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The Reconciliation of Cognitive Dissonance Among Social Workers in Substance Use Treatment Settings

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Walden University
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Abstract

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Treatment Settings

by

Miranda A. Kieler

MSW, Clarke University, 2016

BSW, Clarke University, 2015

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

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Abstract

Although harm reduction (HR) and abstinence-based treatment approaches are both useful in addiction treatment, the former is less accepted and integrated into practice. Social workers who embrace an HR approach but who work at substance abuse treatment facilities that are abstinence based may experience cognitive dissonance because they perceive their work role to be incompatible with social work practice values and education. Little was known regarding how practitioners with a Master of Social Work (MSW) degree experience and reconcile cognitive dissonance related to their HR education and abstinence-only practice in substance use treatment centers. To address this gap in the literature, a generic qualitative study was conducted using Festinger's theoretical framework of cognitive dissonance. A purposive sampling procedure was used to recruit eight participants, all of whom were MSWs at least 21 years old who had at least 1 year of experience working in a substance use treatment setting. Thematic coding was used to analyze data from semistructured interviews. Themes included challenges at the micro, mezzo, and macro level; the presence of other MSWs and years of working experience; use of social work practice skills; the practice of switching jobs; and engagement in self-awareness and cultural humility practices. The findings may inform clinical social workers about HR practices across systems and administrators about curriculum development in MSW programs. The findings may also be pertinent to advocates and policy makers who want to increase the use of HR. More acceptance of HR in substance abuse treatment facilities may help social workers to experience less cognitive dissonance, which may improve working environments.

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Dedication

To my loving husband, Lee, thank you for your ongoing and unwavering support. Thank you for always believing in my capabilities and reminding me of them when I experienced doubt or uncertainty. There is no one else I want to share adventures with in this life. To our coming baby boy, you are, in simplest terms, the inspiration and drive behind my professional and personal development. We cannot wait to meet you.

I would also like to dedicate this work to my parents and in-laws for their constant support, love, and guidance. Thank you for being my personal cheering squad. Lastly, to all the friends and family who genuinely expressed interest and excitement in this journey, I am so thankful for you and the accountability you provided in my life. Thank you all. I love every one of you more than I can adequately express in words.

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Chapter 1: Introduction to the Study

Harm reduction is a treatment approach that holds that any change aimed at reduces dangerous or problematic behaviors in a person's life is a positive change. Harm reduction can be referred to as a philosophy, an intervention, a method, policy, or treatment approach. For this study, "harm reduction" refers to a substance use treatment approach. Brocato and Wagner (2003) noted that the objective of harm reduction approaches is "the reduction of damage related to drug-taking without requiring abstinence at the initiation of treatment, total abstinence during and following treatment, or both" (p. 118). The harm reduction treatment approach is considered pragmatic because it involves meeting clients where they are at in the continuum of substance use, addiction, and readiness for change, which aligns with social work practice and education (Bigler, 2005; Wallace & Kennedy, 2020). Abstinence, the practice of remaining free of all substances, can be a component of harm reduction services but is not a requirement and is not forced within the harm reduction treatment approach (Lee et al., 2011).

The abstinence-based treatment approach, which encourages or requires clients to set treatment goals to remain abstinent from all substances during and after treatment, is the predominate addiction treatment approach in the United States since the 1950's (Futterman et al., 2004; Lee et al., 2011; Wells et al., 2013). In the United States, roughly 65%-75% of substance use treatment centers have abstinence-based treatment orientations (Lee et al., 2013; McKeganey et al., 2004; Tatarsky & Marlatt, 2010; Substance Abuse and Mental Health Services Administration [SAMSHA], 2022). Most (96%) provide relapse presentation services (SAMSHA, 2022).

There are benefits to abstinence-based and harm reduction treatment approaches depending on an individual's needs, current stage or change, and other life circumstances (Brocato & Wagner, 2003). Lee et al. (2013) asserted that although there are benefits to both approaches, the integration of one approach into the other (i.e., using harm reduction for those in abstinence-based settings, or the other way around) along with the acceptability of each approach in the field of addiction, has complex and conflictual undertones among professions working in substance use treatment settings. The lack of integration and acceptance among these two approaches is fueled by the primary theoretical difference concerning the role and consequence of abstinence treatment goals, which in turn fosters conflict between the approaches (Bigler, 2005; Lee at el., 2013; Taylor, 2007). Therefore, it is not uncommon for social workers to experience cognitive dissonance (also referred to as "conflict" in this study), an unpleasant state of being that occurs when actions or ideas are inconsistent and cause distress, when working in substance use treatment centers due to the conflict between approaches (Cooper, 2012; Taylor, 2007). Harm reduction is considered a pragmatic approach, which aligns with social work practice. The approach is endorsed by social workers who have received some form of harm reduction education in their graduate program (Estreet et al., 2017; Eversman, 2012; Moore & Mattaini, 2014). Thus working in substance use treatment settings that do not integrate or use harm reduction treatment approaches may create cognitive dissonance for social workers (Bigler, 2005; Taylor, 2007; Wallace & Kennedy, 2020).

Social workers have reported issues using a harm reduction approach while working with or in agencies that emphasize abstinence-based approaches like inpatient treatment centers, criminal justice, or child welfare departments (Ackerson & Karoll, 2005; Eversman, 2008; Lee et al., 2013, Taylor, 2005, 2007). Social workers who support harm reduction approaches have also reported experiencing conflict with current policies, organizational support, stigma, and acceptability of non-abstinence-treatment treatment practices among other addiction professionals (Ackerson & Karoll, 2005; Davis et al., 2017; Eversman, 2008; Lee et al., 2013; Rosenberg et al., 2020; Taylor, 2005). Some professionals without harm reduction education or training also struggle with the use of this approach.

To date, researchers have mostly focused on the shared or theoretical conflicts related to harm reduction and abstinence-based treatment in addiction treatment, the intersection of social work education and harm reduction practices, the role social workers play in using and advocating for harm reduction policy and interventions, and the significance of implementing harm reduction education into the social work graduate curriculum (e.g., Bigler, 2005; Brocato & Wagner; Davis et al., 2017; Futterman, 2004; Lee et al., 2011; Lee et al., 2013; Rusk & Sarabia, 2022; Wallace & Kennedy, 2020; Zelvin & Davis, 2001). In this research study, I explored how social workers (a) experience cognitive dissonance related to their harm reduction education and abstinence-based treatment approaches and (b) reconcile the conflict between these approaches.

In this chapter, I will provide an overview of the study. The major sections in this first chapter are devoted to the problem statement and the study's purpose, the

significance of the study, potential social implications, definitions of key concepts, assumptions, scope and delimitations, and limitations. I will also highlight the study's theoretical framework and briefly review existing academic literature pertinent to the study.

Background

Harm reduction approaches have existed in North America since 1950. Canada introduced methadone treatment in the 1950s as an alternative approach for treating opioid addiction, with the United Kingdom following suit shortly after this period (Souleymanov & Allman, 2016). This is commonly known as a form of medication-assisted treatment (MAT), which integrates therapy and the use of opioid agonist medications to decrease opioid deaths or related risks and to help increase a user's daily functioning as an alternative from the abstinence model (Souleymanov & Allman, 2016). In the 1980s, European states implemented harm reduction programs, such as safe needle exchange programs, working to decrease the rapidly growing death and infectious disease rates of drug users (Souleymanov & Allman, 2016). Harm reduction became a noted practice in the United States in the late 1980s as a means of addressing HIV/AIDS transmissions spread through intravenous drug use (Des Jarlais, 2017). Although most of the United States Congress still strongly opposed the idea of syringe exchange harm reduction sites during this time, some states, through private funding, began to pilot programs to explore the effectiveness of decreasing HIV/AIDS transmission with safe needle exchange (Des Jarlais, 2017).

Harm reduction approaches are consistent with social work practice related to the treatment of substance use disorders. Since the settlement house and Charity Organization Society movements of the 1800s, social workers have worked with individuals who struggle with addiction (DiNitto, 2005). It was during this time frame that social workers began to help change the perception of alcoholism being viewed as personal moral failure but rather a disease in need of treatment. In the 1990s, the National Association of Social Workers (NASW) created a specialty practice for alcohol, tobacco, and other drugs; partnered with the National Institute on Drug Abuse on addiction grant-funded research projects to enhance social workers' access to federal research funding relating to addictions; and developed social work journals centered on addiction (NASW, n.d.). Additionally, the Association for Multidisciplinary Education and Research in Substance Use and Addiction began encouraging the incorporation of addiction education in all social work programing (DiNitto, 2005).

Since the early 2000s, NASW efforts have increased public backing of harm reduction services and related coalitions aimed at decreasing the stigma of opioid use, reducing the criminalization of drug use, and increasing harm reduction programs, treatment, and policies (Wilson & Dorn, 2016). Through research, social workers have expanded the knowledge base pertaining to harm reducing services such as needle exchange programs, MAT, harm reduction approaches in psychotherapy, prevention, and psychoeducation (Morrison, 2015: Wilson & Dorn, 2016). Many researchers have noted that most social workers who provide services practice harm reduction values and services to some degree, even if they do not name it is as such (Bigler, 2005; Brocato &

Wagner, 2003; Zelvin & Davis, 2001). Social workers with harm reduction education may understand the importance of utilizing more than just abstinence-based treatment approaches when working in addiction treatment settings, addressing client-centered needs and complex dynamics (Estreet, 2017; Eversman, 2012). However, social workers working according to their social work standards and education often navigate organizational, social, and policy constraints that support abstinence-based practices, thus creating conflict related to using harm reduction approaches and established abstinence-based substance use treatment norms.

Davis and Rosenberg (2013) and Rosenberg and Phillips (2004) studied different views regarding the level of acceptance of harm reduction approaches in substance use treatment. They found that acceptance of harm reduction was influenced by personal experiences, years of working experience, organizational culture, resources, training available in the workplace, and individual views of specific types of drug use. This research clarifies why social workers may find themselves working in substance use treatment environments that conflict with the utilization of harm reduction or abstinence-based practices.

The work of Cooper (2012) and Harmon-Jones (2002) provides a theoretical understanding of the cognitive dissonance that social workers experience relating to their harm reduction education and abstinence-based treatment practices and motivations to reconcile these conflicts. Social workers who experience cognitive dissonance in their working environments are likely to engage in actions such as changing actions, such as jobs, or change perceptions about their experiences thus allowing them to work in

alignment with social work education and social work principles (Taylor, 2007). The topic of cognitive dissonance in the social work profession has been examined in previous research on issues such as adoption, stress, child welfare, and medical surgeries (e.g. Burke, 2017; Collins, 2008; Gallagher & Bremer, 2018), but to date, there is very limited research on cognitive dissonance for social workers regarding harm reduction education and abstinence-only treatment practices in the addiction field. By addressing this gap, I sought to increase understanding of how social workers experience cognitive dissonance related to their harm reduction education and abstinence-based treatment approaches in treatment settings and how social workers reconcile the conflict between these treatment approaches, potentially offering ways to reduce or lessen this phenomenon.

<div align="center">**Problem Statement**</div>

The expectation that clients seeking substance abuse treatment practice abstinence may be counterproductive. Individuals who struggle with addiction are unlikely to seek out traditional substance abuse treatment services that feature abstinence-only approaches, potentially never addressing their addiction or high-risk use (Brocato & Wagner, 2003). Most harm reduction programs acknowledge, not unlike abstinence-based approaches, that an ideal treatment goal would be abstinence. However, this is not a realistic or self-determined approach for many individuals who struggle with addiction or substance misuse (Brocato & Wagner, 2003; Burris, 2018; Wallace & Kennedy, 2020). Any change leading to a better quality of life is embraced within harm reduction practice, which aligns with social work values of self-determination and dignity and worth of the

person (NASW, 2008). Social workers who use harm reduction approaches understand that the harm reduction approach creates a point of access to supportive, nonthreatening treatment and increases flexibility in peoples' unique needs and abilities.

However, abstinence-only treatment continues to be the most common practice approach used in substance use treatment settings in the United States (Littrell, 2017; Rosenberg & Phillips, 2004). Since early 2000, roughly 75% of detox inpatient treatment centers and other addiction rehabilitation centers in the United States are rooted in abstinence-based practices (McKeganey et al., 2004; SAMSHA, 2022; Tatarsky & Marlatt, 2010). The requirement that clients cease all use of substances may account for why so few individuals obtain substance treatment. In 2019, only 2.8 million of the 21.6 million people with reported substance use disorders ages 12 and older needing services engaged in substance use treatment (SAMHSA, 2020). Asked why they did not seek treatment even though they reported it as a need, 40% said their decision was because they were not ready to stop using (SAMHSA, 2020). This statistic is consistent with data from 2015 and 2019. Current research suggests that less than 20% of those struggling with a substance use disorder wish to seek treatment in a setting with abstinence-only treatment requirements (Brocato & Wagner, 2003; SAMHSA, 2019).

The harm reduction approach has gained significance in the field of social work in practice, policy, and education due to its client-centered nature, respect for individual rights, utilitarianism, and humanistic philosophy, which embody the core values of social work (Bigler, 2005; Brocato & Wagner, 2003; NASW, 2003; Zelvin & Davis, 2001). In the view of experts, harm reduction methods reduce treatment-related issues such as poor

client retention, poor short-term outcomes, limited access to care, ineffective client-provider relationships, and lack of client-driven treatment plans or collaboration while increasing treatment focused on reduction for those who cannot remain or are ambivalent about engaging in abstinence-only treatment (Brocato & Wagner, 2003; Vakharia & Little, 2017). This approach may also enhance client-social worker relationships through its respectful nature and emphasis on self-determination. The problem is that existing studies demonstrate that some social workers experience conflict with their harm reduction education and substance use treatment centers that may not preference harm reduction approaches, yet they do not provide insight on how social workers experience or reconcile cognitive dissonance.

Current research on the presence and degree of harm reduction education in social work practice shows that many social workers accept and endorse harm reduction approaches after engaging in education and training on harm reduction (Bigler, 2005; Eversman, 2012; Fenster & Monti, 2017). Research indicates that roughly half of all substance use treatment providers, including social workers, endorse traditional substance use treatment practice; the other half likely endorse other practices such as harm reduction (Brocato & Wagner, 2003; Davis & Rosenberg, 2013; Littrell, 2017). Although studies show that harm reduction services effectively reduce transmissions of infectious disease, decrease overdose and mortality rates, and enhance treatment engagement and reduction in use, harm reduction models for therapy continue to develop slowly and do not adequately meet community need (Brocato & Wagner, 2003; Burris, 2018; Drucker & Crofts, 2017). Social workers who find value in harm reduction or multiple treatment

approaches and who work in settings that primarily endorse abstinence-based approaches must attend to and consider these beliefs while bearing in mind organizational cultures and expectations, client needs, and social work principles (Lee & O'Malley, 2018; Rosenberg & Phillips, 2004).

These factors may lead social workers to experience cognitive dissonance when a client's needs and accepted treatment practices in traditional substance abuse treatment settings conflict with their social work education on harm reduction. This dilemma can be challenging for practitioners. Social workers are expected to provide services to individuals struggling with substance use while upholding social work core values and standards (Bigler, 2005; Brocato & Wagner, 2003). Clinical social workers are tasked with ensuring that treatment approaches and goals are based on collaboration, positive regard, and autonomy; however, they may work in settings that create such practice barriers. There is a need for a better understanding of how education endorsing harm reduction practices in social work influences cognitive dissonance and reconciliation experiences for master-level social workers (i.e., social workers with a Master of Social Work [MSW] degree) in substance use treatment settings where harm reduction is not promoted or integrated. The problem is that some MSWs experience cognitive dissonance relating to their harm reduction education and abstinence-based treatment approaches in substance use treatment settings, yet researchers do not know in what ways social workers experience and reconcile cognitive dissonance.

Purpose of the Study

The purpose of this exploratory generic qualitative study was to understand how MSWs experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. Social work practice is complex and often comprised of incompatible responsibilities, from client rights, professional obligations, and personal values to societal responsibilities. Cognitive dissonance and the reconciliation of such conflicts are central experiences of a social worker, often causing distress and work difficulty (Taylor, 2007; Taylor & Bentley, 2005). I explored how MSWs experience and reconcile cognitive dissonance related to harm reduction education and abstinence-only practice. My aim was to provide insights regarding this phenomenon and clarify potential ways to lessen the continued weight of conflict experienced by social workers in these work environments.

Research Questions

The research questions (RQs) for this generic qualitative study were

RQ1: How do master-level social workers experience cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

RQ2: How do master-level social workers reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

Theoretical Framework

I based the theoretical framework for this study on Festinger's (1957) theory of cognitive dissonance. Cognitive dissonance theory posits that dissonance (an unpleasant state of being) occurs when a person presents with two cognitions inconsistent with one another. Festinger asserted that people are motivated to reduce conflict or discomfort because humans desire their actions and thoughts to be congruent. Humans are thought to reconcile dissonance by accepting, disregarding, or altering new or old cognitions.

I discuss cognitive dissonance in relation to harm reduction education in social work and working in substance use treatment in this section and in further detail in Chapter 2. There are some existing studies on cognitive dissonance in the social work profession on issues such as adoption, stress, and medical surgeries (Burke, 2017; Collins, 2008; Gallagher & Bremer, 2018). Social workers who work, or who have worked, in abstinence-only treatment centers may experience dissonance because some substance-use treatment center approaches may differ from social work principles and education. Cognitive dissonance may occur as their professional education might inform them to meet clients where they are and promote humanistic and pragmatic care driven from harm reduction approaches, which may not align with treatment center methods that require abstinence or 12-step involvement (Bigler, 2005; Brocato & Wagner, 2003; Wallace & Kennedy, 2020). Cognitive dissonance may also occur for social workers who favor abstinence-based treatment practices that may conflict with social work teachings or client reported desires. The use of a cognitive dissonance theoretical framework aligned with the generic qualitative approach that I used. The framework was also in

alignment with the study's RQs, which centered on social workers' perceptions of experiencing and reconciling conflict.

Nature of the Study

In conducting this study, I used a generic qualitative approach that involved conducting semistructured individual interviews. A generic qualitative approach was consistent with understanding how, on a broad level, MSWs experience and reconcile cognitive dissonance with their harm reduction education and abstinence-only treatment approaches. Generic qualitative researchers pose how or why questions when not much is known about a specific topic (Percy et al., 2015). There is ample current research on harm reduction approaches and substance use treatment (e.g., Bigler, 2005; Lee et al., 2011; Lee & O'Malley, 2018; Rusk & Sarabia, 2022; Tatarsky & Marlatt, 2010; Wallace & Kennedy, 2020); however, there was limited knowledge of the role of MSW providers and how they reconcile cognitive dissonance related to their harm reduction education and abstinence-only treatment practices. The research topic in this study did not fit within the constraints of established qualitative methodologies; by using a generic research approach, I had the flexibility to use a methodology, theoretical framework, and design that honored the RQs rather than try to align the question to fit within an established and traditional qualitative orientation (i.e., grounded theory, phenomenology, narratology, ethnography, or case study approach). A generic qualitative approach reduces the risk of altering the original spirit of the inquiry (Kahlke, 2014).

The lack of existing literature on generic qualitative research may raise doubts about the quality of this approach. Researchers can explicitly discuss epistemological and

theoretical positions in their study to manage these issues and further justify their choices and research process. Kahlke (2014) stated that generic qualitative approaches require researchers to understand more than one existing qualitative methodology to ensure proper blending of methodologies; this knowledge is also needed to garner the reader's confidence. Knowledge of existing qualitative methodologies also strengthens the researcher's awareness of limitations and bias of the study (Kahlke, 2014).

By using a generic qualitative approach, I was able to engage in thematic analysis and purposive sampling to identify and interpret patterns from the data set that clarified the experiences of reconciling cognitive dissonance among MSWs (see Percy et al., 2015). Etikan et al. (2016) noted that the aim of purposive sampling is to select a sample who are well versed in the study topic (p. 2). Thematic data analysis and purposive sampling supported my attempt to generate a broad and initial understanding across the data set on this research topic. Furthermore, by conducting individual interviews I was able to thematically analyze reported experiences and reflections from a range of MSWs and to offer a broad explanation of the study phenomenon. MSWs who currently worked or who had worked at substance use treatment centers with harm reduction education were the individuals who could provide meaningful insights related to experiencing and reconciling cognitive dissonance through real-world knowledge and experience. I recruited eight participants for this study.

Definitions

Following are definitions of key terms that are used in this study:

Abstinence: The act or practice of refraining from indulging in a behavior or activity (Futterman et al., 2004).

Abstinence-only substance abuse treatment: A treatment approach that favors or requires clients to set treatment goals to remain abstinence from all substances during the course of treatment (Futterman et al., 2004). This term may be referred to as traditional treatment approaches.

Cognitive dissonance: An unpleasant state of being when actions or ideas are inconsistent causing distress (Cooper, 2012).

Disease model of addiction: A disease model that proposes that addiction stems from (a) genetic dispositions and physiological brain changes over time as a person continues to use substances or (b) activation of the brain's pleasure reward system (Becoña, 2018; Skewes & Gonzales, 2013).

Harm reduction: A philosophy rooted in social justice and humanism that focuses on improving public health issues derived from high-risk behaviors and drug use with pragmatic methodologies such as safe needle exchange programs, MAT, HIV prevention education and free testing services, and designated driver programs (Brocato & Wagner, 2003; Futterman et al., 2004).

Harm reduction treatment: An umbrella term for interventions that are intended to reduce the problematic effects of substance use and high-risk behaviors (Marlatt, 1998).

Harm reduction education: A core part of MSW curricula that addresses the concept of harm reduction along with harm reduction approaches, theories, interventions, and the relationship related to harm reduction and social work (Fenster & Monti, 2017).

Inpatient substance use treatment: Facilities that provide 24-hr residential treatment services and diagnosis of behavioral health conditions (SAMSHA, 2020).

Outpatient substance abuse treatment: A type of treatment program that allows an individual to remain in their home environment (rather than in an inpatient setting) while engaging in addiction treatment (National Institute on Drug Abuse, 2019).

Reconciliation experience: The process of restoring congruence or harmony related to social work education and practices in substance use treatment settings (Taylor, 2007).

Social work education: A conceptual framework for the teaching of social work practice in higher education (Estreet et al., 2017).

Assumptions

The main assumptions for this study were that MSWs with experience in the field of addiction would be interested in participating in this study to contribute knowledge on this specific topic. Additionally, I assumed that the study participants would be open and willing to share their perceptions based on their work experiences and comprehend the questions asked. Furthermore, I believed that the participants' attitudes, education, and professional knowledge would reflect their understanding of harm reduction and other substance use treatment practices. I acknowledged that participants' personal experience may shape their perceptions regarding the strengths and limitations of harm reduction and abstinence-based treatment. There was an implicit assumption that there was a theoretical overlap between MSW education, social work practice, and harm reduction as addressed in the literature review (Bigler, 2005; Brocato & Wagner, 2003; Wallace & Kennedy,

2020). Last, I assumed that there was some degree of cognitive dissonance occurring among MSWs with harm reduction education who work in substance use practice setting (see Ackerson & Karoll, 2005; Eversman, 2008; Davis et al., 2017; Lee et al., 2013, Rosenberg et al., 2020; Taylor, 2005). These assumptions were vital to guarantee trustworthiness throughout the data collection and analysis process (see Shenton, 2004).

Scope and Delimitations

The specific focus of this study was the experiences of MSWs with harm reduction education who currently or previously worked in abstinence-based substance use treatment centers. The study included MSWs who were 21 years old and older. The participants in the study had at least 1 year of experience working in outpatient and inpatient substance use treatment settings. Other behavioral health professionals such as alcohol and drug counselors were not included in this study, as the focus of the study was on cognitive dissonance among social workers who work in substance use treatment settings that have abstinence-only approaches. Furthermore, existing studies show that alcohol and drug counselors are more likely to utilize theoretical orientations, including cognitive-behavioral therapy and 12-step principles (Davis & Rosenberg, 2013; Rosenberg & Phillips, 2003; Shenton, 2004). In their study, Rosenberg and Phillips (2003) noted that alcohol and drug counselors reported that moderate or non-abstinence treatment goals were acceptable for only roughly 25% of their clientele. The social workers who engaged in this study may also have favored abstinence-based treatment practices because personal and professional experiences may influence their professional practices and beliefs.

I explored MSWs' experiences of, and means of reconciling, cognitive dissonance related to their education and workplace experiences. Qualitative researchers seek to answer questions relating to how individuals understand and give meanings to their experiences (Kalhke, 2014). Because qualitative research is flexible, it may generate significant information and themes for future qualitative and mixed-methods research of various contexts with similar populations (i.e., its findings may have transferability).

One alternative theoretical framework for examining treatment professions and social workers that was not used in this study is self-efficacy theory. Other researchers have used self-efficacy theory to examine child education, mental health treatment, athletic performance, substance use, sociocultural factors, and intimate partner violence (Fedina et al., 2018; Petrovich, 2003). Petrovich (2003) described self-efficacy as one's perception of achieving desirable results based on personal strengths and abilities. Factors including one's decision-making process may influence self-efficacy. Other factors include the amount of energy one applies to a problem, personal accounts of resilience and determination during difficult moments, the amount of self-limiting thoughts, and the extent of stress or depression one experiences due to a problematic situation (Petrovich, 2003). Due to the complexity of the social work profession and the number of competencies that social workers are expected to demonstrate, a social worker's sense of preparedness and perceptions regarding their capabilities can affect their ability to respond to difficult situations. Other researchers have examined other MSWs' perceptions regarding their ability to complete duties, organize, and execute actions related to working in substance use treatment environments (Fedina et al., 2018).

However, in this study I wanted to scrutinize how social workers who work in these settings experience and reconcile conflicts related to treatment approaches.

Limitations

Social desirability may have affected this study. Klages et al. (2020) noted that socially desirable concerns could be decreased by allowing participants to discuss engagement risks, using nondirective probes, and displaying unconditional regard throughout the interview process. Participants may have been concerned about the risks of confidentiality breaches and its impact on employment. I took all necessary steps to inform the participants of risks associated with engaging in the study, including the limitations to protecting confidentiality to make an informed decision to continue with participation. Another potential limitation of study is the small sample pool of MSWs that have worked in the field of addiction. Although social workers are often the first individuals to encounter a person struggling with substance use issues, the field of addiction continues to be underwhelmed with the presence of social workers.

Participants could have decided or felt the need to refrain from sharing their full experiences. Participants were informed that they were not required to share information that may have impeded feelings of safety and privacy concerning their professional confidentiality and credibility. They were informed that all personal identifying information would be removed from recorded transcribes during the interview process. It is possible some interview questions asked may have led to confusion with responses. There is some risk that personal bias or experiences posed limits to the research as these issues can influence client responses. Additionally, as a social worker with experience

relating to the topic of study, I was aware that personal bias could skew my interpretations of the data collected. To address potential researcher bias in interpretations, I employed member checking to confirm that the participants' perceptions were accurately reported. I also engaged in reflexive journaling to monitor my thoughts and feelings while collecting and analyzing data for the study.

Significance

This study addressed a gap in research by focusing on MSWs perceptions of experiencing and reconciling cognitive dissonance related to harm reduction education and abstinence-only treatment settings. Abstinence-only treatment is beneficial for many individuals seeking recovery. Abstinence-based treatment can help individuals become connected in 12-step programming or other sources of recovery that might be helpful. Harm reduction approaches are also helpful for those capable of reducing use or enhancing safety in the here and now (Brocato & Wagner, 2003). The harm reduction approach reduces the number of people trying, yet struggling, to maintain abstinence because they are not ready, desiring, or able to make abstinence-based changes.

This study showed how social workers experience and reach reconciliation with their social work principles and education, informing them to provide and create "humane and responsive" community services when faced with abstinence-only treatment settings within their communities or vice versa (Bigler, 2005). The goal of this study was to better understand how MSWs experience and resolve cognitive dissonance related to their harm reduction education and abstinence-only treatment settings. In completion of this goal, the researcher was able to use the knowledge gained to highlight barriers and/or positive

factors associated with reconciling or managing such conflicts. The study findings led to implications for future research such as exploring educational approaches in MSW graduate curriculum that address ethics and self-care in practice related to conflicts in social work practice in the field of addictions. The study also suggests that the lack of training, understanding, and support social workers receive about integrating harm reduction and abstinence-based treatment practices in substance use treatment settings is another area important for future study. In addition, this research provided insight on how progress and access to harm reduction interventions in substance use treatment creates or perpetuates cognitive dissonance among social workers. This new research may support social workers in the future who seek to advocate and educate other on substance use treatment and harm reduction practices.

This study's social change implications contribute to the growing body of social work research by highlighting how conflicts experienced by MSWs impact not only the provider but also direct care practices with clients and families. The study showed ways dissonance experienced by MSWs influences attitudes towards self, the profession, and places of employment. The study also revealed whether treatment approaches (harm reduction or abstinence-based) used by MSWs reflect what they consider best practices or if practice approaches used result from the limitations of one's working environment.

Researchers may use this research to explore the use or lack thereof of harm reduction approaches among professionals and agencies and whether current working environments support practice approaches that are aligned with social work standards and

mission. Therefore, the study's findings may advance the safety and care of clients, families, and professionals.

Summary

Cognitive dissonance is experienced by many working professionals. Experiencing cognitive dissonance has been shown to occur among social worker when their social work education or practice misalign with workplace practices or expectations (Taylor & Bentley, 2005). Studies examining cognitive dissonance among social workers have highlighted the significance of exploring how social workers reconcile conflict, particular within the field of addictions and working in treatment settings that promote abstinence-based treatment as social worker education often promotes the importance of harm reduction approaches. By investigating and identifying relevant themes and perceptions of those that engaged in the study, I pursued answers to how MSWs experience and reconcile cognitive dissonance related to harm reduction education and abstinence-only practice.

Chapter 1 explored the study's problem statement, purpose, and significance of study, along with potential social implications, definitions of concept, assumptions, scope and delimitations, and limitations. Chapter 2 discusses the study's theoretical framework and review of existing academic literature related to the topic of study.

Chapter 2: Literature Review

The utilization of harm reduction in substance use treatment practices and social work education has been an ongoing topic of study in social work, education, behavioral health, criminal justice, and public policy (e.g., Bigler, 2005; Brocato & Wagner; Futterman, 2004; Zelvin & Davis, 2001). Social workers with harm reduction education understand the value of utilizing multiple or nontraditional treatment approaches when working in addiction treatment settings to address client-centered needs and complex dynamics (Estreet et al., 2017; Eversman, 2012). However, social workers often face organizational, social, and policy constraints that causes conflict or dissonance related to their social work role, harm reduction education, and work environment (Bigler, 2005; Brocato & Wanger, 2005; Taylor, 2007).

Researchers have examined the topic of cognitive dissonance in the social work profession and the emotional or behavioral impacts on practitioners. They have explored cognitive dissonance related to issues such as transracial adoption, job satisfaction, stress, and medical issues (Burke, 2017; Collins, 2008; Gallagher & Bremer, 2018; Sloane & Williams, 1996). Current research also highlights varying levels of acceptance among addiction professionals regarding the use of harm reduction or non-abstinence goals in treatment (Rosenberg et al., 2020). Still, there is little to no research on how social workers experience and possibly reconcile cognitive dissonance related to harm reduction education and abstinence-only practices in substance use treatment settings.

The problem is that there is little or no knowledge regarding how MSWs' experiences of conflict related to their harm reduction education and traditional substance

use treatment practices or how MSWs reconcile cognitive dissonance related to this problem. The purpose of this exploratory generic qualitative study was to understand how MSWs experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. I begin this chapter by providing an overview of the literature search strategy and theoretical framework of cognitive dissonance, including its relevance to this study. I then review existing research on the harm reduction and abstinence treatment paradigms, harm reduction in social work education, and cognitive dissonance experienced by social workers. The chapter ends with a summary of key points and conclusions and a transition to Chapter 3.

Literature Search Strategy

To find the literature for this study, I began by creating a list of key terms or concepts for the literature review, which constituted the key search words that I used to find relevant studies in Walden University Library's online databases. Key terms included *harm reduction*, *substance use*, *abstinence-only*, *12 steps*, *social worker*, *social work*, *substance use treatment*, *cognitive dissonance*, *reconciliation*, *theoretical conflict*, and *qualitative research*. The databases searched were Social Work Abstracts, Academic Search Complete, APA PsycArticles, APA PsycINFO, SocINDEX with Full Text, ERIC, and SAGE Journals. Resources used included peer-reviewed journal articles, books, and dissertations. Most of these articles were published within the last 10 years. Due to little existing research on this topic, some articles extend past the 10-year time frame to

capture a thorough examination of existing inquiry and draw attention to the topic's history.

Theoretical Framework

Festinger's (1979) theory of cognitive dissonance, which focuses on the relationship and conflicts between cognitions, informed this study. Cognitions in this theory are commonly described as a component of knowledge; thus, attitudes, views, and feelings regarding self, others, and the world are cognitions (Harmon-Jones, 2000). The theory of cognitive dissonance posits that dissonance (an unpleasant state of being) occurs when a person presents with two cognitions that are inconsistent with or unrelated to one another (i.e., a cognitive discrepancy; Harmon-Jones & Mills, 2019).

In Festinger's (1957) theory of cognitive dissonance, a generative cognition or a chosen cognition is the standard by which all other related cognitions are compared and analyzed. According to Festinger (2009), when a pair of cognitions are not in conflict with one another, they are consonant. If two cognitions are not relevant to each other, they may become dissonant. The extent of cognitive dissonance varies based on the dissonance ratio, the number of existing cognitions and values placed upon old cognitions, and how consonant or dissonant they are with a new cognition. In other words, dissonance will increase or decrease depending on the number of cognitions and the importance of dissonant cognitions comparative to consonant cognitions (Harmon-Jones, 2002). Festinger stated that people are motivated to reduce this conflict or unpleasantness because we desire our behavior and thoughts to be congruent (Cooper, 2012). Humans instinctively strive to be in congruence with their beliefs and subsequent

actions. The extent of one's motivation and level of unpleasantness may influence their actions to achieve consonance. In efforts to reduce or eliminate conflict, one may avoid situations that bring on unpleasantness, work to diminish the importance of existing cognitions, or integrate new beliefs that restore balance to old or new cognitions (Cooper, 2012; Harmon-Jones & Mills, 2019).

Three paradigms used to understand cognitive dissonance are the free-choice paradigm, belief disconfirmation paradigm, and induce-compliance paradigm. The free choice paradigm, created by Brehm, postulates that a person experiences a state of dissonance once presented with a decision that sparks internal conflict and inconsistency (Harmon-Jones, 2002; Harmon-Jones & Mills, 1999). Dissonance reduces once a person determines whether the new cognition is more favorable than the existing one it conflicts with and chooses one over another. Harmon-Jones (2002) stated that this outcome is called the "spreading of alternatives."

The belief disconfirmation paradigm utilized by Festinger et al. (2008) presumes that when a person learns new knowledge that does not align with existing learned beliefs or thoughts, the dissonance is activated. People will seek out ways to make the new information less conflicting, such as seeking out people who share similar views to ease acceptance of new cognitions or resolve the new knowledge to protect their existing thoughts or beliefs to restore consonance. For example, a person who smokes may form new friendships with other people who smoke to reduce dissonance about the negative effects of smoking and normalize one's behavior.

The induced-compliance paradigm states that dissonance occurs when a person acts contrary to existing beliefs or views (Harmon-Jones & Mills, 1999). Existing cognitions may inform a person to feel as though a behavior or thought is unacceptable or unpleasant. A person may alter cognitions to justify actions or behaviors as a means of reducing dissonance. People may also use perceived rewards, punishments, or threats to reduce dissonance and cognition discrepancy by assigning greater importance to new cognitions that support previously objectionable behavior or thought. (Harmon- Jones & Mills, 1999).

Over the last 60 years, Leon's theory of cognitive dissonance has been largely criticized and analyzed due to its stance on predicting human behavior, the vague explanation of how one reduces dissonance, and what account individual characteristics have regarding one's ability to tolerate dissonance and how they choose to resolve dissonance (Aronson, 1969; Cotton & Hieser, 1980). The account of free will, inflexibility, and self-perception are thought to influence one's experience of dissonance but have rarely been studied over the years within the cognitive dissonance theory (Aronson, 1969; Harmon-Jones, 2000). The role of self-concept was introduced to cognitive dissonance to enhance the trustworthiness of the theory and account for some of the ambiguity of reducing dissonance (Aronson, 1992; Metin & Camgoz, 2011). Aronson (1992) stated that inconsistent cognitions within themselves are not enough to create dissonance. When cognitions conflict with one's perception of self, dissonance occurs. This assertion focuses on explaining why some individuals experience more dissonance than others or experience dissonance in one situation but not another.

Cognitive Dissonance Among Social Workers

Cognitive dissonance is experienced by many helping professionals. Social workers often experience conflict related to their professional values and job-related expectations or responsibilities, creating distress relating to professional principles (Taylor, 2007). Socials work principles and education that promote human dignity, self-determination, justice, and respect inform expected actions and standards for social workers, which can counter workplace or societal requirements that endorse traditional or institutional practices.

Taylor and Bentley (2005) explored the experiences of mental health social workers and professional dissonance. Professional dissonance is conceptualized as distress or unpleasantness that arises related to social work or professional values and employment requirements or public policies. Social workers are largely responsible and encouraged to provide services to individuals in need of services while upholding the core values and standards of social work practice, which may create conflicts between existing societal, community, or organizational expectations. Taylor and Bentley (2005) explored how 750 clinical social workers managed professional dissonance through cross-sectional, survey design with questionnaires consisting of open-ended questions, case vignettes, and Likert based questions. The study concluded that social workers with longer working experiences and higher levels of devotion to promoting self-determination experience the highest rating of professional dissonance.

In a qualitative study using semi-structured interviews, Burke et al. (2017) explored the presence, role, and reconciliation of cognitive dissonance among 21 social

workers who facilitated transracial adoption plans. Results concluded that social workers experience cognitive dissonance, are negatively impacted by dissonance, and actively work to reconcile cognitive dissonance through various actions. Participants reported dissonance within their personal and professional values systems, dissonance regarding the importance of cultural identity, negatively perpetuating colonization, and upset with their perceived role in transracial adoption. Social workers stated that their experiences concerning the value/behavior conflicts led to physical, emotional, mental, and spiritual distress. The participants reconciled cognitive dissonance by changing jobs to align with their value system or altering or adding to existing cognitions to resolve the dissonance. This study enhances understanding of how social workers perceive, manage, and reconcile dissonance within the workplace and confirms social workers reporting of this phenomenon. Social workers are often tasked with making practice decisions that simultaneously foster client autonomy, protect the larger society, and align with professional and personal values leading to dissonance. Experiencing dissonance and dissonance resolution can create feelings such as confusion and anguish, but hopefully, in the end, lead to professional and personal resolution and growth (Taylor, 2007).

In a qualitative study, Nelson and Merighi (2003) examined emotional dissonance in medical social work practice. The researchers conducted small group interviews with 47 medical social workers from seven hospitals to examine their workplace experiences regarding community, family, and individual factors that have caused dissonance. Social workers reported emotional dissonance relating to the just and ethical duty to clients, community standards of resource allocation, and system deficiencies that impact

community care. Social workers acknowledged that many community issues or lack of

resources for their sickest clients were beyond their control and services. Nevertheless,

they were having internal difficulties with being unable to provide quality client care

reflective of their professional standards. Participants reported family factors influencing

emotional dissonance when addresses end of life care. They reported that family beliefs

and tensions complied with hospital directives impacted their ability to advocate for

compassionate care or discontinue medical care to reduce client suffering based if

appropriate based on medical evaluation. Social workers reported that this created

emotional dissonance, the need to suppress personal and professional values, and

influenced their personal life. Practicing in alignment with ethical standards and holding

the client's best interest and professional values is the ideal approach to reducing

emotional dissonance.

Nelson and Merighi (2003) found that individual factors influencing emotional

dissonance included countertransference and lack of peer or supervisor support in client

care. The researchers suggested that changing the personal meaning of individual factors

that influence emotional dissonance can help lead to reconciliation. Nelson and Merighi

(2003) suggested that medical social workers experience emotional dissonance primarily

due to viewing workplace conflict as a personal shortcoming or failure rather than a result

of systemic influences that impede health care and social work practice. Nelson and

Merighi (2003) stated that continued research is needed to address emotional dissonance,

emotional resiliency, and how administrators can support social workers navigating

systematic shortcomings within workplace settings. This study also highlights the role

that personal values and perceptions of self can influence cognitive dissonance among social workers.

Cognitive dissonance within the perspective of this study occurred when social workers educated on harm reduction teachings and social work principles worked in abstinence-only substance use treatment settings. Such working environments may have conflicted with what they felt would be best client-centered treatment and align with social work teachings. Substance use can treatment settings create moral and challenging obstacles for social workers that led to incidents of cognitive dissonance regardless of their practice orientation. I expected to identify sources of conflict and identify themes that reconciling cognitive dissonance necessitates, therefore answering my question regarding how MSWs experience and reconcile cognitive dissonance related to harm reduction education and abstinence-only treatment practices.

Literature Review Related to Key Variables

The literature review identified the history of harm reduction in the United States and discussed the role of harm reduction in substance abuse treatment. The literature review addressed the role harm reduction has played in social work education as it has helped MSW students and professionals enhance client-centered treatment practices. The literature explored cognitive dissonance experiences among social workers in behavioral health settings and the impact of cognitive dissonance on social workers.

History of the Harm Reduction Substance Use Treatment Paradigm

Harm reduction focus on addressing drug-related health risks and decreasing mortality rates associated with drug use and high-risk behaviors rather than cessation of

drug use itself (Brocato & Wagner, 2003). Harm reduction approaches have existed in North America since the 1950s. Canada introduced methadone treatment in the 1950s as an alternative approach for treating opioid addiction, with the United Kingdom following suit shortly after this period (Souleymanov & Allman, 2016). Canada implemented harm reduction programs to support and protect individuals engaged in sex work. During this time, medical professionals began using MAT, integrated therapy, and opioid agonist medications to decrease substance use-related deaths or overdoses and help increase the users' daily functioning, rather than promoting the abstinence model. In the 1980s, European states implemented harm reduction programs such as safe needle exchange programs to decrease drug users' rapidly growing death and infectious disease rates. Souleymanov and Allman (2012) stated that, by 2009, over 84 countries worldwide had endorsed reduction treatments and policies. By 2009, Europe had 32 countries alone that utilized harm reduction treatments and services such as therapy, needle, and syringe programs (Souleymanov & Allman, 2009).

The harm reduction movement emerged mainly in the United States during the 1980s as human immunodeficiency virus, or HIV, became an epidemic sweeping the nation, leading to half a million deaths by 2000 (Centers for Disease Control and Prevention (CDC), 2001; Lessard, 2014). Harm reduction interventions were effective in lowering risks associated with transmissions rates of HIV and other high-risk behaviors such as unprotected sex. The idea was to reduce high-risk behaviors associated with HIV that drove transmission rates and other health issues such as hepatitis through education, access to resources, change severity and method of use, and other alternative practices,

rather than pushing abstinence from sex or drug use, which historically has not resulted in lower rates of drug use or unprotected sex (Lessard, 2014; Souleymanov & Allman, 2009).

The concept of harm reduction in the United States expanded since the 1980s, incorporating any high-risk behaviors that negatively impact one's life, but a significant focus remains centered on substance use, substance use treatment and related policies. Harm reduction offers an alternative approach to the moral, medical, or biopsychosocial models, noting that abstinence may be the desired goal for some but not pragmatic for others as each person has their own biopsychosocial factors that impact substance use and treatment outcomes (Bigler, 2005; Brocato & Wagner, 2003; Marlatt, 1998). Meeting clients where they are at and recognizing any change that reduces high-risk behaviors as a positive outcome is the essence of harm reduction.

While harm reduction programs focus on decreasing health-related risks, the nature of these programs also addresses increasing access to health care, housing, treatment, and social support. Even with decades of research suggesting harm reduction decreases these risks and lessens policy inequalities, American treatment practices struggled to implement these programs during this period, suggesting potential causation of the current opioid epidemic, poor regulation of resources, and ingrained societal views of addiction or substance misuse (Drucker & Crofts, 2017; Morrison, 2015).

Harm reduction models and its supporters understand the need to address all fundamental issues for change to occur. Harm reduction programs create a point of access to supportive, non-threatening services and maintain flexibility for peoples' unique needs

and abilities. Harm reduction methodologists understand that the ideal goal would be the complete cessation of use. However, any change leading to a better quality of life is welcomed. Although evidence-based research reflects harm reduction programs effectiveness, harm reduction practices remain limited or inaccessible in many substances use treatment settings (Rosenberg & Phillip, 2004). The harm reduction model aligns with social work standards by acknowledging and advocating for treatment services that foster client rights to self-determination and client's rights to treatment services qualified to meet their needs and has been applied to MSW education programs as a result (Estreet et al., 2017; Fenster & Monti, 2017). However, the utilization of harm reduction continues to hold a diversified position in substance use treatment settings, controversially.

Prevalence of the Harm Reduction Approach in Substance Use Treatment

Twelve-step or abstinence-only treatment approaches continue to represent the most common treatment approach in substance use treatment settings in the United States (Littrell, 2017; Rosenberg & Phillips, 2004; SAMSHA, 2022) Approximately 75% of detox inpatient treatment centers and various rehabilitation centers in the United States are founded on the model of abstinence practices (McKeganey et al., 2004; Tatarsky & Marlatt, 2010; SAMSHA, 2022).

Harm reduction approaches have become apparent in substance-use treatment settings today but have faced ongoing political and public conflicts. For example, harm reduction interventions addressing the risks associated with intravenous drug use started to gain traction in 1986 in Connecticut by establishing the first needle exchange program

(NEP) in response to the HIV/AIDS epidemic (Knittel et al. 2010). However, a federal ban on NEPs implemented from 1988 to 2009 slowed down the utilization and accessibility of NEPs because the ban ordered that these programs rely on funding from private dollars or donations. Controversial development and acceptance patterns such as this one are illustrated in other areas addressing NEPs, safe injection sites, and non-abstinence treatment goals in substance use treatment settings in the United States (e.g., Knittel et al., 2010; Madden, 2016; Souleymanov & Allman, 2016). Harm reduction intervention efforts between the 1990s-2000s have also addressed issues related to safe sex and condom distribution, methadone treatment services, and designated driver movements through groups such as Mother Against Drunk Driving and Designated Driver Program (Tatarsky, 2003).

Harm reduction therapy was developed in the 1990s by varying behavioral health professionals and researchers seeking to integrate key tenets of the harm reduction philosophy into individual and group therapy settings (Tatarsky, 2003; Vakharia & Little, 2017). Harm reduction therapy moves away from the moral, medical, or disease model and uses a client-driven, biopsychosocial, and trauma-informed model, meeting the clients where they are at and allowing them to determine pragmatic changes in their lives. The reduction model is thought to be effective when used on its own or with motivational interviewing, cognitive-behavioral therapy, and addressing both substance use and co-occurring disorders (Bigler, 2005; Tatarsky, 2003; Vakharia & Little, 2017). A benefit to the harm reduction model is that it supports clients in determining what changes they are ready to make, reducing the likelihood that clients are presented with unattainable

treatment goals or program expectations that they are not prepared, willing, or able to uphold.

In 2019, only 10% of the 23 million Americans struggling with substance use disorders engaged in treatment services (SAMHSA, 2019). This number has looked the same since 2014 (SAMSHA, 2019). Roughly 40% of those asked why they did not seek treatment, though they reported it as a need, stated it was because they were not ready to stop using, thus associating abstinence as a condition to engage in treatment services (Rosenberg & Phillips, 2003; SAMHSA, 2019). Research showed that approximately 15-28% of individuals do not return after the first treatment session, and 30% stop engaging in treatment services at the first month (Rosenberg & Phillips, 2003; SAMHSA, 2019). Reported factors for not returning to services were uncertainty with being abstinent, lack of client-driven treatment goals, poor rapport, or unsatisfactory professional relationships (Brocato & Wagner, 2003; Tatarsky, 2003).

There are instances where abstinence-treatment goals set unattainable objectives among substance users. Suppose clients are unable, uncertain, or unwilling to work towards abstinence. This expectation can reinforce clients' belief that they are incapable of change or worthy since they cannot meet an idealized treatment expectation. The harm reduction method diminishes the client's anxieties about minimizing one's severity of use and experiencing judgment, supporting clients to be more open about presenting problems and individualized needs at the start of treatment (Brocato & Wagner, 2003).

Due to its theoretical belief, the harm reduction treatment model can address the complications of reaching those who do not want to engage in abstinence treatment

services. The harm reduction method shares a similar epistemology to pragmatism, acknowledging that there is a need to reduce substance use-related health risks in a way that is effective (Lushin & Anastas, 2011). Lushin and Anastas (2011) discussed that harm reduction and pragmatism are more interested in fostering client strengths, addressing high-risk behaviors, and eliciting positive change. Recent research on harm reduction treatment therapy tends to show higher rates of sustained treatment engagement, reduced substance use, reduction of levels of risk associated with drug use, and increased daily functioning due to intentional focus on individualized needs and regard for stated needs (Lushin & Anatas, 2011; Tiderington et al., 2013). Since many individuals struggling with substance use disorders have complex environmental, psychological, and social circumstances, having a flexible and client-centered way of meeting these needs is critical (Lushin & Anatas, 2011). Harm reduction therapy and interventions have been shown to have similar long-term success rates as traditional treatment methods. However, its use in practice continues to face some reluctance within the United States among various providers (Futterman, 2005).

Davis and Rosenberg (2013) examined acceptability of non-abstinent treatment goals among addiction professionals in the United States. Davis and Rosenberg used a quantitative web-based questionnaire with a sample size of 931 American substance use counselors to evaluate the acceptability of non-traditional treatment goals based on alcohol or drug abuse, dependency, and the severity of the disorders. Results concluded that counselors tended to favor non-abstinence plans for alcohol abuse over dependence—this pattern applied to drug abuse and dependence but with lower

acceptance rates with both. Non-abstinence treatment goals conflicted with treatment philosophies or were viewed as ineffective treatment approaches. This research study drew attention to the acceptability of non-abstinence treatment goals among addiction professions in the United States and the extent that personal or professional treatment philosophies influence the utilization of harm reduction. Those with personal histories or experiences with addiction may have reservations or conflict with utilizing harm reduction approaches.

Rosenberg and Phillips (2004) used a quantitative study to determine the extent of acceptability and availability of harm reduction interventions in substance abuse treatment centers. Researchers mailed out a survey utilizing the Harm Reduction Attitudes Questionnaire to 500 substance use treatment organizations by random sampling. The study results concluded that over 50% of the respondent's reported acceptability of harm reduction interventions and would support controlled or moderate reduction of short-term or long-term goals among those struggling with substance abuse.

Lee et al. (2011), using a qualitative study, found that harm reduction workers believe that harm reduction and abstinence-only treatment approaches can be complementarily and increase positive treatment outcomes, but report uncertainty about the likelihood of integrated care due to opposition of harm reduction in traditional practice settings. Lee and O'Malley (2018) reported that professionals and clients argue that harm reduction approaches share a similar 12-step origin from the viewpoint that growth is measured in progress, rather perfection. Lee et al. (2011) noted that additional

study is needed to explore how other providers in varying treatment settings view a relationship between harm reduction and abstinence-based practices.

Rosenberg and Phillips (2004) found that providers face practice barriers in substance abuse treatment settings due to limited access to or use of harm reduction approaches. They found that participants viewed harm reduction as underutilized in working settings due to organizational beliefs that harm reduction did not align with organizational missions or philosophies. Other factors included a lack of resources or training to implement harm reduction approaches and worry about how non-abstinence treatment goals would affect the integrity of treatment for organizations.

Lee and O'Malley (2018) used a grounded qualitative research study with semi-structured interviews and open-ended questioning to describe previous treatment experiences of clients currently involved in harm reduction programs and what encouraged them to stay engaged in one treatment approach over another. The researchers found that clients reported negative treatment experiences in abstinence-only treatment settings. Some incidents included fear of termination of services if they did not maintain abstinence, lack of individualized treatment approaches, and feeling like they were participating in unauthentic treatment. Researchers also concluded that clients reported that harm reduction services allowed clients to feel more authentic, human, and acknowledged in addressing their needs. Lee and O'Malley (2018) suggested that harm reduction promotes a strengths-based perspective, lessening the cultural phenomenon that if one struggles with substance use, it does not assert that someone is incapable of change or lacks insight concerning the need for some degree of change. The researchers noted

that working in treatment settings that primarily utilize abstinence-only treatment approaches can create cognitive dissonance for social workers practicing humanistic principles of social work practice and working to endorse harm reduction approaches and holistic treatment methods. They suggest that examining the role of harm reduction in social work is warranted to further legitimize integrated treatment approaches.

History of the Abstinence-Based Substance Use Treatment Paradigm

Abstinence-based substance use treatment, including the disease model and 12-step therapy, is the preferred modality utilized in substance use treatment by behavioral health professionals (Rosenberg & Phillips, 2004; Tatarsky & Marlatt, 2010). This section will briefly review the disease model of addiction and 12-step therapy and then highlight current abstinence-based treatment practices among professionals.

The Disease Model

The disease model of substance abuse appeared in the United States between the 1930s and 1940s (Becoña, 2018). The disease model of addiction proposes that addiction stems from genetic dispositions and physiological brain changes over time as a person continues to use substances or engages in addiction-related behaviors due to activation of the brain's pleasure reward system (Becoña, 2018; Skewes & Gonzales, 2013). The model assumes that due to continued substance use, areas of the brain that control reward, rationality or decision making, memory, and impulse control, alter after continuous exposure to chemicals or behaviors (Becoña, 2018). The model views addiction as a health-related issue due to the combination of physical or chemical changes in the brain, genetic dispositions, pleasure reward responses, and the genetic risk for tolerance. The

model assumes that abstinence must be maintained due to the physical, brain, and behavioral changes resulting from ongoing substance use (Becoña, 2018). According to Skewes and Gonzales (2013), the disease model developed as a response to the moral and enlightenment model, which posed addiction as personal responsibility and choice. This model introduced a scientific understanding of addiction as an underlying, progressive disease that helps explain the development of withdrawal, tolerance, and overall behavioral changes that occur with addiction. This evidence helped reduce the judgment and stigma of substance use within the user and non-user populations (Skewes & Gonzales, 2013).

This concept has helped professionals in the field of addiction enhance psychoeducation in treatment and adapt treatment services to address more than behavioral interventions. This model introduced biological addiction components to the abstinence or maintenance of addiction, such as cognitive-based therapy, medication management, and recovery-based support, enhancing the range of support and treatment options for those that struggle with addiction.

A limitation of the model is that it does not account for variations among individuals with genetic dispositions that do not develop an addiction (Becoña, 2018). Moreover, the model then cannot account for why those without any genetic dispositions develop addictions. An additional limitation of this model is that it does not account for spontaneous recovery, those that can maintain recovery without additional support or treatment, and those that struggle with ongoing, chronic relapse (Skewes & Gonzales, 2013). More so, it encourages professionals to maintain abstinence-based treatment goals

that can hurt treatment outcomes and dismiss other psychosocial factors that may make abstinence an unrealistic treatment goal for many clients.

Twelve Step Facilitation Model

The 12-step facilitation approach is based on the medical model of addiction and is rooted in spirituality (Campbell, 2005). Drawing from the basic tenets of Alcoholics Anonymous (AA), 12-step facilitation therapy focuses on the three main goals: surrendering to the belief that addiction is out of one's control, increasing client involvement in AA, and brief yet, highly structured outpatient therapy sessions that emphasize AA practices and readings (Campbell, 2005). The therapy model identifies addiction as a chronic disease in which abstinence and fellowship are the determining sources for recovery. Some studies showed that individuals that engaged in therapy services with higher attendance at AA and positive treatment relationships were more likely to maintain sobriety in the following 3 months (Tonigan et al., 2003). Studies also suggested that professionals engaged in 12-step programming with positive experiences are more likely to encourage their clients to engage in 12-step groups, and as a result, their clients are more likely to engage in this such programming with positive experiences (Campbell, 2005; Tonigan et al., 2003). Comparatively, individuals who cannot self-identify with tenets of AA or build positive treatment relationships with professionals are less likely to engage in AA and have poorer treatment retention rates (Tonigan et al., 2003). This model may be effective for some clients who can identify with it; however, it may hinder clients from defining personal successes due to uniformity of treatment and predetermined ideas about successful treatment. Furthermore, it many

discourage professionals from using alternative treatment options that support client needs.

Prevalence of the Abstinence-Based Approach in Substance Use Treatment

The abstinence-based treatment approach accounts for nearly three quarters of treatment models used in the United States (McKeganey et al., 2004; Tatarsky & Marlatt, 2010; Rosenberg & Phillips, 2003; SAMHSA, 2019, 2022). In 2009, almost 75% of treatment centers use treatment approaches, including relapse prevention, cognitive-behavioral therapy, 12-step therapy, and motivational interviewing (SAMHSA, 2010, 2022). Treatment interventions often include random urinalysis testing, group therapy, recovery-support groups, and after coordination to support clients in maintaining abstinence. Professional experiences and sentiments often inform the use of abstinence-based treatment approaches in addiction (Campbell, 2015; Curtis & Eby, 2010).

Campbell et al. (2015) engaged in a randomized trial examining relationships between therapeutic alliance and treatment delivery fidelity with treatment retention in Stimulant Abusers to Engage in Twelve-Step (STAGE-12), a community trial of 12-step facilitation. Campbell et al. (2013) found that clinicians that endorsed 12-step approaches were less likely to endorse alternative therapy practices. Campbell et al. (2015) also found that that higher age demographics, education level, and willingness were factors that would predict whether a clinician was willing to utilized alternative treatment practices. The researcher suggested that graduate education opens the pathway for professionals to learn about more treatment approaches, thus explaining why those with higher education levels might be more willing to learn and utilize different treatment

approaches in practice rather than abstinence-based treatment (Campbell et al. 2015; Estreet et al., 2017).

Davis et al. (2017) examined counselors' acceptability of non-abstinent treatment goals for individuals struggling with co-occurring disorders. Researchers used a quantitative web-based questionnaire with a sample size of 751 American substance use counselors to rate the acceptability of non-traditional treatment goals based on various substance use disorders and mental health diagnoses. Findings concluded that individuals wanting to develop treatment goals centered on reduced use or non-abstinence based are likely to work with counselors who do not support or respect the client's self-determined goals.

Davis et al. (2017) highlighted consistency of findings with other studies examining providers' acceptance of non-abstinent treatment goals when looking at substance use disorders. Davis et al. (2017) provided findings that highlight providers' feelings of non-abstinent treatment goals; however, they did not focus on aspects that have influenced this perceptive for providers, such as education that can change these thoughts.

Davis et al.'s (2017) findings clarified to what degree addiction counselors do not support non-abstinent or reduction goals in treatment. Additional research is needed to help expand knowledge regarding if these perspectives change once training and education are completed and to what degree they stay the same after these interventions. Due to the lack knowledge, researchers do not know how social workers perceive experiencing cognitive dissonance with their harm reduction education and substance use

treatment centers that do not use or integrate harm reduction approaches, or how social workers reconcile cognitive dissonance.

Abstinence-based treatment practices are the most used treatment approaches today due to factors such education levels, the experience of professionals, acceptance of the treatment approach among professionals, personal histories concerning addictions, conflict related to organizational missions or philosophies with alternative therapies, and lack of resources or training on new approaches (Campbell et al. 2015; Davis et al., 2017; Rosenberg & Phillips. 2004). Higher education levels and graduates within the last two decades due to the increased knowledge of harm reduction, especially in social work graduate programs, may support the expansion and acceptance of using alternative treatments in substance use treatment practices potentially creating conflict in work settings.

Social Work Education and Harm Reduction

The NASW has endorsed harm reduction practices and interventions since the late 1980s (DiNitto, 2005; Wilson & Dorn, 2016). Social workers have identified the need for specialty practice for substance use and increasing education and training of addiction, harm reduction, and substance use (NASW, n.d.). Social workers formed *The Center for Social Policy* and *Practice Social Work Perspective on Drug Policy Reform* to share the responsibility of addressing and enhancing social work welfare and addressing issues like harm reduction (Vakharia & Little, 2017). The NASW has also included harm reduction practices as a part of the Standards for Social Work Practice with Clients with Substance

Use Disorders (NASW, 2013). Harm reduction as an intervention therapy and policy is also mentioned in manuals, textbooks, publications, and journals of social work.

The harm reduction approach aligns with social worker standards sharing similar core values such as self-determination, client autonomy, self-efficacy, and honoring the dignity and worth of a human being (NASW, 2003; Tatarsky, 2003; Vakharia & Little, 2017). During the last two decades the profession of social work has paid special attention to role of harm reduction education in higher education programs and its impact on social worker student's attitude and knowledge of harm reduction.

Estreet et al. (2017) assessed the extent that harm reduction education would alter students' attitudes after completing an intervention course module. Researchers conducted a mixed-method study between 2011 to 2015 with 124 master-level social work students. Students completed a 3-hour module centered on harm reduction philosophy and intervention, principally related to opioid use disorders. Estreet et al. used the Harm Reduction Attitude Scale pre- and post-completion of the module. Statistically significant findings showed that positive attitudes towards harm reduction interventions for opioid use increased posttest.

Estreet et al. (2017) highlighted consistent findings with other studies suggesting that social workers are more likely to have positive attitudes towards utilizing harm reduction methods and perceive it as beneficial for their clients after engaging in education training. Researchers noted that a gap in education among social work students was present. Some students reported having to take nonacademic classes to learn about substance use disorders or never completed an educational course that focused on

substance use and treatment approaches while in their graduate program. Estreet et al. reported concern with generalizability as the study's participants are exclusively master social work students.

Fenster and Monti (2017) explored if a 15-week education course changed 66 United States graduate social work students' attitudes regarding working with clients with substance use disorders and using harm reduction methods. Fenster and Monti (2017) engaged in a quantitative study with a pre-experimental, one-group pre-and post-test design. The measurement tool consisted of a 23-item survey developed from the Substance Abuse Attitude Survey and the Harm Reduction Acceptability Scale. Results found that after completing the education course, students moved from neutral to negative views of harm reduction principles and interventions to positive attitudes to utilizing a harm reduction approach with clients or in treatment services.

Moore and Mattaini (2014) examined the increasing need for social work students to consider alternative treatment approaches as more clients present for social work-related services, and abstinence-only methods may not always be effective. Using a quantitative study, the researchers conducted a random assignment study with participants in experimental or control groups with a convenience sample of 100 participants from an NASW New York City chapter members list. The Harm Reduction Acceptability Scale and the two-item response (pretest-posttest design) measure if students in the experimental group that received the intervention would have different attitudes posttest. Results showed that students in the experimental group shifted mindsets regarding the utilization of harm reduction approaches and reported an

increased openness to harm reduction approaches than students in the comparison group whose posttest indicated less open-mindedness toward the idea of utilizing harm reduction approaches. The study found that social workers working with clients with substance use far outweigh other behavioral health professionals working with the same population and that education on harm reduction leads to positive feelings about using these interventions in practice among social workers (Moore & Mattaini, 2014).

Similarly, Senreich and Straussner (2013) examined MSW student's attitudes and knowledge about providing treatment services to those that struggle with substance use. They found that MSWs students that completed a specific substance use disorder course predicted modestly higher positive attitudes with working with those that struggle with substance use. Their research also noted that MSW students that had personal experience with substance use reported a positive attitude toward substance users.

Some studies showed that social work students may have negative feelings towards those that struggle with substance use or with harm reduction approaches based on personal values, experiences, or attitudes about the effects substance use has on children of substance users (Eversman, 2012). Furthermore, a few studies showed that social workers who do not have education on substance use and harm reduction approaches within their graduate programming may have varying views and acceptability toward those that struggle with substance use and may preference abstinence-only treatment approaches over harm reduction (Eversman, 2012). However, regardless of the direction, it was of value to understand the role that education has informing social workers about harm reduction and its relation to the social work profession; moreover,

how social work education informs MSWs' perceptions of harm reduction and dissonance in the workplace, as a result.

Gaps in the Research

The research gaps included a lack of studies that explore cognitive dissonance and reconciliation among social workers working in addiction treatment settings that endorse harm reduction approaches based on their education and professional standards. Existing literature provided some understanding that social workers with harm reduction education are more likely to endorse harm reduction practices and experience conflict related to their education and abstinence-only practice settings but did not address what social workers should do when faced with such cognitive dissonance (Estreet et al., 2017; Fenster & Monti, 2017). Research also indicated that harm reduction philosophies in treatment lead to better treatment outcomes when integrated into substance use treatment practices, but traditional practices continue to be the preferential treatment approach (e.g., Gallagher & Bremer, 2018; Lushin & Anastas, 2011; Tiderington et al., 2013). Existing research also provided insight into the experiences of social workers in various fields such as health care and child welfare and how ecological factors and organizational processes create dissonance with their social work values and standards and report that further study is needed to explore how to address and lessen dissonance among social workers in the workplace (Burke, 2017; Nelson & Merighi, 2003).

Summary and Conclusions

More research was needed to understand further how social workers reconcile cognitive dissonance related to their education and professional roles. We knew that

social workers in various fields experience dissonance due to their professional standards or education misaligning with societal, organizational, or systematic processes, not unlike socials workers working in the field of addictions (Brocato & Wagner, 2003; Taylor, 2005). Yet, we did not know how MSWs experience and reconcile conflict with their social work education that supports harm reduction approaches while working in traditional use treatment settings. We could not say for sure that social workers find themselves able to reconcile such conflicts or in what way conflict was occurring. Research that focused on how social workers experience and reconcile conflicts of this nature was necessary so researchers could utilize the knowledge gained from this study to highlight challenges, successes, or other factors associated with social workers reconciling conflicts related to their education and professional treatment settings. By conducting a qualitative research study using semi-structured individual interviews with MSWs, it granted participants the opportunity to share their experiences of cognitive dissonance and reconciliation efforts. I address the research design and data collection methods used in the study in Chapter 3.

Chapter 3: Research Method

The purpose of this exploratory generic qualitative study was to understand how master-level social workers (MSWs) experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. I used a generic qualitative approach to gather data via individual interviews with MSWs who had experience working in substance use treatment centers and with harm reduction approaches. I asked participating MSWs about their working experiences and the reconciliation of cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. The chapter starts with a review of the research design and rationale of the study. Next, I review my role as the researcher for this study. The chapter proceeds with an examination of the methodology, including recruitment, participation, and data collection. Issues of trustworthiness and ethical procedures are emphasized prior to the summary.

Research Design and Rationale

The RQs for this generic qualitative study were

RQ1: How do master-level social workers experience cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

RQ2: How do master-level social workers reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

Experiencing cognitive dissonance and reconciling conflicts are everyday experiences in the social work profession, often causing strain and hardship in the workplace (Taylor, 2007; Taylor & Bentley, 2005). In conducting this generic qualitative study on how MSWs experience conflict and reconcile cognitive dissonance related to harm reduction education and abstinence-only practice, I sought to broaden understanding of this phenomenon and identify themes occurring within this topic. Cognitive dissonance theory was used in this study to explain cognitive dissonance and how it occurs among MSWs with harm reduction education who work in treatment settings. Cognitive dissonance theory explains that conflict occurs when two cognitions or action are inconsistent with another; it also explains why individuals are motivated to resolve dissonance and in what ways they may go about resolving conflicts (Cooper, 2012). Harm reduction education, for the purpose of this study, centered on education provided in MSW programs and in trainings that address the philosophy of harm reduction and harm reduction methods and concepts. The aim of the study was to enhance understanding regarding the disconnect or integration relating to harm reduction and abstinence treatment (Fenster & Monti, 2017). Abstinence-based treatment is defined as a treatment approach that favors abstinence as the customary outcome for substance use treatment goals (Futterman et al., 2004). Many social workers may have abstinence-based orientation which can conflict with the more recent integration of harm reduction in social work practice (Davis & Rosenberg, 2013; Rosenberg & Phillips, 2004). New social workers with harm reduction education may experience conflict with tradition practices that preference abstinence-based treatment.

One of the most prominent similarities among qualitative research approaches is their disciplinary roots or origins (Creswell, 2016). Anthropology, philosophy, sociology, and other social sciences are disciplines with commonalities in terms of qualitative methods. This relationship is understandable because qualitative researchers desire to understand human experiences and how one gives meaning to human affairs (Percy et al., 2015). Although sampling and data collection processes vary by design, the fundamental goal of qualitative research is to gain understanding through analysis of people's words, actions, or behaviors (Creswell, 2016). Whether conducting an ethnographic study, engaging in participant observation to cultivate an account of a community, or conducting semistructured interviews to describe or explore a phenomenon, a researcher gain insight by learning about and analyzing others' words, actions, or practices. What separates qualitative approaches is the purpose of the RQ and what a researcher must do to best answer the true nature of the question (Creswell, 2016).

For this study, I used a generic qualitative approach in which I conducted pre-structured individual interviews to understand the working experiences of MSWs in substance use treatment centers. This research approach aligned with the qualitative individual interview methodology by providing individual settings that promoted conversations concerning professional perceptions and experiences. Zucker (2009) stated that generic research is appropriate when a researcher explores, describes, or interprets experiences.

The use of a generic qualitative approach helped me understand, on a broad level, how participating MSWs interpreted working experiences and how they reconciled

cognitive dissonance with their harm reduction education and abstinence-only treatment approaches. Furthermore, because of my professional experience and the preexisting knowledge I had using the generic approach provided the flexibility to discuss subjectivity, use the ongoing practice of reflexivity, and act as a research instrument (Percy et al., 2015). Last, a generic qualitative approach allowed me to use purposeful sampling and inductive analysis to examine participants' accounts of their experiences of reconciling cognitive dissonance (see Percy et al., 2015).

Other qualitative methodologies would not have been appropriate for this study. Case studies require in-depth inquiry that facilitates the exploration of a phenomenon as it naturally occurs; the researcher uses various data sources collected at a specific moment or time or throughout a particular period (Baxter et al., 2008). Case study researchers examine in-depth the how or the why of research questions concerning a specific subject or comparable subjects of more considerable size and range. The aim of the grounded theory approach is to find the emergence of theories based on data induction and explain differences and similarities among concepts found in the data. One principle of grounded theory is letting essential themes form rather than forcing them into predetermined categories. Because I had some preconceived thoughts about what might be happening relating to the topic of study, I concluded that grounded theory was not appropriate as it requires researchers to suspend all preconceived notions about what might be occurring and remove any focus on identifiable issues (Evans, 2013). In conclusion, the generic qualitative approach was an appropriate option to answer this study's RQs.

Role of the Researcher

I was a data collection instrument in this study. As a current licensed independent social worker (LISW), I had 9 years of experience exploring my position, responsibilities, and experiences in the social work profession and the field of addiction. My understanding of harm reduction and social work has evolved during that time frame. Significantly, my knowledge expanded beyond initial values and insights regarding the relationship and conflicts between harm reduction, social work education, and commonly provided and endorsed substance use treatment practices. As a novice social worker, I often used abstinence-based treatment approaches when working with clients in substance use treatment settings, without challenging what the driving factors of this approach was, thus accepting the status quo of addiction treatment practices. Many of my colleagues, during my early years of practice, preferred the abstinence-based model, so it appeared to be the standard. My view of consensus related to harm reduction and abstinence-based treatment was also limited. However, as my knowledge and experience grew, I struggled to ignore the conflicts and congruencies between social work standards and traditional treatment practices. I began looking into why abstinence-based treatment practices are the most utilized in substance use treatment settings and factors that encourage this practice. I began to question what encouraged some social workers to preference one approach over another or if there could be integration between the two approaches.

Bigler (2005) encouraged social workers to reflect on substance use practices through the lens of harm reduction and social work education and values. I found that

social work values naturally align with harm reduction as both practices are person-centered, humanistic, and focus on improving one's overall being and quality of life. Over the years, I have found the importance of being flexible with treatment modalities as social workers need to consider treatment approaches that best fit client needs independently. This approach at times could be abstinence-based treatment, and other times, it could be harm reduction or other holistic approaches. However, abstinence-based practices continue to overshadow other evidence-based practices (Brocato & Wagner, 2003; SAMSHA, 2020).

Because of my position as the data collection instrument, a novice researcher, and a social worker, I considered that these aspects might create bias regarding the interview process and analysis. I kept a reflexive journal to manage and lessen researcher bias throughout the study. Engaging in reflexive journaling was vital throughout the study as it allowed me to record all my emotions, thoughts, and questions, which otherwise could impact the research study and outcomes. I also engaged in member checking, asking the participants on volunteer bases to review the data collected and interpretations of the interviews to verify data accuracy and manage any potential researcher bias. Last, I worked to develop rapport and trust with each participant by demonstrating thoughtfulness, compassion, and openness during each interview. Appendix A contains the interview guide that I followed.

Protecting participant privacy is a primary ethical principle of qualitative research (Morse & Coulehan, 2015). Ethical considerations regarding adequate procedures to ensure participant confidentiality are not without controversy. Morse and Coulehan

(2015) state that removing or changing the names in a study is often not enough to protect a client from being identified. They posit that elements such as keywords, demographic tags, and descriptive disclosure of site locations all put a client at risk for violating confidentiality. One example they used to describe ways a participant is at risk of privacy violation is that when you couple small sample sizes and unique populations, special interest or private parties may have motivating interests to identify specific participants. I considered how to safeguard participant privacy in this study. I recognized the importance of creating a safe environment virtually where participants could express themselves openly and share all thoughts, experiences, and processes of reconciling cognitive dissonance related to harm reduction education and abstinence-only treatment practices. To ensure privacy, I thoroughly informed the participants of privacy risks, including confidentiality, disclosure, the interview process, the interview's purpose, and the interviewer's intended use of data.

Last, I did not conduct interviews in current or past work environments or hold a supervisory role that would have created a noted power difference. There were no private funding sources or partnerships that might impact my role as a researcher or engagement considerations among participants. I informed participants that I was a doctoral student at Walden University, along with the purpose of this study in terms of my program and degree trajectory. I removed all identifying information relating to states, names, and places of employment to reduce the risk of privacy breaches.

Methodology

This study was a generic qualitative study. Data were collected through guided

semi-structured interviews with MSWs. As generic qualitative research focuses on broad

representation rather than in-depth analysis, the sample size consisted of eight

participants to represent the selected population (Percy et al., 2015). Data saturation was

attained when new themes no longer appeared during the interview process. I used

purposive sampling for the interviews, seeking out professionals that were a part of this

experience and could provide real-world reflections. Each interview was allotted up to 60

minutes to ensure adequate time for interview question, with respect to participant's time.

Participants received a $15 gift card via email as an incentive for engaging in the study.

Based on the population of study, the monetary value of the gift card was not coercive,

nor did it bribe participation. MSWs with harm reduction education currently working or

who have worked at abstinence-only treatment centers are the individuals who could

provide a meaningful and broad reflection of reconciling cognitive dissonance of this

nature through real-world knowledge.

Participant Selection Logic

Recruitment of MSWs did not utilize partner organizations, rather websites, social

media platforms such as Facebook groups, and posted ads published on social work-

specific forums such as one dedicated to Iowan social workers, or social media pages

such as Iowa Mental Health Providers or Become a More Effective Therapist. Interviews

were not conducted in clinical settings or at work locations. There are benefits of using

partner organizations or community gatekeepers because these environments may often

be "participant rich," and using organizations or informational gatekeepers can help focus on highly desired participants can ease the recruitment process and duration of time it takes to meet data saturation (Archibald & Munce, 2015). However, limitations of partner organizations or community gatekeepers are that the participants invited may already be overloaded by those seeking them to engage in research studies, struggle with being invited to engage or informed about the study by those in supervising positions, and it may not encourage or reach those in typical or non-traditional MSWs roles to engage in the study (Archibald & Munce, 2015). When posting online in open public forums or groups, I did not anticipate needing permission to distribute the invitations. I also used the Walden Research Participant Pool as a recruitment tool, after receiving approval from Walden University.

I included inclusion criteria in the online recruitment posting and in the informed consent. Participants who could not interview in English were excluded from this study since I am not fluent in additional languages and do not have access or resources for a translator. The exclusion criterion was implemented to ensure ethical participant and consent, protection of interviewees, and accurate representation of the data. MSWs with less than 1 year of experience and under 21 years old were also be excluded. Since the population of focus was MSWs, this program degree was a participant requirement. There were no exclusion criteria for the study based on gender, race, sexual orientation, ability, religion, or ethnicity.

Instrumentation

In this qualitative research study, I was an instrument for the study. I also utilized additional tools to conduct this study. The first instrument utilized was an audiotape recorder feature on Zoom. A recorder allowed me to record the interview while attending to and maintaining a connection with the participants. I focused on decoding the participant's words afterward. The second tool that I utilized was a semi-structured qualitative interview guide (see Appendix A) created to help answer the RQs for the study. I used Zoom to transcribe the recordings into a verbatim transcript. I also used Excel spreadsheets to hand scribe corrections and to complete the coding process using the words and expressions verbatim from participants. This approach can reduce issues with the trustworthiness and validity of the data. Excel spreadsheet was also used to track and record the times and date of all interviews with a unique id number. I utilized personally scribed notes and reflective journaling in a notebook.

The purpose of utilizing interviewing for this study was to understand the meaning social workers provided related to experiences of cognitive dissonance between their education and substance use treatment settings and reconciling cognitive dissonance related to their harm reduction education and abstinence-only practice. When formulating interview questions, I attempted to be aware of open-ending structuring, personal bias or leading questions, the terms or language used, and the clarity of the questions asked (Turner, 2010). I structured questions that emphasized social workers' views of harm reduction and abstinence, highlighted working experiences with abstinence-only treatment and harm reduction practices, and that aimed to investigate the presence of

conflict or lack thereof related to harm reduction and abstinence approaches. Questions aimed to examine the experiences of potential reconciliation of conflict related to harm reduction education and abstinence-only practices (Taylor, 2007).

Because I could not presume that the conflicts were one-directional, I formulated the questions to allow social workers to share negative or neutral feelings about either harm reduction or abstinence-only practice (Turner, 2010). I also formulated questions that could explore the presence and extent of cognitive dissonance and whether social workers expressed a desire to resolve these conflicts (Jensen, 1979). Last, I explored how other qualitative research articles on harm reduction, abstinence treatment, and provider acceptance developed their interviewing questions for some direction and insight when creating the qualitative interview guide (Davis & Rosenberg, 2003; Lee et al., 2011; Rosenberg & Phillips, 2004).

Procedures for Recruitment, Participation, and Data Collection

I identified participants through purposive sampling, which is the process of selecting individuals or groups of individuals that are knowledgeable and experienced regarding the identified phenomenon (Etikan et al., 2016). I posted a flyer to various social media sites to connect with MSWs that had worked in substance use treatment settings for at least one year. Participants did not currently have to be working in a substance use treatment centering to engage in the study. I included inclusion criteria on online postings along with my contact information. Potential participants contacted me by email expressing interest of engagement. Participation screening occurred through email responses, with participants making initial contact with me. Participants who did not meet

the inclusion criteria were thanked for their willingness to engage in the study. Once confirmed that a participant met the inclusion criteria, they were emailed an informed consent form for review. They replied to the email with the words "I consent" to verify consent. After receiving inform consent from participants returned via email, I reached out to the participants with potential time and dates for Zoom interviews and confirmed interview meetings. I contacted the interviewees by email to complete the member checking step after transcription and coding. In the email I shared interpretations from participants interview via email so the participant could confirm whether my interpretations were accurate. None of the participants expressed concern with my interpretations. The sample consisted of eight participants. I continued the recruitment process until at least eight study participants were recruited allowing me to achieve data saturation (Percy et al., 2015).

I collected data using the Zoom audiotape recorder feature. All interviews were conducted individually over Zoom over a 2-month period, with me acting as the sole researcher in this study. To ensure preserve privacy and participant confidentiality, I conducted virtual interviews via in a private office was I was alone. Each interview was allotted 60 minutes with time reserved at the end of the interview so that the interviewee could ask any follow up. I used the Zoom transcription feature to transcribe responses. I shared with participants the Zoom transcripts of the data during follow-up. I did not include any personal identifying information relating to the participants, including names of the participants, graduate programs, currently states the participants lives in or past or current working institutions. All interviews were assigned a unique identifying

participant number. I informed each participant how I would code and secure the data at the end of each interview. I allowed each participant to review the data collected and interpretations to verify data accuracy and manage any potential researcher bias as a follow-up. Last, after the interviews, I engaged in notetaking to write down initial impressions, biases, and interpretations. Recruitment did not result in too few participants, so I did not have to debrief with my committee on how to enhance recruitment efforts.

Data Analysis Plan

I used Zoom transcription feature to create verbatim transcripts of all interviews. I used inductive analysis, specifically thematic coding, and developed codes based on the common themes and patterns in the data provided by participants. Developing codes from the participants' words allowed me to manifest the experiences of reconciling cognitive dissonance based on direct words or quotes (Percy et al., 2015). I started analyzing the data by gathering all interview materials and handwritten notes and reading the material to get a sense of what is depicted. I examined all transcribed notes to begin formulating initial codes in an Excel spreadsheet. I reviewed participants' answers several times while comparing my handwritten notes to accurately describe what was communicated about participants' experiences and insights. Then, I took this information and begin formulating categories move to themes. Themes are distinguished as underlying aspects of social issues or phenomena. Themes describe "what might be happening." Themes are the answers to the RQ(s) (Saldaña, 2016). I arrived at the final themes theorized from this analysis that answer how MSWs experience and reconcile cognitive dissonance related to

their harm reduction education and abstinence-only practice in substance use treatment settings. I engaged in reflective journaling and used my committee members to reduce issues with biases and subjectivity during data collection and analysis. Discrepant cases utilized in the study and supported answering the study's RQs.

Issues of Trustworthiness

Trustworthiness consists of four components, which are credibility, transferability, dependability, and confirmability. Shenton (2004) states that the process of ensuring credibility happens when "investigators attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented" (p. 63). In other words, credibility asks if one's findings align with what is really happening. One technique that I utilized in this study to ensure credibility was initial coding to evaluate the codes with a comparative review. I also engaged in member-checking, following up with participants and allowing them to review data collection and interpretations of the data.

Transferability, or the degree that one's study results hold true in other circumstances, is another way to support trustworthiness in qualitative research (Shenton, 2004). For this study, I discussed data collection methods, ethical considerations, researcher subjective, participant attitudes, and the time, location, and size of the study (Shenton, 2004). By providing readers access to this information, they can understand the research process and results and how or in what ways it transfers to their study, investigation, or participants experiences (Shenton, 2004).

Dependability is the scope that similar results would occur if the same data method, process, participants, and analysis were performed (Shenton, 2004). One way to

ensure dependability is to include the research design and its implementation within one's

study (Shenton, 2004). I shared in-depth the research design, data collection instruments,

analysis, and the coding process to promote dependability.

Confirmability is the presence of neutrality and specified efforts in a study to

manage and reduce the impact of researcher bias and subjective. I used reflective

journaling and thematic coding to ensure confirmability. These strategies helped ensure

that the data sources were analyzed with minimal bias.

Ethical Procedures

I submitted the Walden University Institutional Review Board application after

successfully meeting the initial oral defense requirements. After a thorough review of the

application and one revision request, the Board granted its approval to conduct the

interviews. Walden University's approval number for this study is 07-15-22-1004892,

with expiration date of July 14, 2023. The final approval informed consent form was

provided to each social work participant that engaged in this study. The informed consent

totaled 3 pages in length; ensuring all critical components were reviewed and included.

While social workers are not outright a vulnerable population, social workers often work

with vulnerable populations and under challenging settings; therefore, ethical

considerations were examined significantly due to the topic of study. This study did not

seek out MSWs that have a personal history of substance use. However, I acknowledged

that this is a potential issue that may arise when seeking out participants as those with

personal histories relating to addiction may enter the field as professionals. Due to the

ethical principles and standards of the social work profession, I assumed that all MSWs

have or were engaging in self-care practices to ensure best practices to clients,

colleagues, and communities and not currently struggling with active addictions. While I

did not intentionally plan to recruit professionals I know personally, three Midwest

providers decided to engage in this study. I engaged in conversation with them about

their rights concerning engagement and withdrawal, along with my professional

standards and commitment to creating a safe, confident, and comfortable environment.

Neither participant expressed any concerns with engaging in the study.

    The questions asked during the interview process were not expected to cause any

harm or distress that would be greater than ordinary day to day stressor individuals

experience. I reviewed all risks and benefits of engaging in the study as outlined in the

informed consent form. I reviewed confidentiality with all participants and informed

them that personal-identifying information would not be used during data collection,

analysis, and reporting. Interviews were assigned a unique identification number.

Participants were informed prior to the study that all engagement is volunteer based. I

reviewed that if participants decided to engage in the study, they were allowed to change

their mind later and that they could stop participation at any time. I did not contact

participants unless they sent an email expressing initial interest in the study or sent a

message asking for additional information regarding the study. I followed up with all

volunteers to inform them whether they were selected for the study.

    I followed all ethical procedures during the recruitment of possible participants by

publishing a posting that advertised the study in professional online forums or social

media outlets. If any potential participants met the study's criteria after expressing

interest, I emailed the informed consent form before the interview and waited to receive written consent before continuing with the interview process. I reviewed the purpose of audio recording the interviews and how the data would be utilized and stored. Participants received sample interview questions and details about the study before the interview as outlined on the informed consent. These actions aimed to help participants with preparation and ease any anxiety about engaging in the study.

All data and forms were stored in a private home office in a locked file cabinet. I was the only person that had access to the data and knowledge of its stored location. The laptop utilized required a password to grant access. Any handwritten material such as notes, or a journal were also locked in the secure cabinet. Data collected from this study will be kept for at least 5 years, as the university requires, and will be destroyed after 5 years. Data will be securely deleted from my external hard drive by pulverizing the hard drive. Any notebooks or papers will be shredded and then cross-shredded. The interview did not uncover any unreported felonies or issues related to mandatory reporting such as abuse that would have necessitated reporting to the proper authorities.

<div align="center">**Summary**</div>

This generic qualitative study attempted to acquire a deeper understanding of cognitive dissonance occurring among MSWs with harm reduction education that have worked in abstinence-only substance use treatment settings. I recruited eight participants and complete individual interviews to collect data. To remain in compliance with Walden University's Institutional Review Board policies and procedures, I did not engage in research activities prior to gaining approval. Chapter 4 includes a summary of results.

Chapter 4: Results

In this generic qualitative study, I sought to understand how MSWs experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. In this chapter, I discuss the setting and demographics of participants, describe the data collection process, and present evidence of trustworthiness and the study's results. The RQs for this generic qualitative study were

RQ1: How do master-level social workers experience cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

RQ2: How do master-level social workers reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings?

Setting

I used three means to recruit the study's eight participants. The first approach involved use of the social media platform Facebook. I posted an initial recruitment flyer to four individual Facebook groups: (a) Iowan Mental Health Providers with 1,100 members; (b) Become a More Effective Therapist with 19,000 members; (c) Walden University Doctoral Social Work, Human Services, and Counseling with 216 members; and (d) Training Resource Group for Mental Health Professionals with 13,00 members.

Each group had an active and sizable membership and was purposive to the participant inclusion criteria for this research study.

The second approach involved using Walden University's Participant Pool, for which Walden's Institutional Review Board and Participant Pool Administration provided their approval. I completed a required form, providing a description and the purpose of my study, which the Participant Pool Administration then posted on their website. Last, I requested that the recruitment flyer be posted on a local online social worker forum run by northeastern Iowan social work educators and behavioral health providers. Due to the small and unique nature of this forum and concern with confidentiality, I am not identifying the group's title.

On July 16th, 2022, I posted the recruitment flyer to the following Facebook groups: Iowan Mental Health Providers; Become a More Effective Therapist; and Walden University Doctoral Social Work, Human Services, and Counseling. I posted the recruitment flyer on the Training Resource Group for Mental Health Professionals on July 24th, 2022. Upon my initial postings, I received four responses from participants, two of which resulted in screening, informed consent, and interviews. Within the next 2 weeks, two more interviews were conducted after screening and consent were completed. Within the first month, I received six different inquiries about the study, which did not result in participation. Interviews did not occur because the inquirer did not provide consent, they did not meet inclusion criteria, or the respondent replied via email to indicate their interest in study participation but never followed up to set an interview time. By the middle of August, I had completed a total of six interviews with participants.

In September 2022, I conducted the final two interviews for the study. Participants initiated all initial injuries, whether they resulted in an interview or not. The final sample size was eight participants. Two participants were from Iowan Mental Health Providers, three participants were from Become a More Effective Therapist, two participants were from the local online forum for Iowan social workers and educators, and one was from the Walden University Participant Pool. The geographical locations where specific respondents were recruited appeared to influence the content of their responses. Some participants were from larger cities either in the South or on the East or West Coast, where access to harm reduction treatment approaches was more prevalent. The legalization or decriminalization of substances in some states influenced treatment referrals, evaluation, planning, and outcomes for clinicians and clients. Participants in the Midwest or rural areas noted less access to various harm reduction treatments and interventions. Regardless of geographic location, all participants reported experiencing stigma and or harm reduction issues, whether with families, communities, or the larger society.

The disclosure of demographics included years in a position, years working in the professional field, or years postgraduation from an MSW program. To protect study participant identity and mitigate any potential bias when interpreting results, I did not collect demographic data such as race, ethnicity, religion, race, gender, and sexual orientation. As a result, to refer to study participants, I use the singular "they," "their," and "them," as well as their participant ID (e.g., P1, P2).

Demographics

All the study participants were 21 years or older, had graduated from an accredited MSW program with elements of harm reduction and substance use education, and were currently working or had worked in substance use treatment settings for at least 1 year. I recruited participants from across the United States. In this section, I provide a profile of each participant.

P1 was a licensed clinical social worker and licensed clinical professional counselor with 4 years of working experience as an MSW with a total of 7 years of experience working in addictions. Their experience included working at a MAT program that primarily prescribed methadone, Suboxone, and buprenorphine. They then worked for the local hospital system with pregnant women who used opiates, after which they moved to an intensive, specialized female outpatient program. This work centered on helping pregnant and parenting women with dependent children.

P2 was an LISW with 14 years of experience working as an MSW. They worked as an addiction therapist for 7 years providing group and individual therapy. During this time, they also facilitated courses centered on prevention education. They also worked with their local drug court team, working with women in the program who were engaged in therapy services. They had worked as a college counselor and outreach educator for the last 7 years. At the time of the study, they were working in private practice, providing therapy and attention-deficit hyperactive disorder coaching.

P3 was a licensed clinical social worker and certified alcohol and drug counselor (CADC) at the second level of certification (i.e., CADC-II) with 13 years of working

experience as an MSW. They worked as a therapist providing functional family therapy and alcohol and drug treatment to children and families. They then moved to private practice and continued providing treatment. They also provided family therapy with a local juvenile corrections department in which engaged in cognitive behavioral therapy and generalist social work. They held a director position in a community program for substance use for 6 years. They then moved into nonprofit management, working with a Health Resources and Services Administration opioid implementation grant providing Suboxone, Sublocade, primary health care, and outpatient substance use treatment. At the time of the study, they worked in a macro-level position with the state doing behavioral health planning.

P4 was an LISW and CACD with 10 years of experience working as an MSW in addiction treatment and programming. Their professional experience included working as an addiction counselor for those who struggled with substance use and gambling disorders, facilitating intensive outpatient care, extended outpatient care, and individual therapy. They also worked with a local drug court, engaging with women in the program and facilitating an outpatient women's group. They also worked as a lead counselor providing clinical reviews for counselors and reviewing documentation. At the time of the study, they held a supervisory/director role and maintained a small client caseload. They also provided supervision for LISW candidates and supervision for certified alcohol and drug counselors.

P5 was a licensed master social worker (LMSW) with 31 years of experience working in addiction treatment. They worked in an abstinence-based treatment center,

providing group therapy for families, along with intensive outpatient services. They also engaged in MAT services, conducted evaluations for those charged with operating while under the influence, and provided education courses for individual charged with domestic abuse. They worked primarily with families addressing the impact of relationships and addictions.

P6 was an LMSW and CACD with 6 years of experience working in addictions as an MSW. They had worked in field of addictions for a total of 18 years. They held the role of a director of a halfway housing program. They then moved to a clinical director position at an outpatient, residential recovery service. They moved to school social work while working part-time in substance use treatment with co-occurring disorders. Before obtaining an MSW degree, they worked as a residential counselor at a women's and children's treatment program, provided patient support at a dual diagnosis residential center, had a part-time position in which they performed mobile crisis work, and worked at a MAT treatment center.

P7 was an LMSW and CADC with 2 years of working experience. They worked at a methadone clinic for a year and a half. At the time of the study, they worked in their local school district as a school-based therapist. P8 was an LMSW and CADC with 5 years of working experience in addictions. They worked in an outpatient methadone clinic and their local county jail. At the time of the study, they worked for adult protective services; in the position, they used harm reduction methods.

Table 1 provides an overview of current professional credentials participants held in addition to having an MSW degree, and Table 2 provides a summary of participants' years of experience as a master-level social worker.

Table 1

Summary of Participants' Professional Credentials

Type of licensure	Frequency
Licensed Master Social Worker (LMSW)	4
Licensed Independent Social Worker (LISW)	2
Licensed Clinical Social Worker (LCSW)	2
Licensed Chemical Dependence Counselor (LCDC)	1
Certified Alcohol and Drug Counselor (CADC)	5

Table 2

Summary of Years of Experience as a Master-Level Social Worker

No. of years of experience	Frequency
0-5	3
6-10	2
11-15	2
16-20	0
21 or more	1

Data Collection

Using a purposeful sampling strategy, I obtained a sample of eight participants. The sample size for this study was consistent with other basic qualitative research studies where data saturation was met (Kahlke, 2014; Percy et al., 2015). Data saturation is met when little or no new insights or experiences are gathered during data collection and analysis. Data saturation occurred with a sample size of 8, which is the approximated sample size suggested in Chapter 3.

A recruitment flyer was posted on a total of 4 social media sites and one online forum for social workers. Walden University's Participant Pool was also utilized in this study. Any interested participants made initial contact by emailing me about engaging in the study. Any participants who did not meet the inclusion criteria were thanked for their willingness to engage in the study. Once confirmed that a participant did meet the inclusion criteria, I emailed the informed consent form for review. After reading the form, they replied to me via email with the words "I consent" to verify consent. After receiving informed consent from participants returned via email, I reached out to the participants with potential times and dates for a Zoom interview. I then confirmed the 1-hour interview based on their availability. Each interview started with an introduction reminding participants of the purpose of the study, the voluntary nature of the study, the risks and benefits of being in the study, payment for the study, privacy rights, and the process for follow-up. Two participants were from a social media site called Iowan Mental Health Providers, two were from the local online forum for Iowan social workers
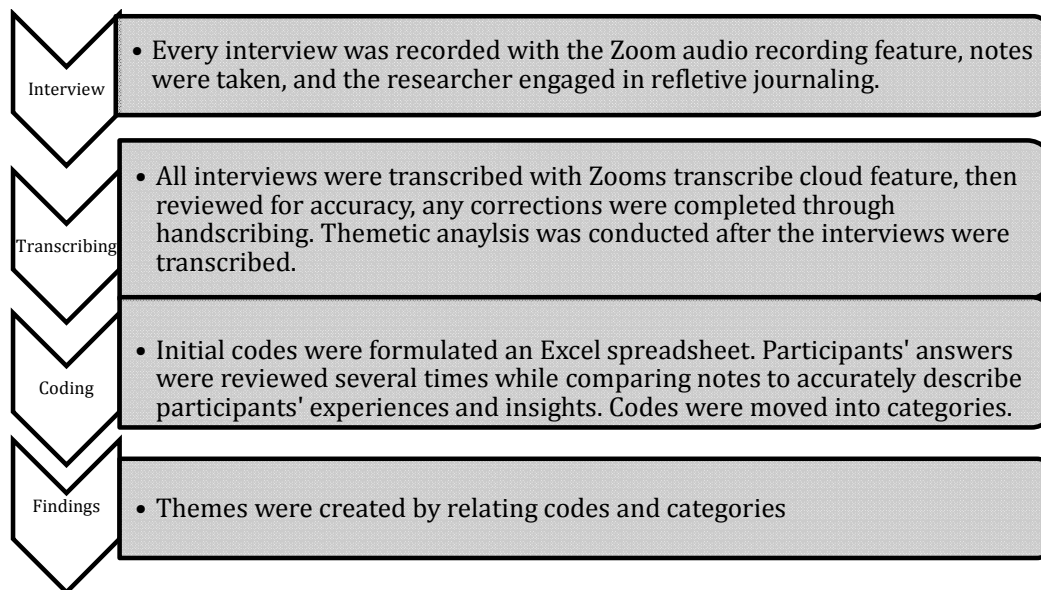
and educators, and three were from a social media site called Become a More Effective

Therapist, and one from the Walden University Participant Pool.

On one occasion, I worked with one participant to reschedule the time and date of

an interview due to the participant having a work-meeting conflict. Another participant

needed to reschedule due to a personal scheduling change. All other interviews were

conducted as scheduled. One participant had trouble connecting to Zoom, so I worked

with the interviewee to help them proceed with engaging in the interview. They were able

to engage and complete the interview in the allotted hour. No other issues occurred

during data collection.

<div align="center">

Data Analysis

</div>

All interviews were conducted in a private office and recorded via Zoom with

participant consent. Interviews were recorded by enabling audio transcription in Zoom, in

which the interviews were saved as cloud recordings with downloadable transcripts. The

research reviewed each transcript for transcribing errors and corrected them manually, if

found. Hand notes were taken and written on a new interview guide form (see Appendix

A) each time. The interview guide included semi-structured interview questions. Each

interviewee was assigned a unique id number to manage the data and to help ensure

confidentiality (i.e., P1, P2, P3). Figure 1 outlines the steps used during data collection

and analysis.

I used the interview guide to ensure consistency throughout the interviews and

produce participant experiences that would be sufficient to answer the RQs. Figure 1

outlines the actions taken during data collection and analysis.

Figure 1

Inductive Data Process

Interview	• Every interview was recorded with the Zoom audio recording feature, notes were taken, and the researcher engaged in refletive journaling.
Transcribing	• All interviews were transcribed with Zooms transcribe cloud feature, then reviewed for accuracy, any corrections were completed through handscribing. Themetic anaylsis was conducted after the interviews were transcribed.
Coding	• Initial codes were formulated an Excel spreadsheet. Participants' answers were reviewed several times while comparing notes to accurately describe participants' experiences and insights. Codes were moved into categories.
Findings	• Themes were created by relating codes and categories

Coding

Each interview was conducted using the same semi-structured interview guide

with the two RQs in mind: (a) how do master-level social workers experience cognitive

dissonance related to their harm reduction education and abstinence-only practice in

substance use treatment settings? (b) how do master-level social workers reconcile

cognitive dissonance related to their harm reduction education and abstinence-only

practice in substance use treatment settings?

I generated codes for this study with thematic analysis, highlighting sentences and

words connected to the participant's subjective experiences relating to the RQs (Percy et

al., 2015). Categories were then created as patterns were identified between sentences

and phrases. After categories were formulated, the next step centered on combining and

clustering any elated patterns into themes. Themes are characterized as underlying aspects of phenomena that provide answers to RQs (Percy et al., 2015).

A total of 107 codes were found, and then shifted into 18 categories. Some categories formulated included supervision, education, advocating, collaboration, switching jobs, respecting client self-determination community, agency, and family barriers, systemic issues, societal stigma, limiting provider/client-driven treatment, lack of integration, lack of boundaries and clear-cut practices relating to harm reduction, uncertainty concerning personal theoretical orientation, shifting theoretical orientations, presence of MSWs, years of working experience among MSWs and other colleagues. RQ 1 generated two themes (system-level issues and current employment and years of work experience of MSWs in work settings), and RQ 2 generated three themes (utilizing social work practice skills, switching jobs, and engaging self-awareness and cultural humility practices).

Discrepant Cases

Two discrepant cases were notable but did not influence the study results. P4 and P5 both noted that they support harm reduction practices but have theoretical orientations that favor abstinence-based treatment practices. As noted in Chapters 1 and 4, I did not have any preconceived notions that all social workers would preference harm reduction over abstinence-based practices as personal experiences relating to addiction and working environments can influence preferences of treatment practices (Rosenberg & Davis, 2004). While both participants reporting favoring abstinence-based treatment practices, both worked in treatment centers with MAT services and reported utilizing harm

reduction practices at times with their clients throughout treatment. P4 and P5 both stated they had worked with clients that stopped the use of a substance such as opiates or benzodiazepines but continued to smoke THC or drink alcohol in some capacity. So, while their preference to abstinence-based treatment practices shifted the narrative at times, they both highlighted ways in which their social work education and practice encourages them to meet clients where they are at, foster client self-determination, and utilize harm reduction practices. This narrative is similar to all other participants in the study.

Evidence of Trustworthiness

Credibility

I am a licensed independent social worker who has worked in addictions as a social worker for 8 years, with 12 years of experience in working in addiction treatment settings This past working experience supported my ability to enhance the interview process by adding additional information and knowledge to the content of the interview questions and questions asked by participants. I employed some basic counseling skills used in practice that helped elicit clarification, restatements, reflection, and paraphrasing to ensure credibility (Shenton, 2004). I helped clarify questions for participants that needed interview questions reframed or repeated. I remained intentional about building rapport, being attentive, and utilizing open-ended responses to aid the interview process. I also engaged in member-checking and allowed study participants to review collected data and interpretations of the data.

Transferability

I discussed data collection methods, ethical considerations, researcher subjectivity, participant attitudes, and the study's time, location, and size to help support transferability (Shenton, 2004). By sharing this information, readers can have clarity of the research process, results, and how it might transfer into their study, investigation, or participants' experiences (Shenton, 2004). All interviews were completed in the same respect. Interviews were held via Zoom and recorded using Zoom's cloud recording feature. Interviews were then transcribed using Zoom transcription feature and reviewed via hand scribing to ensure accuracy. Moreover, I used the same semi-structured interview guide for interview sessions to help maintain uniformity. Last, I tried to create vivid accounts of participants' words and statements to help connect readers to their experiences.

Dependability

I used the same methods for each interview when recruiting participants, utilizing data collection instruments, and engaging in data analysis to support dependability. Each interview was conducted using the same semi-structured guide and reviewed using the same thematic analysis process actions. All data analysis steps are outlined and shared in this chapter. I also engaged in reflective journaling and note-taking to examine bias or unexpected outcomes regarding the data collected.

Confirmability

Confirmability or the presence of objectivity demonstrates specific efforts in a study that reduce and control the impact of researcher bias and subjectivity (Shenton,

2004). I used reflective journaling and thematic coding to safeguard confirmability.

These strategies helped ensure that the data sources were analyzed with little bias and that

any bias that might have occurred was accounted for and examined.

Results

The intent of this exploratory study was to answer the following RQs: (a) How do

master-level social workers experience cognitive dissonance related to their harm

reduction education and abstinence-only practice in substance use treatment settings? and

(b) How do master-level social workers reconcile cognitive dissonance related to their

harm reduction education and abstinence-only practice in substance use treatment

settings? All eight participants in the study shared how they experienced and reconciled

cognitive dissonance related to the harm reduction education and abstinence-only practice

in substance use treatment settings which generated. themes for each of the questions. For

RQ1, two themes were discovered: challenges at the micro, mezzo, and Macro level;

presence of other MSWs and years of work experience. For RQ2, three themes emerged:

utilizing social work practice skills, switching jobs, and engaging self-awareness and

cultural humility practices. Tables 3 and 4 provide the themes and definitions for RQs 1

and 2, respectively.

Table 3

Themes and Definitions for Research Question 1

Research Question 1	Theme	Definition
How do master-level social workers experience cognitive dissonance related to their harm reduction	Theme 1: Challenges at the Micro, Mezzo, and Macro Level	Social workers use harm reduction and abstinence-based practice based on personal preference and attitudes, organizational

	education and abstinence-only practice in substance use treatment settings?		support, community stigma, and state and federal funding.
		Theme 2: Presence of Other MSWs and Years of Work Experience	The presence and current employment of MSWs and the years of experience might influence the utilization of one modality over another.

Note. MSW = Master of Social Work.

Table 4

Themes and Definitions for Research Question 2

Theme	Definition
Theme 1: Utilizing Social Work Practice Skills	Engaging in acts of supervision, education, advocating, and collaboration
Theme 2: Switching Jobs	Changing position that align with personal and/or personal values
Theme 3: Engaging in Self-Awareness and Cultural Humility Practices	Practices that reduce issues with transference, bias, and judgment and that enhance client self-determination

Findings for Research Question 1

There were two main themes found in the process of trying to answer RQ1: challenges at the micro, mezzo, and macro level, and current presence or employment and years of work experience of MSWs in work settings.

Theme 1: Challenges at the Micro, Mezzo, and Macro Levels

When exploring the ways social workers experience cognitive dissonance within their daily practice, participants noted that challenges within different system levels influence conflicts.

Micro-Level Challenges. The micro-level refers to clinician practices, which included what measures clinicians used to select practice approaches (harm reduction or abstinence-based), which included the evaluation of client progress, personal preference to practice approaches, personal feelings, or emotional responses to client relationships, and one's formations of client problems. All participants shared that the utilization of treatment practices was based on preference informed by either personal interest or beliefs, one's education, and work experience. Participants noted that professional assessments included examining "client readiness," "history of addictions," "whether clients were truly dependent," "meeting clients where they were at," "helping clients live their best lives," "balancing client self-determination and safety," providing "supportive and caring," "being effective," and "causing harm or doing good." P3 noted that:

> I care about people, and I care about their lives. And I want to make sure that they're living their best life, and want to know how can I be helpful so they can live their best life? And if that means that we get them a tent, and a sleeping bag and the jacket because their cold and [clients] are like, "Yeah, I can't rent an apartment, because, you know, I've blown out of everything and I've done this, and that"… I [say I] just want you to be able to stay alive. And to me, that's harm reduction, because it allows them to live their best life.

P7 and P1 both referenced the importance of coming from a place of client self-determination and aligning their practices with social work education and values. Social workers in this study regardless of preferred treatment practices, noted that one of the biggest sources of conflict related to how they felt about their clients on an individual

basis and how they then might justify treatment approaches without clear policy or practice guidelines within their agency, which a few of the participant reported not have. Two participants mentioned that at times they found themselves uncertain if they were helping or hurting their client's treatment process. One participant that leans towards abstinence-based practices stated that they felt like they had to justify harm reduction practice with their teams and with themselves. The reported that they would use harm reduction practices, often with clients that used cannabis but had stopped the use of all other substances; therefore, they could reduce personal conflict with using harm reduction by noting an increase in client functioning and client's current capacity and readiness for change.

P7 stated that when working in an abstinence-based treatment setting with a client that was there for cannabis related issues they experienced a deep personal conflict and pain as they advocated to work from a harm reduction practice based on client's mental health needs and personal assessment of client's condition but could not do so due to agency guidelines and client's involvement with another agency (Department of Human Services):

> I feel like it is very conflicting, especially as a social worker, everything that's like that work taught just doesn't, to me, doesn't coincide with that kind of approach [abstinence]. Because everything we know about working with people is meeting everyone where they're at and everyone's circumstances are different, you know, like, give them the resources that they need. And then there's this approach that's like, very rigid. And so, it just makes it's very conflicting. I think it's hard to

operate that way just because I don't see the benefit of it. And so, to me, it just, it just doesn't sit well, like it doesn't feel ethically correct.

Many clinicians made personal judgments to utilize harm reduction based on professional assessment of client need. P5 preferred abstinence-based practices but worked at an agency with a MAT clinic and would utilize harm reduction methods based on client determined needs. P5 reference this sentiment in their interview:

So, it just depends on helping the person get what they want out of treatment and asking them what they are willing to do. And that looks different because addiction is complex, and you sometimes need to use different methods.

P3 ran a harm-reduction oriented outpatient community center and was highly supportive of harm reduction services in professional practice. However, at times they'd reported that they could experience some dissonance between harm reduction practices and their education on the neuroscience of addiction medicine and treatment. P3 reported that they would have to be mindful in practice concerning personal feelings about their client's current situation or formulation of the problem and work to align with client self-determination:

And so, part of me is like, you know, you have freewill, and I want you to be able to make whatever decision you want. But I also know that for many people, that it's a hijacked brain, right. Like the function of the structure has now been changed. And are you really able to make decisions that are in your best interest? And so, I think there's a careful balance. That's why so there's like, there's these dueling thoughts, right?

P4 and P1 noted similar personal dissonance noting that without explicit organizational policy and procedures they were left to make personal clinical judgements about treatment approaches, progress, and safety. They both discussed treatment benefits of harm reduction but reported that at times they felt that harm reduction could be more effective for client's and the treatment process if integrated with other treatment approaches.

P6 transitioned from favoring an abstinence-based approach to a harm-reduction approach over the years as their personal understanding and assessment of effective treatment practices shifted:

When I first started in the field; it was very one size fits all, twelve-step abstinence based. And so, to think somebody was going to use methadone, or somebody was going to use something to assist them in their recovery was like unheard of. It's like they were cheating. But you know, now, especially with the opiate crisis, and just looking at the breaking that stigma, I really feel that there's not a one size fits all model. There are many different pathways to recovery. Now, I think, with, I don't identify as a person in recovery. But I strongly support individuals being involved in the 12-step program, just because I've seen how many people that really need that structure and support. I mean, just like everybody needs a support system and that structure, especially in recovery moving forward. But I see it as just both, as one of many pathways to recovery.

P4 also discussed how personal experiences and relationship with the client could influence clinicians support of harm reduction practices:

Um, so it's just difficult, I think it's like we are always kind of trying to determine,

or keep in mind our own, you know, like judgments and bias about certain

substances. So, it's like when it comes to alcohol, okay, well, it's legal. Um, you

know, I have ____ that are alcoholics. And whereas other people might be like, oh

no, I don't really care. And to me marijuana is like, I'm just like, ah, like, it's like,

not a big deal, I guess. So, you know, some counselor they might have like, one

cocktail here and there, but you know, they're using THC gummies every night.

And then another counselor might be like, well, I don't really think that that's that

bad because they technically, you know, they live in ____, or whatever [where

THC is legal]. So, um, which is tough because at____ we didn't see anyone from

out of state. Or, you know, "technically out of state" like here we do here, right.

Because they could be on any insurance, we do run into so it's like, well, it is legal

where they do live, what do we do. However, it's sort of again thinking about

your own biases.

Alternatively, two participants reported that they were trained in or preferred an

abstinence-based approach and adopted that in their work. They noted, however, that they

would support other professionals using harm reduction services or their clients using

MAT services or following low-risk guidelines. They reported that the use of their

preferred approach was influenced by what they personally perceived as being more

effective and allowed them to build a relationship with their clients. All participants noted

that the relationship build with client's and meeting client's needs were their top priority.

Mezzo-Level Challenges. The mezzo-level describes practice settings regulations and expectations (this includes families, community, organizational cultures, services provided, access to trainings, agency mission, and funding sources).

P2 discussed the challenges of working with clients seeking services in organizations or agencies where harm reduction is not supported:

I think there's some frustration and just like a degree of difficulty added to the work because sometimes the points that your clients are making, leave you trying to defend client decisions against [agencies] but that you're also part of, right? And then you may want to help your client with their stated goals. And you have to help them to work within the systems that they're in, not the systems they want to have in their lives. And so, I think its frustration is probably the main feeling, both for your client and in kind of all of that, right.

P7 had frustrations as well with working clients seeking services in organizations or agencies where harm reduction is not supported but discussed the impact that it had on them personal and how it impacts how their felt about the work they were doing and "if it was helpful or more hurtful to the client." They shared:

Personally, I feel like I felt even worse than I did professionally. Just because I don't know, I just think it's one of those things where like, my values, regardless of like, my profession, and the core values that go along with being a social worker, like, personally, I didn't see that person as someone who had like a horrible addiction and, you know, got themselves where they're at or had a huge problematic life because of their marijuana use.

P2 reported similar issues, mainly focused on organization culture and implicit practices:

    I think, um, I don't know if there were always policies, but they were how things

    were done in supervision. So, I mean, there was a time where I remember being

    told, you know, at different points in my career, like, well, you need to be

    recommending something, right. And for treatments, and often that meant it or

    like, I think there were also times that in order to successfully complete treatment,

    one must abstain for a certain period of time, or something like that, to call that

    successful treatment. And so, again, I don't know that anything was ever written

    down anywhere or in a policy, but that was what we were taught was a practice.

    And so that always, I think that piece kind of ties in and that would create some

    dissonance for me, because I'm like, well, you know, sometimes it was you need

    five groups who gets it, who knows that five groups, and these five specific

    groups are going to make the difference for this individual. And so those kinds of

    things would give me a lot of cognitive dissonance, which I think do sort of tie

    back to that. So, kind of just an overall idea of more what, I guess, kind of like

    minimum treatment expectations that aren't personalized

Participants consistently reported that two primary sources at the mezzo-level caused cognitive dissonance were family and community perceptions. Three participants referenced that families could either be a support in the treatment process or a barrier. Participants noted that families and communities often have strong opinions about harm reduction and clinicians' utilization of harm reduction. Participants noted that this added an extra layer of difficulty to their work due to the pushback, judgment, and

misconceptions they experienced regarding the value of their work and harm reduction practices.

Macro-Level Challenges. Macro-level challenges include societal stigma, access to state and federal funding, policies, and practices within larger agencies such as child welfare and legal systems (Lacasse & Gambrill, 2015). Three participants mentioned struggles with cognitive dissonance when working with clients involved in other organizations, agencies, or the department of corrections that require abstinence. P2 talked about struggles trying to navigate client self-determination if their client was involved in other systems such as probation:

> I think a specific example, that's not maybe individual but one that would come
> up a lot is having many clients who were drug users. So, drugs other than alcohol
> as their primary drug of concern, meth, heroin, something like that, that would
> have long term goals of being able to have low risk alcohol use. I think one thing
> that I think can become a disservice to the client is, again, when they have those
> external factors, like probation or otherwise, they're not able to have the support
> to play around with those kinds of choices and test out harm reduction in a safe
> setting where they have support to process and reflect on how that's going.
> Because they have to put that off until they've successfully completed treatment
> and gotten out of the system. I think that puts clients at some risk, where they may
> try to make those choices and then not be in supportive services and have that
> kind of support system there to be able to process how that's working for them.

And so, I think that's one example that comes to mind that what happened frequently

P3 reported similar experiences working with other agencies like emergency departments and law enforcement that have been unwilling to treat or refer clients to services with the belief that they would not benefit from services because they were going to continue to use or that the person using should be responsible for seeking out treatment on their behalf:

Like, there's agencies culturally that just unwilling to treat people that are going to continue to use. I think I said this before, that there is still a culture of criminality and punitive values with a belief that that gets people sober. Which makes them feel good, not the client, but makes the system and the agencies feel good.

P6 reflected on the internal conflict they experienced trying to uphold client self-determination while managing working partnerships that have different expectations for the client. They shared that being in this position can make it challenging to best support their client's lives:

However, we know with some of the population that we work with in the substance we are seeing those that have external motivation. So, they wouldn't be there unless there was correctional probation, DHS, and so how do we meet your goals, but at the same time, ultimately meet your goals while you're complying with your PO or DHS worker. And I think that as a substance use provider, that's kind of a fine line, because we're working for the patient, not DHS, not probations. And so, we want to support the client and their decisions. But if their

decisions aren't marrying the expectation of the external motivation, and it is why

they are participating in treatment, it's kind of a lose, lose. So how do you support

the patient, or the client being self-determined, but also help them identify what

they need to do to get out of that legal system or the DHS involvement?

P7 discussed the conflict with the larger society and long-held views of those that

struggle with addiction and how that impact harm reduction practices but also clients

accessing services:

Yeah. I mean, I think just like the societal views that people have towards certain

populations such as addiction [create conflict]. I think when you're in it

[addiction], you can probably take some of that on of like, the outside world,

right? Like, nobody has hope for you. Nobody thinks highly of you. And I think

sometimes they internalize that. A lot of addicts do. And so, I think that adds to

the conflict. But I do think, mainly, it's that structural level of, like, the mindset.

And just like you said, where it's not like the addict that is necessarily the

problem. It's the way that we're approaching it.

P1 discussed how societal views of acceptable use and misconceptions of harm

reduction continue to impact the implementation of harm reduction programs and

treatment approaches. They highlighted the frustration of being in a geographical area

that imposes harm reduction policies:

So, a bar is like somewhere that you can go purchase alcohol, pretty much drink

as much as you want, unless they kind of cut you off and tell that you're super

intoxicated. But it's literally a safe using sight. It's just that it happens to be

alcohol. So, when somebody told me that perspective, it was actually another social worker, she was giving a presentation about something that she mentioned bars being safe using sites, and I was like you're absolutely right. People are so against, especially here in the ___ are so against like any notion of like a safe use or decriminalizing anything, or even the needle exchange programs. We've tried to get them started here multiple times in __. And it's, it's been it's always been shut down. But yeah, hopefully the perspective continues to shift. Because not only is it healthier for the client for them to direct their treatment on some level, but it's also better for society because those harmful behaviors are reduced.

Another participant discussed their personal feelings regarding their experiences living in a conservative town and how they felt like the community views impacted harm reduction utilization:

I think some of the difficulty for me is that the world of substance use has been so criminalized that it is like "oh now you're now a criminal". And so, like, just trying to overcome, like, that kind of mindset, that if you're using your criminal, instead of like, if you're using a drug, like, you have a disease of the brain, it does not make you criminal. And so that's a different concept that in living in a really conservative areas, you know, like, just keep showing up in these areas and saying the same thing.

Theme 2: Presence of Other MSWs and Years of Work Experience

The second theme uncovered that the presence of other MSWs, and the years of work experience for clinicians, influenced their experiences with the utilization of harm

reduction or abstinence-based practices in treatment settings. Five participants referenced how the presence or lack of MSWs within a work environment appeared to influence the utilization of harm reduction practices and policies. Participants also noted that years of work experience among staff, social workers, and other counselors influenced conflict between utilizing and supporting harm reduction practices in treatment settings.

P5 and P4 shared that their preference for abstinence-based treatment was influenced by years of practice and work experience. P5 had worked in addictions for 30 years and shared that it was only in the last 10 years that they were introduced to harm reduction due to their agency implementing MAT services. P4 had over 10 years of experience working in addiction. They reported entering the field working at an agency that preferred harm reduction but switched to an outpatient center with an abstinence-based approach. They discussed that they changed their preferred treatment approach due to practice wisdom and supervision they received from their supervisors, who had worked in addictions for over 40 years. While their situations are slightly different, their experiences highlight how training, education, and organizational culture influence treatment approaches.

Two participants reported that when working in the presence of MSWs, agencies tended to adopt harm-reduction practices, and when there was a decrease in MSWs within an agency, agencies appeared to revert to abstinence-based practices. Two participants felt that their colleagues' age and years of working experience influenced whether someone was supportive of harm reduction services and if/how conflict then appeared within the workplace. Two participants reference that they felt that with more

harm reduction education and training, young social workers were more likely to utilize harm reduction practices, educate other professionals about harm reduction practices, and create individualized treatment plans.

P6 discussed feeling a shift in the field of addiction having more of an expectation that providers have MSWs degrees and felt like this has influenced the presence of harm reduction in treatment centers.

> I feel from my experience, and the network people I've worked with, those individuals are retiring now. So here, we're having a new flux of professionals. And I think the MSW is you know, just an expectation. Now, I know, I'm on the ___ and so we do the _____. So, it would have been the year, the last year before the pandemic that we had it, I was surprised how many agencies were there with tabletops. Or surprised because it was a conference that did not require their individuals to be certified as drug and alcohol counselors, because they were expected to be licensed (as MSWs). So, I think we're moving that way. And so that comes with that strength-based perspective and where I think that more support the harm reduction approach

P2 discussed experiences of cognitive dissonance with abstinence-based practice and treatment recommendations. They reported that over time the agency they worked at developed a more client-driven treatment process and integrated more harm reduction practices. They noted that the presence of MSWs increased as this change began to take hold but could not assert that this was the main cause of the change that occurred.

As I reflect back, and I don't know that this correlation is causation. But, you know, when I started there, were not very many MSWs there. And so when I think about the early, and then when I left, there were several. And so, I don't know if that has a role and an influence in there. Or that's just a coincidence. But is an interesting thing to think about. Again, I think some of its bigger field stuff

P3 discussed how their advocacy for harm reduction increased the use of harm reduction practices in the organization they became the director of but noted that, after they left their position, the agency went back to abstinence-based practices

And when I transitioned to the county job, that was a community mental health program, they were an abstinence-based program, and I rocked the applecart because I'm like okay [agencies] can say, you know, like, oh, you're on probation, and they want you to be completely abstinent, but how do we help you get there? Because I, you know, if you're telling me you want to get off probation, or parole, and you must be sober, like, let's let us help you get there. And that doesn't have to mean like today, you stop using totally, but let's make that. So, I think there is a way that it can blend, but I happen to live in a rural conservative community that is it's all or nothing, right? Like, you're going to stop using them today and that's the only way you're going to. And so, when I left, they went back to an abstinence-based model. And I think one because it's easier, right? It's real black and white- you are using, or you're not using but it's not always helpful.

Many participants shared experiences related to how the presence of MSWs within their working environment influenced policy and practices or the lack thereof

related to harm reduction. They shared how having MSWs present in the workplace helped reduce dissonance and other challenges as they could confide, consult, and find shared understandings in treatment approaches and professional values.

Findings for Research Question 2

There were three main themes found in the process of trying to answer RQ2: utilizing social work practice skills, switching job positions, and engaging self-awareness and cultural humility practices. Utilizing social work practice skills referenced engaging in acts of supervision, education, advocating, and collaboration to resolve or lessen cognitive dissonance. Social workers also reported changing position that align with personal and/or personal values and practicing cultural humility and self-awareness to reduce issues with transference, bias, judgment, and that enhance client self-determination.

Theme 1: Use of Social Work Practice Skills

When exploring how social workers reconcile cognitive dissonance between harm reduction education and abstinence-based treatment in substance use treatment settings, all social workers in this study referenced at least three of the following practices: the use of supervision, advocacy, and consultation.

Supervision and Consultation. The use of supervision and consultation was noted to be most helpful in coping with or resolving cognitive dissonance within treatment settings. P6 shared their experiences that highlight the importance and power of supervision and consultation:

I believe, is important to have good clinical supervision, and have that time set

aside to discuss cases and stuff like that. So, again, I think I see this just with my

own experience of being a clinical supervisor. We got so many other obligations

now related to funding sources and insurance company and stuff like that, it takes

away from one seeing the patient at times. But that clinical supervision is more

than like, hey, we need to check off these boxes and say we did this for

accreditation. We are really sitting there in case consultation stuff, like that's all,

I've always been a real firm believer of having good supervision

P4 also noted how international supervision and consultation support social workers and

helps resolve issues in practice:

So, I think the staffing aspect of it is so important, like supervision. I have carved

out supervision time with each counselor, not just for my [personal] supervising

of them, but also just like having these discussions. And we have team staffing.

But we also have like a team huddle, like these team kind of building meetings,

where we talk through a lot of that [conflicts in practice relating to harm reduction

and abstinence-based treatment]. And so, I feel like always being mindful of it

and recognizing it is important

P3 discussed that supervision was valuable to them because it allowed them to be

challenged and informed by outside perspectives and expand their knowledge based of

harm reduction practices. They noted that supervision provided them with opportunities

to engage in self-reflection and re-center on client-driven practices.

Many of the participants in this study referenced experiencing cognitive dissonance, which created feelings of frustration, irritation, dissatisfaction, disappointment, and powerlessness but they were able address these issues in supervision, with colleagues, in team meetings, or consultation demonstrating the value of this social work practice in treatment settings.

Advocacy. As social workers described experiencing cognitive dissonance within different system levels in theme 1, they stated that advocacy for their client and their social worker standards were another way they reconciled conflict. Participants discussed engaging in advocacy when working directly with clients and other agencies like child welfare, law information, and the department of corrections and when working with families or communities at large. They also discussed treatment advocacy within their places of employment regarding client progress, client services, referrals, termination or services, and treatment planning. The role of advocacy was often driven by feelings of frustration, irritation, and disappointment for their clients and their professional role. Advocacy felt effective and meaningful for many participants. P3 discussed how ongoing advocacy has led to state-level changes in policy related to harm reduction and treatment practices and how that keeps motivation and support alive:

> And another thing is there's social workers out there doing this advocacy work, so I'm going to give props to all those. Everybody in our profession that is like, even fighting hard for this finally, we can pursue some traction and we are seeing traction in our state

Others discussed engaging in client advocacy with places of employment or among their coworkers. Many noted that they would have to advocate on behalf of their client's treatment needs and the utilization of harm reduction. As social worker's part of our professional obligation is to address gaps in treatment services that negatively impact client's needs and their ability to live well-balanced and healthy lives. Participants referenced why the role of advocacy is so important when working with clients that struggle with addiction:

> One of our roles is to advocate. So, if that means aligning with the clients seeking resources that we have, and if somebody is trying to actively prevent that, or stray away from that, then I'm going to go on the other side, and just make sure that the clients have access if they want it. So, I think that advocacy piece, as social workers, is our responsibility to not only inform the clients of their options and help them access the things that are going to work for them, regardless of if a supervisor disagrees, or if another colleague disagrees or whatever. The goal is making sure that clients have access to those things.

Other participant discussed larger roles of advocacy at mezzo-levels to improve client's outcomes but also to feel as though their work aligned with social work principles:

> Agency settings are going to be thinking their approach or about insurance companies. We hear things like "hey, they've already been to residential, how many times and we're not going to pay for a second time". And here, it's my job to advocate and be like, "Hey, you know, this is part of the illness, and if this person still having the symptoms, you know, it could take several times before a

treatment approach works". And so, really advocating and it can be hard because sometimes, you can be a lone individual in a bigger room. I'm saying kind of going against the norm with insurance companies and really trying to advocate with insurance companies and stuff.

Theme 2: Switching of Job Positions

Three participants in the study reported that they changed their job positions to better align with their professional and personal values. One participant discussed how the dissonance they experienced eventually resulted in them switching jobs:

I just did not like the rigidity of the abstinence-based programs. I think we all feel that way. But like, it is what it is, and I think I got to that point where I was like I can't change the entire agency, but I can change my job, so I don't feel like this anymore. You know, I just can't, but I also think like, whenever my clients would express like, their feelings of like, discontentment, or discouragement, I feel like I was very good at being like, I know, it sucks, I wish it wasn't this way and that always helps. Because I think a lot of times my clients saw that, like, I wasn't trying to be this like, forceful, rigid person, but it is what it is.

Another participant was very forthcoming that it was an easy decision to changes jobs because they could not practice in abstinence-based setting in their full authenticity and that was the heart of their work:

There was a little bit of frustration. I think that's what I like about my job now after switching which is I get to be more of the harm reduction. Not so much so

much of the abstinence piece. The only conflict I have now is with the community

and families.

These actions reinforce how changing jobs reduced cognitive dissonance among

social workers and gave insight to high turnover rates in the field of addiction and why

supervision and agency support are critical pieces of support social worker in substance

use treatment settings and improving treatment outcomes for clients.

Theme 3: Engagement in Self-Awareness and Cultural Humility Practices

Multiple participants reported that they could reduce or lessen cognitive

dissonance by engaging in self-awareness and cultural humility practices, which allowed

them to remain client-centered and aligned with practice values. When reflecting on how

cognitive dissonance made them feel personal, they discussed the importance of being

aware of emotional responses, biases, transference, and managing these feelings.

I think irritation pops up first, like, are you serious? Like you said, you wanted

XYZ. And I think that those feelings kind of pop up first, and that's just my stuff

that that emerges because I want so much for people that, that it's just really just

my stuff that that that shows up. And then I'm like, okay that's mine. What is it

about? I just care about people, and I want them to stay alive. And so, am I like,

me being irritated with clients, or even counselors are not helpful. People don't get

better because you're angry. Counselors just don't get better because you're angry.

And so, it's a lot of my own stuff, and what I want them to be, and I got to just

soften and be how can I help *you* because clients and our counselors have their

own conflict. And so, then it's importance for me to look at how can I be helpful in resolving their conflict.

P4 discussed personal responsibility in caring for themselves and reducing issues with subjectivity and bias through therapy, self-reflection, and ongoing trainings for cultural and professional development:

I mean, honestly, seeing my own therapist is helpful. Also using ____ as a resource. She's retiring this year, but she's amazing. And she offers a motivational interviewing workshop. It's optional but if you can log on, great. We do a lot of skill, like practicing, but we do a lot of, like, processing with cases, and clients and stuff. I do talk a lot to my therapist, just about like work stuff, and I noticed some of my personal thing's kind of like leaking over into my work with this person, or, or even my work with this, with this coworker or something. I think all those things are really helpful, because obviously, we can't always recognize the connection with ourselves. So, it's, it's nice to have like other people to kind of bounce it off.

Two other participants reference their experiences working with pregnant women using opiates and working to acknowledge and manage personal values and biases to ensure that they remained centered on their client's best interests and needs. They reported the complex interpersonal examination required in thinking about what successful treatment "looks like" and how they upheld their social work values of respecting the dignity and worth of the human being. All these themes reflect ways in which the challenges of utilizing harm reduction in different system levels and use among

social workers share or create cognitive dissonance among social worker standards such as self-determination, client autonomy, self-efficacy, and honoring the dignity and worth of a human being.

Summary

This research study aimed to understand how MSWs experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-based treatment settings. To answer these RQs, I conducted eight semi-structured qualitative interviews with MSWs that worked empathetically and competently in the field of addiction and had harm reduction education.

I collected data by conducting individually recorded Zoom interviews. The audio recording feature of Zoom transcribed the interviews. Throughout the data analysis procedure, 107 codes were identified and moved into 18 categories which included varieties such as supervision, education, advocating, switching jobs, respecting client self-determination, community, agency, and family barriers, systemic issues, societal stigma, limiting provider/client-driven treatment, lack of integration, lack of boundaries and clear-cut practices relating to harm reduction, uncertainty concerning personal theoretical orientation, shifting theoretical orientations, presence of MSWs, years of working experience among MSWs and other colleagues. RQ 1 generated two themes (system-level issues and presence of other MSWs and years of working experience), and RQ 2 generated three themes (utilizing social work practice skills, switching jobs, and engaging self-awareness and cultural humility practices. Study participants all shared experiences of cognitive dissonance and its impact on their professional and personal

lives, defending the literature in this study, revealing that MSWs experience a significant amount of cognitive dissonance within their working environment, which requires the ongoing practice of reconciliation. More so, the findings provide a real portrayal of the emotional conflict and stress social workers experience in these situations. The following chapter will discuss the interpretation of the findings, the study's limitations, recommendations for future research, and implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

In this exploratory generic qualitative study, I sought to understand how MSWs experienced and reconciled cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings. Use of a generic qualitative methodology yielded a broad, yet rich understanding of the study participants' experiences and feelings. Study results showed that participating MSWs experienced cognitive dissonance related to harm reduction and abstinence-only practice in substance use treatment settings and worked to reconcile (whether consciously or not) conflicts they experienced. Additionally, although not all participants in this study preferred a harm-reduction approach over an abstinence-based approach, all actively used the harm-reduction approach in practice. Last, all MSWs in this study had a profound and shared desire to support clients' needs, enhance client well-being, and reduce practices that appear to oppress vulnerable populations.

Abstinence-based practices are the most used substance abuse treatment approaches in the United States today due to education and training geared towards this approach, limited acceptance of other treatment approaches among professionals, providers' personal histories concerning addictions, the incongruence of alternative therapies with organizational missions or philosophies, and lack of resources or training on new approaches (Campbell et al., 2015; Davis et al., 2017; Rosenberg & Phillips. 2004). Participants in this study discussed various ways that they experienced and reconciled cognitive dissonance related to harm reduction and abstinence-based treatment, which reflected the findings in the literature review in Chapter 2. In this

chapter, I interpret the study findings in relation to the RQs, discuss the limitations of the study, offer recommendations for further research, consider the study's implications for positive social change, and provide a conclusion to the study.

<center>**Interpretation of the Findings**</center>

The results in Chapter 4 reveal study participants' experiences and the process of reconciliation related to harm reduction and abstinence-based treatment practice. In this section, I interpret participants' experiences and answer in relation to the RQs.

Research Question 1: Experience of Cognitive Dissonance in Substance Use Treatment Settings

The findings for RQ1 are consistent with research showing that social workers want to practice in alignment with personal and professional values and will work to uphold this consistency in practice (Bigler, 2005; Brocato & Wagner, 2003; Taylor, 2005). Social workers experience cognitive dissonance within the workplace due to various factors, including personal or professional conflicts with values and judgments and ecological or organizational issues (Burke et al., 2017; Nelson & Merighi, 2003). Theme 1 for RQ1, challenges at the micro, mezzo, and macro levels, reflects findings in current research suggesting that social workers experience cognitive dissonance at various system levels causing significant rates of distress, confusion, and anguish, that they are motivated to resolve through action (Taylor, 2005). Findings in this study reveal that not only did all participants experience cognitive dissonance, but they were likely to experience conflict across all system levels (micro, macro, mezzo).

MSWs in this study shared how they attempted to make practice decisions that supported client autonomy, safeguarded society, and supported professional values to reduce dissonance. For example, some participants reported that a source of conflict related to not being able to provide services that promoted self-determination and client readiness due to organizational policy. These experiences relate to Taylor's (2005) finding that social workers with higher levels of devotion in promoting client self-determination experience the highest ratings of professional dissonance. However, not all reported experiences of dissonance related to professional values; some related to personal ones. This finding is consistent with research showing that even with harm reduction education and training and high or moderate acceptability of harm reduction, it is not unreasonable for MSWs to experience dissonance related to their values or beliefs (Eversman, 2012). For example, some participants discussed experiencing cognitive dissonance working with pregnant clients who continue to engage in substance use, wanted non-abstinence treatment goals, or engaged in MAT services. A few participants discussed reducing this type of dissonance and cognition discrepancy by giving greater importance to new perceptions regarding client care, how they understood their role as a provider, and when they needed to prioritize their personal values and refer a client to help reduce previously unpleasant behavior or thought which allowed them to continue to work with clients effectively while lessening conflictual thoughts and actions (Harmon-Jones & Mills, 1999).

The second theme found for RQ1, presence of other MSWs and years of work experience, related to findings in the literature suggesting that social workers are more

likely to receive harm reduction education in graduate programming or training and, as a result, are more like to utilize harm reduction approaches in practice. Campbell et al. (2015) and Estreet et al. (2017) showed that higher education levels could influence a counselor's willingness to learn and use different treatment approaches in practice, rather than just an abstinence-based approach. Willingness was noted to be a result of being exposed to different treatment approaches in education. Beyond a willingness or degree of acceptability, graduate education in harm reduction can lead to more positive feelings about using harm reduction in practice among social workers, which helps social workers have an optimistic view of their work (Moore & Mattaini, 2014). One difference found in the literature is that Taylor (2005) reported that social workers with more years of experience were more likely to utilize diverse treatment approaches due to knowledge and confidence, which counters the results of this study, which indicated that longer years of experience were indicators of an MSWs utilizing an abstinence-based treatment approach more regularly. One potential influencing factor in this study that could account for this discrepancy is that the two participants with 10 or more years of experience in this study worked primarily in abstinence-based treatment settings, where they had supervisors who favored that approach to treatment. Both participants also had personal family experiences relating to addiction, which research shows can influence a provider's utilization of alternative treatment approaches and acceptance of non-abstinence treatment goals (Davis et al., 2017; Rosenberg & Phillips. 2004).

Research Question 2: Strategies for Reconciling Cognitive Dissonance

The first theme found for RQ2 was utilizing social work practice skills to reconcile cognitive dissonance, particularly skills such as supervision, consultation, and advocating, which are hallmarks of social work standards and professional practice (NASW, 2008). Supervision in social work practice provides social workers with emotional and educational support while challenging clinicians to examine their treatment approaches and biases that might interfere with the treatment process (NASW, 2008). As noted by participants in this study, self-care practices, concerns about cultural competence, and exploring ways to uphold clients' right to self-determination, even when in conflict with personal and professional values, were critical issues; they utilized supervision to address and reduce dissonance.

Nelson and Merighi (2003) found that factors influencing emotional dissonance included countertransference and lack of peer or supervisor support in client care. Social workers repeatedly discussed the importance of effective supervision and how having positive relationships with their supervisors and peers allowed them to reduce or resolve cognitive dissonance within the work environment. Social workers also engaged in case consultations to employ appropriate interventions and help reduce risks associated with liability and malpractice (NASW, 2008). According to the NASW (2008) Code of Ethics, "social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice."

From their own experiences, the participants in this study provided first-hand insight regarding the value of advocacy when working with clients and reconciling cognitive dissonance relating to harm reduction and abstinence-based treatment practices. Participants described emotional upset and distress when they could not engage in advocacy or practice ethically while holding the client's best interest, needs, and professional values in mind, a practice that is thought to reduce emotional dissonance (Burke, 2017; Nelson & Merighi, 2003). Taylor and Bentley's (2005) findings confirmed that social workers with strong values concerning client-driven care are more likely to experience dissonance. Findings in this study showed that high levels of distress occurred when trying to support client-driven care by using harm reduction but being unable to do so for various reasons (i.e., personal feelings towards clients or use, lack of clear policy or practice guidelines within their agency that impacted direct practice, uncertainty on how to justify treatment recommendations or services, and personal histories relating to addiction.).

Using these social work practice skills effectively and as warranted is essential for social workers to upload the professional mission of social work, which is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 2008, p. 1). Social workers are tasked with ensuring that all vulnerable populations have access to services that allow them to live whole lives. They are obligated to advocate and address gaps in services that prevent people from accessing the services they need to make positive changes in their lives.

The second theme to emerge when trying to answer how social workers reconcile cognitive dissonance was switching jobs, which is consistent with previous research indicating that social workers who experience cognitive dissonance in work settings are likely to engage in behavioral changes, such as changing jobs or perceptions about their experiences (Taylor, 2007). One social worker in the study reported that they had to switch jobs because working in an abstinence-based treatment center felt incongruent with her professional values. They constantly tried to manage the dissonance between work expectations and professional and personal values. Relating to cognitive dissonance theory, people instinctively desire to be in congruence with thoughts and subsequent actions. One's perceived level of unpleasantness may influence the level of action they take to resolve the dissonance (Cooper, 2012; Harmon-Jones & Mills, 2019). The participant demonstrated how their reported dissonance and perceived intensity led to an action-based change (switching jobs).

Another participant noted that, while they did not experience distress working in abstinence-based treatment settings because they believed that they had an obligation to do the job that was asked of them, they ended up switching jobs to work for a harm reduction-based agency. When asked why, they reported that they wanted a job that better aligned with their values and beliefs of what social work practice and client care should be. In this study, switching jobs allowed MSWs to align with social work education and principles. Existing research confirms that social workers value being able to work in environments that foster harmony between social work principles and values (Bigler, 2005; Taylor, 2007; Taylor & Bentley, 2005).

The last theme uncovered was engaging in self-awareness and cultural humility practices, which social workers reported as essential interpersonal behaviors to reduce cognitive dissonance and improve client-therapist relationships and overall feelings about their work. Participants reported that self-awareness allowed them to be mindful of how their personal thoughts, experiences, and emotions influenced how they viewed client choices, organizational practices, and more significant societal issues. They reported that the more they were able to practice self-awareness, the more they were able to process how this supported or hindered their ability to provide effective services at any system level.

Alvarez-Hernandez and Choi (2007) define self-awareness as building awareness of one's prejudice or hindrances that impact their ability to work ethically with specific populations or social issues. "Self-awareness assists the social worker in ethical decision-making by constantly challenging perceptions that could interfere with the social work values of respect and dignity of the individual" (Alvarez-Hernandez & Choi, 2007, p. 388). Participants in this study were vigilant about perceptions relating to harm reduction and abstinence-based practices and how this informed their professional behavior and values.

Cultural humility is the willingness to suspend assumed professional knowledge and experience about a person or issue based on generalizations relating to client identities. It allows clients to be the experts on their stories and current needs (Marsiglia et al., 2021). Many participants expressed that their ultimate goal as a professional was to meet clients where they were at, empower client self-determination, and honor the needs

of their clients. Participants noted that to do that, they needed to shelve preconceived ideas about treatment needs, what they thought clients needed to improve their lives, views about their working environments or other agencies, etc., and center on how clients view their current circumstances, what an ideal life would be, and how they would get there, and would with the client to achieve that outcome. By practicing cultural humility, social workers can engage in ongoing self-awareness and self-evaluation to help reconcile dissonance that occurs relating to personal practice, client care, treatment methods, work settings, and other issues relating to utilizing harm reduction in abstinence-based treatment settings.

Interestingly, the two participants in this study who favored abstinence-based treatment mentioned personal biases and different experiences influencing this preference, along with how they managed these factors so that they had minimal impact in practice and reduced dissonance when working with clients or in various treatment settings. They engaged in self-awareness, and cultural humility practices as social workers are encouraged and as it is deemed best practice. They also were competently informed of the effectiveness of harm reduction and shared that they used harm reduction in treatment and under what conditions they may have felt comfortable doing so. Even with education and training in harm reduction, they reported that they continued to lean towards abstinence-based treatment practices to be congruent with their beliefs and actions professionally and personally. These findings relate to research suggesting the need to explore how varying degrees of free will, inflexibility, self-perception, and tolerance of dissonance are thought to influence one's experience of dissonance and how

they go about reconciling dissonance (Aronson, 1969; Cotton & Hieser, 1980; Harmon-Jones, 2000). Understanding what role of bias, self-awareness, and personal experiences play in influencing direct practice and the utilization of harm reduction could bring to light factors that continue to impact utilization and its effectiveness at a micro-level.

Cultural humility practices aid social workers in becoming more aware of their personal beliefs and cultural identities that influence feelings related to using specific treatment approaches, how they work with clients that struggle with addiction, and how this leads to conflicts with existing cognitions. By becoming more conscious of inconsistent cognitions concerning behaviors, perceptions, attitudes, and beliefs that impact the utilization and effectiveness of harm reduction in abstinence-based treatment settings, social workers can assess whether changes in behavior, thought, or action needs to occur to reconcile dissonance and to help improve overall social work practices (Burke et al, 2017).

Limitations of the Study

A limitation of this study is participant recruitment. First, over half of the participants were from the same Midwest state, which could influence participant response as they could experience similar issues with treatment limitations, community stigma, and state policies. They might have received similar graduate education if they went to school in the same state or city, thus reducing geographic representation, which can be sought after in basic qualitative research (Percy et a., 2015). These factors could influence stronger feelings towards one treatment approach over the other, along with similar experiences of conflict in treatment settings. However, Percy et al. (2015) stated

that external generalization is optional in generic qualitative studies if the participant sample is highly knowledgeable about the topic and can provide rich content knowledge on a particular topic, which the participants in this study were able to do.

Another limitation of this study is that study specifically recruited MSWs with harm reduction education or training that had worked in an abstinence-based treatment setting; therefore, the participants in this study may have had a greater personal investment in the study's research and interview questions, which could have influenced client responses. An additional limitation to consider is that social workers that have only worked in treatment centers that match their preferred orientation (i.e., preference for abstinence-based treatment working in an abstinence-based treatment setting) may experience little to no cognitive dissonance, which may have influenced how participants experienced and perceived cognitive dissonance related to harm reduction and abstinence-based treatment settings. Last, as discussed in Chapter 1's Limitations section, there was the risk that personal bias, experiences, or social desirability posed limits to the research as participants were at times uncertain how to phrase things or were questioned whether they should make a specific statement. I worked to create a supportive and safe environment. I reminded participants of their privacy rights and that they should share what they felt comfortable sharing to help reduce the possibility of these issues occurring (Klages et al., 2020).

Recommendations

As this was a generic qualitative study focused on generating an initial yet broad investigation on how MSWs experience and reconcile cognitive dissonance related to

harm reduction education and abstinence-based treatment, repeating another qualitative study with a slightly larger sample size would increase the study's dependability thus confirming or discrediting whether these findings are valid when applying findings to a larger population. The repeated study should also be more intentional in expanding recruitment to all regions of the United States. Even though this study was open to all MSWs living in the United States, more than half of the sample in this study lived in the same region; therefore, a more diverse geographical location could help strengthen external validity (Kahlke, 2014; Percy et al, 2015).

Another approach to consider in a repeated study would be to gather more demographic data, mainly related to age and types of courses or training received in graduate programming. As noted in the research, harm reduction education in graduate programming, along with age and years of experience, play a significant role in the utilization, acceptability, and comfortability of using harm reduction in treatment (e.g., Eversman, 2012; Fenster & Monti, 2017; Senreich & Straussner, 2013). Therefore, a greater understanding of what type of content or courses a student took, along with age and years of experience, could increase understanding regarding factors at a micro level that impact practice decisions and cognitive dissonance related to harm reduction. Last, as uncovered in this study, harm reduction continues to be a controversial treatment approach for a multitude of reasons, such as lack of training, lack of organizational support, personal histories and biases of the provider, conflict related to organizational missions, and state funding or insurance issues (Campbell et al., 2015; Davis et al., 2017; Rosenberg & Phillips, 2004). therefore, future studies should thoroughly examine how

social workers experience cognitive dissonance at all system levels (micro, mezzo, and macro) and its impact on the social work profession and treatment outcomes.

Implications

This research study can guide development at the individual, organizational, and policy level. I explored MSWs' experiences and reconciliation of cognitive dissonance related to harm reduction education and abstinence-only treatment settings. Abstinence-only treatment benefits many individuals seeking recovery, but harm reduction approaches are also helpful for those capable of reducing use in some capacity (Bigler, 2005; Brocato & Wagner, 2003). This approach reduces the number of people not seeking services and struggling to maintain abstinence because they are not ready, wanting, or able to make an abstinence-based change in the here and now (Lushin & Anatas, 2011; Tiderington et al., 2013). Both approaches hold effectiveness and value in addiction treatment, but harm reduction practices continue to lack integration, acceptability, and utilization in treatment settings, which creates conflict within the social work profession as many social workers are informed to work from a harm reduction perspective (Bigler, 2005; Lee et al., 2011).

As a result of the study, researchers can better understand how MSWs are currently struggling or resolving cognitive dissonance relating to harm reduction and abstinence-only treatment and build on this study by examining in-depth how factors at various system levels impact the experiences of MSWs. They could find ways of advocating for changes at each level to reduce dissonance or conflict among MSWs

trying to utilize treatment approaches that best fit client needs improve development of effective harm reduction services.

In that case, on an individual level, researchers may utilize the knowledge gained from this study by expanding research relating to barriers and positive factors associated with reconciling conflicts at the micro level. Most social workers are faced with micro-level conflicts for the first time in their working environments without a sense of preparedness or knowledge on how to address and resolve cognitive dissonance related to harm reduction practice issues (Taylor, 2005). Nor do they have explicit ethical guidelines that help inform decision-making regarding harm reduction and abstinence-based treatment. Using additional qualitative research and interpretive analysis as a methodology can help connect the theory-practice divide along with build insight to characteristics, practices, and systems that influence this problem (Kahlke, 2014).

Most social workers are taught to meet clients where they are at and provide humanistic and client-centered care. However, they are not always taught how to address barriers at various systems levels (including personal basis, experiences, and assessment of the client) that impact their ability to cope and resolve these conflicts. Many social workers turn to their supervisors for support and guidance (NASW, 2008). This is a great practice social workers have supervisors that are prepared to help clinicians address these issues and hold the same professional licensing; if not it can become problematic as supervisors feel unprepared, clinicians feel unsupported, and it leads to issues such as burnout and job termination.

At an organizational or mezzo level, these findings may lead to implications for future research centered on new educational approaches in MSWs curriculum that address ethics concerning harm reduction and social work. As research in this study indicates (Estreet, 2017; Eversman, 2012; Fenster & Monti, 2017) and participants' responses confirm, social work education, trainings, and commitment to social work values and client self-determination are large indicators of whether a social worker utilizes harm reduction practices or not and whether they feel prepared using harm reduction in practice. At a macro level, this study justifies how the lack of progress and access to harm reduction interventions and policies in substance use treatment creates and perpetuates dissonance among social work practice and harm reduction interventions, thus supporting the notion that advocacy for changes in policy and practice is warranted (Drucker & Crofts, 2017; Morrison, 2015).

In 2019, the Council of Social Work Education was awarded the Substance Use Disorders Expansion of Practitioner Education in Social Work Grant to create and disseminate a standardized curriculum for substance use courses in MSW-accredited programs and enhance social work faculty and field supervisors' ability to teach substance use content competently (Council of Social Work Education, 2022). Other grant objectives include increasing the number of social work students that register for substance use courses, improving their knowledge and understanding of substance use, substance use disorders, and working with substance use clients (Council of Social Work Education, 2022). Although the Council of Social Work Education and the NASW have committed to enhancing substance use and harm reduction education, neither association

has extensively developed curricula and trainings that teach ethical and self-care practices relating to social workers utilizing harm reduction approaches in treatment settings. Not only would social workers benefit professionally from learning explicit ways of addressing issues relating to harm reduction at all system levels (micro, mezzo, and macro) as found in this study, it is likely that they would benefit and potentially improve skills on how to reconcile conflicts as they arise.

Initial findings in this study provide insight into how social workers have been reconciling cognitive dissonance related to harm reduction and abstinence-only treatment settings. Additional study is needed to help create and develop social work practice guidelines, curricula, and policies related to navigating these types of conflicts that social workers experience. The study's results show a need to implement more harm reduction-based education, training, and practice guidelines, as all participants reported experiencing issues of some sort related to using harm reduction approaches in addiction treatment at all system levels. Expanding research on addressing barriers for MSWs using harm reduction approaches at the micro, mezzo, and macro will help assess how to support clinicians utilizing and promoting harm reduction practices.

Conclusion

Future research concentrated on harm reduction education, practices, and policy can improve social work practice and its alignment with addiction treatment. This qualitative study sought to understand how MSWs experienced and reconciled cognitive dissonance related to their harm reduction education and abstinence-based only treatment settings. Results showed that all social workers in this study experienced cognitive

dissonance when utilizing harm reduction practices confirming that more needs to be done to enhance alignment between social work practice, harm reduction, and abstinence-based treatment approaches. Burris (2018) stated that, while we cannot expect "social or political consensus any time soon on the roles of inequality, despair, and their structural determinants . . . there is a huge reservoir of compassionate concern that cuts across parties and ideologies" (p. 31). Researchers know that there are fundamental differences between harm reduction and abstinence-based approaches; nonetheless, there needs to be continued efforts centered on improving integration between the two to enhance addiction treatment practices for those that seek and for those that provide such services. An element of social change is supporting policies and practices that increase equality and social justice, even without consensus (Burris, 2018).

One role of social work is to promote the client's right to self-determination, uphold the dignity and worth of all beings, and explore the advancement of services that align with these standards (NASW, 2008). Social workers should continue to engage in advocacy that promotes reforms improving anti-oppressive practices in the addiction field, such as using harm reduction. The field of social work should continue to address gaps between social work ethics, values, and its application to harm reduction education and practice to improve working conditions and general guidelines and alignment within the social work profession. These actions can reduce undue dissonance and stressors social workers experience as they already brave difficult work daily. More efforts must be made to protect and support those who enter the field committed to the service of others.

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Appendix A: Interview Guide

Participant Code: Date:

Location:

Time Started: Time Stopped:

Total Interview Time:

Supplies for interviews

> • Virtual interviews held in private locations
>
> • Informed Consent Form
>
> • Audio Recorder
>
> • Interview guide
>
> • Spiral notebook
>
> • Pens

An explanation of informed consent and consent forms for each interviewee will be completed prior to starting the interview.

Introduction

Thank you for agreeing to participate in this research study. My name is Miranda Kieler, and I am a PhD student at Walden University. I am conducting this study to fulfill program requirements for the degree of Doctor of Philosophy in Social Work with a specialization in addictions. As a reminder, this study is exploring how master-level social workers (MSWs) experience and reconcile cognitive dissonance related to their harm reduction education and abstinence-only practice in substance use treatment settings.

The interview can last up to but no more than 60 minutes. I will ask 13 questions during the interview process regarding your experiences an MSW and reconciling cognitive dissonance-related to harm reduction education and abstinence-only practices. I will leave time for you to ask any questions at the end of the interview. You may follow-up with me after the interview with any questions or concerns via email.

I understand that this topic can be difficult and has the potential to bring up uncomfortable memories of past working experiences. Please know that at any time you wish to stop or take a break, we will do so. It is not unusual for professionals in the field of social work to have personal histories with addiction. You are not required to disclose any personal history outside of the questions asked, however if during the course of participating in this interview you experience any emotional or psychological distress, I would urge you to call SAMHSA's National Helpline which is, 1-800-662-HELP (4357).

The session will be recorded to ensure that I do not miss any important pieces of information that you are willing to share with me today. All responses will be kept confidential and any personal identifying information will be removed to protect your privacy.

Please remember that participation in this interview is completely voluntary. You may withdraw from the study at any time without consequence.

Are there any questions or concerns you have before we begin?

With your permission we will begin this interview. I am going to record the start time before I begin asking questions.

I'm going to start with some general questions about you and your professional experience as an MSW.

- How many years have you practiced as MSW?

- Can you share a little about your past and current job positions or duties have you have had in the behavioral health field as an MSW?

- Harm reduction has many accepted definitions and is considered by some a theory, an approach, practice, policy, or treatment method. Drawing on your experience and education as an MSW, how do you define harm reduction?

- How might you explain to someone the consensus or lack of consensus related to harm reduction and (traditional) abstinence-only practices in substance use treatment settings?

- Share with me your experiences with abstinence-only practices in substance use practice.

- Share with me your experiences with harm reduction in substance use practice.

- What are your feelings regarding client self-determination in substance treatment practice?

- What are your feelings regarding client self-determination as it relates to harm reduction?

- Can you tell me about any experiences relating to a conflict you have had related to utilizing harm reduction in abstinence only practices while working in a substance use treatment setting?

- If conflict has occurred: what did that conflict, feel like for you? (Exploring if cognitive dissonance occurs).

- Was this conflict reconciled? Yes/No What are you able share with me about the reconciliation?

- Are there ways that your position as an MSW has influenced/not influenced cognitive dissonance related to abstinence-only practices and your harm reduction education (Turner, 2010)?

- Are there any factors that have created or counteracted cognitive dissonance related to your harm reduction education and abstinence-only practices in your experience as an MSW?

Conclusion

- Is there anything more you would like to add or wanted to ask me before we finish today?

My next steps will be analyzing the information you have provided me. If you are willing, I would like to contact you for a follow up to ensure the truthfulness or accuracy of data and have you review the transcript. I can also send you a 1–2-page summary of the study's results once the study is complete. Thank you again for your time and have a wonderful day.

Interview Format

The researcher will conduct virtual interviews via Zoom. Some of the language and questions used in this study may have required additional explanation.