical (Lord, 1973). Specifically, this design attempted to answer research questions by assessing whether or not there were differences in outcomes of counselors after facilitating Seeking Safety therapy. There were limitations to the ex post facto design incorporated in this study. The most common was that although, it did not allow for cause-and-effect inference. In other words, the degree to which the type of counselor caused differences in outcomes and length of stay is uncertain. Other limitations were 1) the independent variable cannot be controlled or manipulated; and 2) clients were not randomized by counselors.

These limitations and other extraneous variables could produce confounded effects (Mitchell & Jolley, 2004). Yet, with full acknowledgement of the inherent limitations of ex post facto designs, they provided a way to address problems that cannot be investigated in laboratory situations but were nonetheless important in understanding the nature of phenomena (Lord, 1973).

## Ethical Guidelines and Confidentiality

Without regard to the type of design, all research studies must follow ethical standards designed for the protection of participants and the public. Archival data used in this study did not include any personal identifiable information, such as names, diagnoses, or presenting problems, which could compromise the identities of past clients at B&B. Data were viewed at the facility where treatment was provided and where medical records were maintained and secured. No medical records or paperwork was removed for the facility site. All records were entered on a data collection sheet following a preset coding system as described in the data collection procedure above. No identifiable client information was extracted from the permanent medical records. In addition, the coded information, although not identifiable, was maintained by the investigator on a secure password protected computer during the time the study was conducted. Data will continue to be stored on a password protected compact disc by the investigator for a period of 7 years. These procedures satisfied the Protected Healthcare Information (PHI) concern, which states:

Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources were publicly available

or if the information was recorded by the investigator in such a manner that the subjects cannot be identified, directly or through identifiers linked to the subject (Health and Health Services Policy for the Protection of Human Research Subjects, section 46.114 [4]) and the APA ethical standard 8.05 part (b), which also allows for an exemption from the requirement of obtaining informed consent when conducting archival research.

Approval by the IRB of Walden University was obtained. Guidelines found on the Walden's University Research Center specified the role of the university, which was to protect all who made a significant contribution to the creation of records and who may be impacted by the result of the research (http://researchcenter.waldenu.edu/). The Walden University IRB does not require researchers to provide information as it related to Informed Consent for archival records (http://researchcenter.waldenu.edu/).

Approval from the chief financial officer at B&B was obtained to gain access to client medical records, after approval had been granted by Walden's University IRB. The investigator signed a confidentiality agreement complying with B&B procedures for the protection of client information. B&B was given evidence of IRB approval and assured that due diligence was applied to the collection and presentation of all client information. The staff at B&B will have access to this study's finding when it is completed.

## Summary

This chapter provided a detailed account of the research design, the rationale and the methodology for conducting this study. Specifically, this chapter discussed the research design, questions, hypotheses and variables. In addition, the population, sample and sampling procedures were highlighted. Afterward, procedures for data collection, as

wells as the type of assessments and intervention were described. Lastly, statistical analyses and ethical considerations applicable for the research methodology were discussed along with any potential threats and limitations. Chapter 4 will provide information regarding the testing of the research hypotheses using quantitative statistical analysis and it will summarize all statistical findings.

# Chapter 4

## Introduction

The purpose of this study was to determine whether there were differences in clients' treatment outcomes based upon the type of counselor who conducted an EST for individuals diagnosed with PTSD and SUD. This study used an archival, nonexperimental design to determine if variables such as mental health scores, length of stay and substance abuse scores were significantly different among mental health counselors and substance abuse counselors. RQ1 asked whether, after receiving Seeking Safety therapy, clients' mental health outcomes and length of stay differed when comparing mental health counselors to substance abuse counselors. The null hypothesis predicted that there would be no differences between mental health scores and length of stays based upon type of counselor. The alternative hypothesis predicated that there would be differences between mental health scores and length of stays based upon type of counselor. RQ2 asked whether, after receiving Seeking Safety therapy, clients' substance use outcomes differed when comparing mental health counselors to substance abuse counselors. The null hypothesis predicted that there would be no differences between substance use scores based upon type of counselor. The alternative hypothesis predicated that there would be differences between substance use scores based upon type of counselor.

This chapter presents the demographic and statistical analyses to answer RQ1 and RQ2. The descriptive statistics for type of counselors is provided. In addition, descriptive statistics characterizes the sample of 455 clients records who participated in an outpatient

treatment program. Finally, different statistical tests, their significant findings, and the post-hoc analyses, organized by the research questions and hypotheses are presented.

## Descriptive Statistics

Table 2 shows frequency related to type of counselor per client chart reviewed. Mental health counselors provided more Seeking Safety therapy groups (64.2%) than substance abuse counselors (35.8%).

Table 2

*Frequency and Percent for Type of Counselors per Case*

| Counselor | Valid *n* | Percentage |
|---|---|---|
| Mental health | 292 | 64.2 |
| Substance abuse | 163 | 35.8 |

*Note. N* =455.

An independent sample *t* test analysis was run in order to determine if mean differences existed between clients insofar as their beginning mental health scores at the start of the program. Results of the *t* test revealed no significant differences between the mean BDI score for clients assigned to mental health counselors ($M = 17.15$, $SD = 4.961$) and substance abuse counselors ($M = 15.58$, $SD = 5.633$), $F(453) = 3.615$, $p > .05$.

Table 3

*Frequency and Percent for Gender*

| Gender | Valid *n* | Percentage |
|---|---|---|
| Female | 312 | 68.6 |
| Male | 143 | 31.4 |

*Note.* $N = 455$.

Table 4

*Frequency and Percent for Age*

| Age | Valid *n* | Percentage |
|---|---|---|
| 16-26 years | 75 | 16.5 |
| 27-35 years | 198 | 43.5 |
| 36-44 years | 84 | 18.6 |
| 45-53 years | 68 | 14.9 |
| 54-68 years | 30 | 6.5 |

*Note.* $N = 455$.

Table 5

*Frequency and Percent on Race/Ethnicity*

| Race/Ethnicity | Valid *n* | Percentage |
|---|---|---|
| Asian | 10 | 2.2 |
| Black | 140 | 30.8 |
| Hispanic | 91 | 20.0 |
| Indian | 19 | 4.2 |
| White | 195 | 42.9 |

*Note.* $N = 455$.

Table 6

*Frequency and Percent on Education*

| Education | Valid *n* | Percentage |
|---|---|---|
| High School | 320 | 70.3 |
| Associates | 39 | 8.6 |
| Bachelor | 64 | 14.1 |
| Master | 28 | 6.2 |
| Doctorate | 4 | .9 |

*Note.* $N = 455$.

From the descriptive findings, the data showed that of the 455 study participants, 69% of the charts reviewed were for females and (31%) were for males. With regard to age, the largest percentage of clients whose charts were reviewed (44%) were between 27-35 years in age. The racial/ethnic background of the clients whose charts were reviewed were 43% White, 31% Black, 20%)Hispanic, and 6% Asian and Indian. The majority of the clients (70%) had at least a high school education.

## Findings for the Research Hypotheses

To investigate RQ1, the following hypotheses were purposed:

$H_0$1: There are no significant differences on scores of the BDI and on participant's length of stay between mental health counselors and substance abuse counselors.

$H_a$1: There are significant differences on scores of the BDI and participant's length of stay between mental health counselors and substance abuse counselors.

For the purpose of RQ1, Hotelling's $T^2$, a special case of the one-way MANOVA, was run to determine the differences in treatment outcomes based upon type of counselor. Two measures of treatment outcomes were assessed: changes in scores on the BDI and the participant's length of stay in treatment measured in weeks. Participants received treatment from either a mental health counselor or a substance abuse counselor. Preliminary assumption checking revealed that data was normally distributed as assessed by Shapiro-Wilk test ($p$ >.01); there were no univariate or multivariate outliers, as assessed by boxplot and Mahalanobis distance ($p$ > .001); there were linear relationships, as assessed by scatterplot; there was no multicollinearity (|r| < .9); and there was

homogeneity of variance-covariance matrices as assessed by Box's M test ($p$ = .001). Participants' change in BDI scores and length of stay were higher with mental health counselors ($M$ = 2.53, $SD$ = 2.0, and $M$ = 10.96, $SD$ = 4.1, respectively) than with substance abuse counselors ($M$ = 1.2, $SD$ =1.2, $M$ = 7.99, $SD$ = 4.0, respectively; See Table 7). There was a statistically significant difference between mental health counselors and substance abuse counselors on the combined dependent variables $F(2,452) = 55.136$, $p < .001$; Wilks' $\Lambda = .804$; partial $\eta 2 = .196$. A Bonferroni adjusted $\alpha$ level of .025 with a simultaneous 95% confidence level was used. Mean BDI change scores and length of stay for mental health counselors were 1.2 marks, 95% CI (.83 to 1.5) and 2.9 marks 95% CI (2.0 to 3.8) higher than mean BDI change scores and length of stay for substance abuse counselors. There were statistically significant differences in BDI change scores and length of stay in weeks between participants who were treated by mental health counselors versus participants treated by substance abuse counselors, $p <$ .001, effect size of d = .39.

Table 7

*Means and Standard Deviations for Change in BDI Scores and Length of Stay*

| | Counselor Type | Mean | Std. Dev. | N |
|---|---|---|---|---|
| Chg. BDI | Mental Health Counselor | 2.53 | 2.0 | 292 |
| | Substance Abuse Counselor | 1.32 | 1.2 | 163 |
| Stay in Weeks | Mental Health Counselor | 10.96 | 4.1 | 292 |
| | Substance Abuse Counselor | 7.99 | 4.2 | 163 |

To investigate RQ2, the following null hypothesis was proposed: There are no significant differences on clients' substance abuse scores between mental health counselors and substance abuse counselors. The alternate hypothesis was: There are significant differences on clients' substance abuse scores between mental health counselors and substance abuse counselors. For the purpose of this research question, the test of two proportions, also known as a chi-square test for homogeneity, was run to determine if differences exist between mental health counselors and substance abuse counselors based on whether their participants remained sober or relapsed. Four hundred and fifty-five participants were randomly assigned to either a mental health counselor or a substance abuse counselor for treatment. Two hundred and ninety-two were assigned to a mental health counselor and 163 were assigned to a substance abuse counselor (see Table 8). All participants were sober at the beginning of treatment. The test of two proportions used was the chi-square of homogeneity. At the conclusion of the length of stay, 248 (85%) of participants assigned to mental health counselors remained sober compared to 93 (57%) of the participants assigned to substance abuse counselors, a difference in proportions of .1, $p = .001$.

Table 8

*Counselor Type by Change ins Substance Use Score of Sober Versus Relapse*

| Counselor Type | Sober | Relapse` | Total |
|---|---|---|---|
| Mental Health Counselor | 248 | 44 | 292 |
| % in Counselor | 84.9% | 15.1% | 100% |
| Substance Abuse Counselor | 93 | 70 | 163 |
| % in Counselor | 57.1% | 42.9% | 100% |

## Conclusion

The findings from the statistical analyses revealed that the data supported both alternate hypotheses in that there were significant differences on clients' scores of the BDI and clients' length of stay between mental health counselors and substance abuse counselors. Further, there were significant differences on clients' substance abuse scores between mental health counselors and substance abuse counselors. Results of an independent sample *t* test showed no differences between participants in terms of their beginning mental health scores at the start of the program. Also, all participants were equal on the substance use scores because each were required to be sober for a least 30 days verified by a urine analysis. The Hotelling's $T^2$, a special case of the one-way MANOVA, revealed statistically significant differences between mental health counselors and substance abuse counselors on the combined dependent variables (i.e. change in BDI scores and clients' length of stay). A Bonferroni post hoc test showed

clients' mean BDI change scores and their length of stays were higher for mental health counselors than they were for substance abuse counselors.

The test of two proportions, chi-square of homogeneity, showed that there were differences in proportions between clients assigned to mental health counselors compared to those who were assigned to substance abuse counselors. This finding was based on the percentage of clients who remained sober versus those who relapsed.

Results from the Hotelling's $T^2$ and the chi-square of homogeneity, indicated that despite using a manualized treatment, measures of mental health, length of stay, and substance use differed when comparing mental health counselors to substance abuse counselors. Chapter 5 provides further interpretation of these findings, their implications for social change, and recommendations for future study.

# Chapter 5: Discussion, Conclusion, and Recommendations

## Introduction

The purpose of this study was to determine if differences in treatment outcomes existed between mental health counselors and substance use counselor after conducting a manualized treatment called Seeking Safety. This particular treatment was chosen for this study because the author purported that because the treatment was manualized, it could be effectively implemented without regard to type of counselor. Specifically, the study was to determine if treatment variables such as clients' mental health scores, their length of stays, and clients' substance use scores differed when comparing mental health counselors to substance abuse counselors after they had administered Seeking Safety treatment to clients in an outpatient treatment facility. The study was conducted to help treatment providers who were mandated to use standardized treatment identify the type of counselor who could significantly predict better treatment outcomes and longer lengths of stay in treatment programs.

The key findings in this study showed statistically significant differences in changes in clients' scores on mental health scores, in their length of stay, and on clients' substance use scores, based upon whether they received treatment from a mental health counselor or a substance abuse counselor.

The study used archival data retrieved from an outpatient mental health and substance use treatment program in Southwest Texas. Demographic information such as gender, age, ethnicity, and education were collected from each clients' mental health chart who met criteria for inclusion in the study. Each client had to have had at least six

Seeking Safety sessions to be included in the data collection. In addition, clients' beginning and ending mental health scores on the BDI, their length of stay in the program, and their beginning and ending substance use score was collected. Each client had to have at least 30 days of sobriety before being eligible for the program, hence, all substance use scores at the beginning of treatment were the same.

The independent variable was type of counselor (i.e., mental health counselor or substance use counselor). Dependent variable one and two were clients' BDI change score (i.e., differences between their beginning and ending scores on the BDI) and clients' length of stay in the program, which was measured in weeks. The null hypothesis to address RQ1 was that there were no significant differences on clients' changes scores on the BDI and on their length of stays between clients of mental health counselors and clients of substance abuse counselors. The alternate hypothesis to address RQ1 was that there were significant differences on clients' change scores on the BDI and their length of stays between clients of mental health counselors and clients of substance abuse counselors. The third dependent variable was clients' substance use scores based upon whether the client remain sober or relapsed while in the program. The null hypothesis to address RQ2 was that there were no significant differences on clients' substance abuse scores between clients of mental health counselors and clients of substance abuse counselors. The alternate hypothesis to address RQ2 was that there were significant differences on clients' substance abuse scores between clients of mental health counselors and clients of substance abuse counselors.

## Interpretation of Findings

The goal of the current study was to investigate whether there were differences in treatment outcomes based upon the characteristics or type of counselor delivering an empirically supported manualized treatment designed for clients with co-occurring PSTD and SUDs. Seeking Safety is a present-focused empirically supported manualized therapy designed for the integrated treatment of PTSD and SUD (Najavits, 2002b). According to the author, it was developed to be effective despite the type of counselor conducting the treatment. However, subjective characteristics differed when comparing mental health counselors to substance abuse counselors (Najavits et al., 2011; Oser et al., 2011). Although, the goal of manualized treatment was to hold constant the impact of counselors' characteristics, research showed that standardization of treatment did not remove all therapists' nonspecific traits (Nissen-Lie et al., 2016). This study's findings confirmed the knowledge in the discipline, which indicated that despite providing treatment using a standardized manual, clients receiving treatment had different treatment outcomes based on the type of counselor.

An independent sample *t* test analysis was used in order to determine if mean differences existed between clients as it related to their mental health scores at the start of the program. Clients who received treatment from mental health counselors as compared to clients who received treatment from substance use counselors did not differ in terms of severity of mental health disorder as measured on the BDI. This finding indicated that clients who were randomly assigned to either a mental health counselor or a substance use counselor was equal in terms of depression, which is a common measurement of

mental health functioning. This finding was used to hold constant clients' mental health characteristics being a factor in explaining differences between treatment outcomes. Clients were also equal in terms of their substance use score because criteria for admission to the program was 30 days of verifiable sobriety. Therefore, all clients randomly assigned to either a mental health counselor or a substance use counselor did not differ in terms of their beginning substance use score. Ths finding was used to hold constant that clients' substance use characteristic was a factor in explaining differences between treatment outcomes.

To address RQ1, the Hotelling's $T^2$, a special case of the one-way MANOVA, was run to determine the differences in clients' change scores on the BDI and differences in length of stay in treatment when comparing mental health counselors with substance use counselors. The archival data used in this study showed statistically significant differences in clients' change scores on mental health scores and on length of stay in treatment in terms of weeks between clients based upon whether a mental health counselor or a substance use counselor administered the treatment. Clients treated by mental health counselors had a change in their mental health score of 3 points, whereas participants treated by substance abuse counselors had a change in their mental health score of 1 point. This change is statistically significant and the clinical implications means an improvement in mental health functioning for clients. Lower scores on depression scales can also have a corresponding effect on other major areas of a clients' life, such as better physical health and better social functioning. The findings in this study also showed significant differences between mental health counselor and substance

use counselors on the treatment measurement of length of stay in the program. On average, clients who received treatment from mental health counselors stayed in the program 3 weeks longer than participants who were treated by substance abuse counselors. This difference is statistically significant and clinically significant because research has shown that longer stay in treatment is associated with better treatment outcomes (Zang, Gerstein & Friedmann, 2008). Specifically, in addition to improvements in mental, physical and social wellness, clients who stay longer in treatment sustained their recovery from alcohol and drug use (Zang, Gerstein & Friedmann, 2008).

Previous research offered a rationale for the findings in this study related to substance use counselors working with clients who also had co-occurring mental health disorders. Fahy (2007) contended that substance use counselors did not have adequate training nor a foundation in EST for PTSD, which could lead to "burnout" and poor outcome for clients. Silver Wolf (Adelv Unegv Waya) et al.'s (2014) study showed that mental health counselors and substance abuse counselors differ in their attitudes toward ESTs. They found that substance use counselors were less likely to adopt EST unless they were mandated to do so and if they found them intuitively appealing (Silver Wolf [Adelv Unegv Waya] et al., 2014). Substance use counselors used in this current study were mandated to use the EST Seeking Safety; however, rather or not they found it intuitively appealing was not measured. Finley et al. (2017) and Neukrug and Milliken (2011) also found differences in attitudes between counselors regarding how they used treatment manuals. Mental health counselors offered significantly higher favorable ratings for use of manuals than did substance use counselors (Finley et al., 2017). Mental

health counselors and substance use counselors in Neukrug and Milliken's (2011) study also differed in their beliefs regarding whether or not it was unethical to use treatment that was not evidenced-based. Mental health counselors' ratings were higher on this than substance abuse counselors (Neukrug & Milliken's). Hence, differences in treatment outcomes can be a function of how counselors differ in terms of their beliefs about using manualized treatment and how they differ in terms of working with co-occurring mental health disorders.

To address RQ2, the test of two proportions, chi-square of homogeneity was performed to determine if differences existed between mental health counselors and substance abuse counselors based on whether their clients remained sober or relapsed. The archival data showed statistically significant difference in that 85% of clients who were treated by mental health counselors remained sober throughout the program. Whereas only 57% of participants who were treated by substance abuse counselors remained sober. This statistically significant difference has clinical implications in that a return to drug use can have a deleterious effect on many areas of clients' lives including an toll on public health, safety and economics.

Previous psychological research, specifically in the area of countertransference theories, may offer an explanation for differences found in this study wherein clients who were treated by mental health counselors remained sober at a higher rate than clients who were treated by substance use counselors. Countertransference theory, historically derived from Freud's psychoanalytical perspective, described a range of emotions counselors might feel towards clients, which could be negative or positive and could have

an effect on how they administer treatment and ultimately affect treatment outcomes (Stefana, 2015). The author of *Seeking Safety* in Najavits et al. (2000) posited the idea of the "paradox of countertransference theory" when working with people diagnosed with co-occurring PTSD and SUD (p.11). According to these authors, counselors who identified with clients diagnosed with mental health disorders tended to be "too nice" and counselors who identified with clients diagnosed with SUDs tended to be "too harsh." Other research that may explain differences in whether clients remain sober or relapsed based on the type of counselor can be found in how mental health counselors compared to substance abuse counselors were traditionally trained. According to research by Beck et al. (2005), mental health counselors were trained using motivational interviewing approaches, while many substance use counselors were trained using confrontational approaches. These authors showed that although confrontational approaches may be helpful with clients with a single substance use diagnosis, it may be retraumatizing for clients with co-occurring diagnoses. In this study, clients had both a trauma-related mental health diagnosis and a substance use diagnosis. A return to substance use by clients with trauma related symptoms may be indicative of clients self-medicating if they have not yet established other coping strategies.

The findings in this study supported the theoretical foundation in Chapter 2. The literature review described social psychology theories, which explained how the presence of others (i.e. counselors) could influence treatment behaviors of clients. Specifically, social psychology theory developed by Allport in 1929, the theory of reasoned action developed by Fishbein's in 1979 and the role theory, as conceptualized by Deutsch and

Krauss in 1965 provided the theoretical framework for how counselor type may be a factor in client's treatment outcome. According to Allport's theory, clients' treatment behaviors, (e.g. whether they stayed in treatment or whether clients remained sober) could be influenced by the actual "presence" of their respective counselors' characteristics (i.e. the type of counselor). Scaife, O'Brien, McEune, Notley, Millings, and Biggart (2009) used Allport's theories of social psychology to highlight how adolescence peer groups influenced substance abuse among their cohorts. Hence, this theory could explain how counselors can influence client's outcome. Findings in this study could also indirectly lend support for Fishbein theory of reasoned action which postulated that attitudes and beliefs have influence on behaviors. Shearer and King (2001) research showed that counselors could be categorized along a theoretical continuum, with extreme markers of powerlessness versus empowerment. Substance use counselors typically held "powerless" beliefs relate to how people change; whereas, mental health counselors were more likely to endorse an empowerment idea for change (Shearer & King, 2001; Silver Wolf [Adelv Unegv Waya] et al., 2014). Although, this study did not allow for direct analyses of counselor's attitudes and beliefs, it can be conceptualized that counselors in this study could also be measured along a theoretical continuum related to their beliefs and attitudes and thus explain the differences in treatment outcomes found in the analyses. In a study by Roberto et al. (2014) the theory of reasoned action predicted that substance abuse treatment providers with positive attitudes and beliefs about medication resulted in somewhat positive treatment. In addition, Sorsdahl, Stein and Myers (2012) stated that counselors' beliefs about addiction

could predict their helping behavior and their suggested treatment decisions. This study's finding of differences between counselors can indirectly confirm that of other studies which used the attribution theory as a framework for investigation. Klingemann, Schläfli, Eggli and Stutz (2013) found that when counselor attributed the cause of a mental illness to be under the control of the client, counselors were more likely to endorse coercive treatment. However, Philip, Chadee, and Yearwood's (2014) study showed that the opposite was true in that when counselors attributed their client's illness not of their own making, counselors were willingness to help. Reiland, Lauterbach, Harrington and Palmieri (2014) stated that attribution theory was useful in understanding how beliefs about the causation of behaviors influenced decisions about treatment, which could influence client outcomes.

In summary, statistically significant differences were found on all dependent variables (i.e., on client's mental health scores, their length of stay in treatment and their substance use scores) when comparing mental health counselor to substance use counselors after delivering a standardized treatment for co-occurring disorders.

## Limitations of the Study

While findings in the study and criteria for admission in the program showed that clients were equal on mental health and substance use scores at the beginning of the program; however, no test was performed to hold constant other potential confounding variables, which may have accounted for client's characteristic difference. For example, prior client's history of drug use and type of drugs used may account for differences in treatment outcomes. Further, clients could have been in the group with either a trauma-

related event or a diagnosis of PTSD. Since the former would likely have less symptomatology then the later, clients may have differed in the severity on this mental health indicator.

Another limitation is that mental health counselors and substance use counselors may have differed in their formal training, and in the training that they received from the program as it related to conducting Seeking Safety. No test was performed to hold constant differences in counselor training. Since clients were assigned a counselor at the beginning of the program and remained with that counselor throughout the program, clients' treatment in Seeking Safety was facilitated by the same counselor throughout their length of stay. This procedure addressed the potential for clients to have received treatment from multiple counselors. Lastly, counselors were either mental health counselors or substance use counselors. Hence, counselors were not cross-trained which addressed the potential for a confounding counselor characteristic.

There are limitations to the ex post facto design incorporated in this study. It does not allow for cause-and-effect inference. In other words, the degree to which the type of counselor "caused" differences in outcomes and length of stay is uncertain. Other limitations are 1) the independent variable cannot be controlled or manipulated; 2) clients were not randomized by counselors.

These limitations and other extraneous variables may produce confounded effects (Mitchell & Jolley, 2004). Yet, with full acknowledgement of the inherent limitations of ex post facto designs, still they provide a way to address problems that cannot be investigated in laboratory situations but are nonetheless important in understanding the

nature of phenomena (Lord, 1973). Therefore, results should not be generalized without further study.

## Recommendations

Future research is recommended to explore other subjective characteristic of counselors, which may affect treatment outcomes, even when counselors are using a manualized treatment protocol. While this study investigated type of counselors as a characteristic of counselor that influenced clients' outcome, other attributes which are noteworthy are counselor's beliefs and emotional reactions. Future research could measure counselors' beliefs and attitudes and their respective emotional reactions prior to them implementing a manualized treatment. Outcomes could then be examined using counselors' beliefs and emotional reactions as independent measures. There are objective tools that could be used to measure beliefs and emotional responses. Chapter 2 cited research, which supported how beliefs and emotional reactions of a counselor could influence their behavior, which in turn could influence the behaviors of clients. Further the literature review in Chapter 2 described studies, which found that beliefs and attitudes differed between type of counselors. Specifically, in that mental health counselors held an empowered belief and had a more lenient emotional response compared to substance use counselors who held a powerless paradigm and tended to be harsh in their emotional response to clients. The clinical and social implications is that if research could isolate the specific belief and emotional reaction that produced the best treatment outcomes; then even between types of counselor there would be a better match of counselor characteristics and thus an increase in quality of care for clients.

Future research is recommended to explore rather the type of setting would result in different findings. Chapter 2 described research where counselor's characteristics differ depending on the setting. This study's focus was in an outpatient treatment facility, which tends to be a longer length of stay, and composed of client's who have had some previous treatment episodes. Future research could examine rather or not type of counselor resulted in different outcomes in an inpatient setting. Chapter 2's literature cited studies where professionals in an inpatient setting held a medical paradigm where those in outpatient facilities were more inclined to adopt a biopsychosocial model of care. In, addition, clients in inpatient usually have a lower level of functioning that may be a factor in treatment outcomes being influenced by the type of counselor. Further, an inpatient setting may allow researchers to control for the possibility of auxiliary treatment being a confounding effect. It was not possible to control for this extraneous variable in this study. The clinical and social implication in knowing whether type of counselor meant better treatments outcomes in an inpatient setting could mean reducing acute suffering since the severity of mental health conditions are usually higher in these setting. Also, there could also be a reduction in health care cost since inpatient programs are usually more expensive than outpatient facilities.

Future research should consider an alternative research design. This present study was a quantitative archival design using existing data. This research plan allowed for the use of data, which was collected from a time prior to the beginning of the study. The data was from a time that was 2 to 4 years earlier that this study's analyses. Although, this nonexperimental design allowed for hypotheses testing for between groups differences

when experimental studies are not practical, it would be worthwhile to garner resources for different research methodology. This study's design is popular within the social science field; however, its limitation is that it is not able to establish causal relationships. A research design that has subjective characteristics of counselors as the independent variable and focus of study can be used to support an association, between counselor's attributes and treatment outcomes. Much of the literature as described in Chapter 2 has focused on objective professional characteristics such as sex, gender, years of training, length of experience, licensing, education and theoretical orientation. The literature review for this study found few studies, which examined subjective personal characteristics such as counselors' beliefs, attitudes, implicit theories, emotional reactions and interpersonal skills. According to the research described in this study, much of the research focus of study was on treatment outcome or the characteristics of clients.

## Conclusion

Overall, this study added to the research by supporting that despite the use of manualized treatment, which was purported to control from characteristics of counselors, there were significant differences between treatment outcomes based upon the type of counselor. Mental health counselors as compared to substance use counselor differed in mental health outcomes, lengths of stay in treatment and substance use outcomes. This study however, was not able to identify the specific counselor characteristics that may have been factors to account for the differences in treatment outcomes, such as counselors' beliefs or emotional reactions. In addition, this study is not generalizable to other settings because of its research design, hence, these questions are left to future

research. These questions could be addressed by measuring beliefs and emotional reactions of counselors beforehand and then using a research design, which would allow for counselors to be the focus of the investigation as an independent variable, thus establishing a relationship between counselor characteristics and treatment outcomes.

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