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Reconciling Harm Reduction Philosophy and Approaches Among Abstinence-Only Substance Abuse Treatment Professionals

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Walden University
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Abstract

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MSW, Walla Walla University, 2009

BS, Eastern Oregon University, 2002

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

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Abstract

Historically, substance use disorder (SUD) treatment in the United States has been firmly grounded in abstinence-only treatment approaches. Harm reduction as a treatment model has gained additional traction. With increased rates of opioid use, overdoses, and advancements in medications for SUDs, harm reduction treatment approaches are becoming more important to improve lives of people who use drugs. Little is known about how counselors who have been educated, trained, and deliver abstinence-based SUD treatment reconcile use of harm reduction into their practice. To address this gap in literature, a generic qualitative study was conducted using the social constructivism theory. A purposive sample of 10 certified SUD counselors in the Pacific Northwest participated in semi-structured interviews which were analyzed using thematic coding. Counselors socially construct their understanding of abstinence-only treatment through professional standards, client safety, and personal recovery experiences, while harm reduction knowledge is shaped by cultural, community, and peer influences. Counselors apply harm reduction pragmatically and flexibly, prioritizing continuous learning and professional growth. Findings can be used to inform SUD counselors about harm reduction and improve schools, educators, and clinical supervisors about harm reduction. Findings are also relevant for advocates and policymakers aiming to promote adoption of harm reduction practices. More acceptance of harm reduction in the SUD field can increase overall knowledge and lead to shifts in social knowledge and acceptance of multiple treatment approaches.

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Dedication

To my supportive husband, John, thank you for being my best friend and loving partner in life. We have built an amazing life and family, and through all of this, you have supported all my endeavors and reminded me that I can achieve anything. You remind me that I am capable and erase all my self-doubt. To my children, Brenell, Sir, Tre, and Anton, you are my inspiration to grow, improve, and show you that dreams are possible. To my mother, who, if alive, would be in the front row hollering her ever-wavering support. Thank you, Mom, for believing in me and my abilities.

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Special thank you to Dr. Sean Hogan, my chair. You have offered me strong and steady support. I am grateful for your guidance through this doctoral journey. To my second committee member, Dr. Lindy Lewis, thank you for your practical feedback and support.

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Chapter 1: Introduction to the Study

According to the National Institute of Drug Abuse (NIDA, 2024), drug overdose rates in the United States increased by approximately 58% from 2019 to 2022. These increasing rates of overdose are in part due to the infiltration of fentanyl, which can be found in pill form or added into other drugs, such as methamphetamine or cocaine. With these increases in overdose rates and the number of Americans using and abusing opioids and other substances (NIDA, 2024), substance use disorder (SUD) counselors and social workers are encountering an increased number of individuals seeking treatment services. Harm reduction treatment approaches have also increased as drug use has increased. According to Gannon and Pasman (2023), harm reduction is "rooted in respect for the rights and autonomy of people who use drugs, the goal of harm reduction interventions is to improve overall health and quality of life rather than eliminate drug use entirely" (p. 2). Despite the increase in harm reduction strategies, abstinence-based treatment continues to permeate SUD treatment modalities (Paquette et al., 2022; Volkow, 2020). Counselors and social workers have historically been trained, educated, and socialized to use abstinence-based treatment approaches. This formal and socially learned abstinence-based treatment paradigm is now being challenged with the emergence of new knowledge regarding addiction and substance use treatment.

In this study, I conducted individual interviews with 10 SUD counselors who endorsed abstinence-based treatment to understand how they reconciled the inclusion of harm reduction into the treatment process. By understanding how SUD counselors reconcile or integrate potentially competing views, education, training, and public

messaging can be developed to increase adoption of harm reduction interventions in the SUD continuum. These interventions could significantly decrease the number of overdose deaths, increase the quality of life of people who use substances (PWUS), and improve treatment outcomes. In this chapter, I offer a comprehensive overview of the study. This includes the problem statement and study's purpose, its significance, potential social implications, definitions of key concepts, assumptions, scope and delimitations, and limitations. Furthermore, I outline the theoretical framework that underpins the study and provide a concise review of relevant academic literature.

Background

Treatment of SUDs in the United States has ranged from no regulation to intense regulation, which either influenced or was influential in terms of availability of treatment services to those who are suffering. The Puritan ideology that people should abstain from drugs has been endemic in the United States from its inception. Historically, treatment of SUD was done by medical doctors either in communities or secure institutional settings, or individuals were placed in jails to sober up as a form of treatment. In 1914, the United States Congress passed the Harrison Anti-Narcotic Act. This act taxed the sale and use of opium, opioids, and cocaine. Doctors and pharmacists had to register and report their prescriptions to the Department of Treasury through the newly formed Bureau of Narcotics (Courtwright, 2015). This was an attempt to regulate medical doctors, track the importation of narcotics, specifically disallowing the use of opiates to treat individual addiction to opioids, all of which hindered a physician's ability to treat individuals with SUDs (Courtwright, 2015; La Crosse Public Library, n.d.).

From 1919 to 1933, the United States operated under the Volstead Act, which was the act that enforced the 18th Amendment, which mandated prohibition. During these years, manufacturing, selling, and using alcohol were illegal. Additionally, doctors could prescribe alcohol for medical purposes but could also be prosecuted if they knew individuals were drinking and did not report them to the authorities. The temperance movement was very active during this time period; it advocated for a dry nation, further reinforcing that abstinence was the only option. In 1937, the Marijuana Tax Act was passed, making recreational use of marijuana illegal despite very limited marijuana use in the United States. The anti-marijuana policy was enacted due to propaganda about individuals from Mexico coming into the country using marijuana and committing crimes. In 1966, the Narcotic Addiction Rehabilitation Act (NARA) called for states to increase treatment services for people using drugs, mainly for states to civilly commit these people (Rettig & Yarmolinsky, 1995) Most states experienced significant strains on their state hospital systems and diverted PWUS to outpatient treatment settings. The NARA had specific requirements for treatment including access to methadone maintenance treatment (Rettig & Yarmolinsky, 1995). It was necessary to require access to methadone as there was aversion within medical communities to treat people using opioids, and formation of opioid treatment programs was needed (Stroud et al., 2022).

In 1970, the Controlled Substances Act was passed, creating a schedule of drugs based on their dangerousness, which affected which drugs could be prescribed and also informing severity of criminal charges used by law enforcement. Additionally, this act eliminated mandatory minimum sentences for drug charges and allocated money to

increase research and create treatment for people who use drugs. The Controlled Substances Act also provided clarifying language about health professionals "determining the scope of the practice of medicine in this area" (Rettig & Yarmolinsky, 1995, p. 124), and not law enforcement, while limiting access to methadone treatment. Despite this clarification, the Food and Drug Administration (FDA) increased its regulation of methadone in 1972, creating onerous regulatory requirements for methadone clinics and participants (Stroud et al., 2022). The Anti-Drug Abuse Act, which was passed in 1986, increased consequences for possession of drugs, making most possessions a felony. Mandatory minimum sentences returned based on drug schedules via the 1970 Controlled Substances Act. This act had little to do with treatment of drug abuse, but instead took criminal approaches to remedy a medical disorder (Didwania, 2020).

Abstinence-based treatment has a deep-rooted history in the context of SUD interventions, particularly in the United States. This can be traced back to the temperance movements of the late 19th and early 20th centuries, which involved advocating for complete abstinence from alcohol and other intoxicating substances (White, 2000). This movement was driven by a combination of religious, moral, and social reform agendas that viewed substance use as a moral failing and significant societal ill. The belief that total abstinence was the only viable solution to overcoming addiction gained prominence and significantly influenced development of early treatment programs and public policies related to substance use (Levine, 1978).

The profession of SUD counselor is fairly new. Historically, these counselors were typically lay professionals, often individuals who had quit drinking or using drugs themselves (Hagedorn et al., 2012; White, 2000). Establishment of Alcoholics Anonymous (AA) in 1935 marked a pivotal moment, further solidifying the abstinence approach via the framework of the 12-step program (W., 2019). AA's philosophy emphasized the necessity of complete sobriety as a prerequisite for recovery, a notion that was later adopted by numerous other mutual-help groups and lay professional treatment programs (Kurtz, 2002).

As the field of addiction treatment evolved, abstinence-based methodologies continued to dominate. One significant adaptation of the 12-step philosophy is the Minnesota Model, which emerged in the 1950s. This model involves integrating AA principles with professional medical and psychological care, promoting a holistic and multidisciplinary approach to treatment (Bose, 2021; Hazelden Betty Ford Foundation, n.d.). The 1950s also marked a significant increase in formal outpatient and residential treatment facilities, most using the Minnesota Model. With a more formalized treatment approach, the need for professional SUD counselors increased.

In 1970, the National Association for Addiction Professionals (NAADAC) was formed, and the professionalization of SUD counselors began. With this professionalization also came standardization of ethics and training requirements (Hagedorn et al., 2012). These training requirements recommended training involving treatment theory, which at the time was heavily grounded in the disease model, which endorsed abstinence-only treatment approaches (Ehrlich, 1961; Page, 1997). Abstinence-

based treatment has become deeply embedded in training and practices of SUD counselors and social workers, often serving as the cornerstone of their therapeutic approaches (Iliades, 2022; Volkow, 2020). Despite the emergence of harm reduction and other alternative strategies, abstinence remains a central tenet in many SUD treatment settings, reflecting its historical and cultural significance (Marlatt, 1996).

Harm reduction treatment has emerged as a pragmatic and evidence-based approach to addressing SUDs by focusing on mitigating adverse health, social, and legal consequences associated with drug use, rather than solely emphasizing abstinence (Kimmel et al., 2021; National Harm Reduction Coalition, n.d.). This paradigm gained traction in the late 20th century as public health experts recognized limitations of abstinence-only models, particularly for populations where immediate cessation of substance use was neither feasible nor realistic (Marlatt, 2002). Harm reduction encompasses a spectrum of interventions, including needle exchange programs, supervised injection facilities, opioid substitution therapies (e.g., methadone or buprenorphine), and distribution of naloxone to prevent overdose fatalities. These strategies aim to reduce transmission of infectious diseases, prevent overdoses, and ameliorate other health complications, thereby enhancing overall wellbeing of individuals who use drugs (Hawk et al., 2017).

The harm reduction philosophy is rooted in public health principles and human rights frameworks, advocating for nonjudgmental and noncoercive services that are tailored to people who use drugs. This approach emphasizes meeting individuals where they are and providing support to minimize harms associated with drug use, without

necessitating complete cessation of substance use (Ritter & Cameron, 2006). Harm reduction programs yield substantial public health benefits, including reductions in HIV and hepatitis C transmission, decreased mortality from overdose, and increased engagement with treatment and other health services (Des Jarlais et al., 2009). Despite facing some opposition, particularly from advocates of abstinence-only models, harm reduction continues to gain acceptance as a critical component of comprehensive SUD treatment and public health strategy.

Despite the need to create more comprehensive SUD treatment approaches, level of acceptance of harm reduction approaches varies. Counselor personal experience, years of experience in the field, training, and organizational culture all contribute to level of acceptance (Davis & Rosenberg, 2013). Social phenomena are socially and culturally constructed (Mercadal, 2023). Learning and knowledge are co-constructed through interplay of individual motivation and societal or environmental influences (Amineh & Asl, 2015). SUD counselors, who are often in recovery from SUDs, have constructed their knowledge about the most effective treatment approaches using their own experiences, norms, and treatment facilities.

Due to the need for more expansive SUD treatment approaches, SUD counselors have been faced with the need to integrate more harm reduction approaches into their practices. Jordan et al. (2023) found professional identity of counselors significantly shaped their perceptions of harm reduction, leading to important implications for both clinical practice and professional training. Further, Kieler (2023) found, through supervision, advocacy work, moving to job positions that better align with beliefs and

values, and practicing cultural humility, masters-level social workers who worked in the SUD field were able to mitigate their cognitive dissonance. There is limited research about SUD counselors and their beliefs about SUD treatment services as well as how they include harm reduction into treatment approaches. By addressing this gap, I sought to increase understanding of how SUD counselors who endorse abstinence-based treatment approaches include harm reduction approaches into treatment and if changing social constructs have influenced this phenomenon.

Problem Statement

Substance use and SUDs are highly stigmatized social problems (Lloyd, 2013). It is considered a moral failure (Barry et al., 2014). These ideologies stress addiction is not curable and can only be controlled or placed into remission via total abstinence (Barnett et al., 2020; Bell et al., 2014). Because these ideologies are ingrained in U.S. society and education and training of SUD counselors, it is likely they hold similar beliefs about clients they are treating (Mercadal, 2023; Taylor et al., 2021). For clients where abstinence is not their goal, accessing treatment services may prove to be difficult due to abstinence-only models. This leaves these clients vulnerable, as they are unlikely to seek out treatment services that lack harm reduction approaches (Brocato & Wagner, 2003). Due to the opioid crisis, increasing harm reduction has become critical to SUD treatment approaches. About half of all SUD counselors endorse abstinence-based treatment practices (Brocato & Wagner, 2003; Davis & Rosenberg, 2013), which means others endorse some sort of harm reduction model.

Keeping people who use substances alive is the first step in the recovery process (Taylor et al, 2021). This is especially true with the burgeoning opioid use in the United States (NIDA, 2024). Further steps include developing an opioid response in all SUD treatment settings that is based on a harm reduction model that does not include abstinence language or ideology. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2021) found 21.6 million people in the United States were in need of SUD counseling services, and of those people who did not seek treatment services, 40% did not actively engage in treatment services because they were not ready to stop using. Furthermore, Individuals who access harm reduction services are three times more likely to stop using drugs compared to those who did not engage in services, as well as five times more likely to enter into treatment services (Hagan et al., 2000).

The problem is SUD counselors who have their own using and recovery experiences and education and training which is largely grounded in abstinence-based models are faced with the integration of harm reduction into the SUD treatment field. Approximately 71-87% of social workers actively serve clients experiencing SUDs (Wells et al., 2013). Social workers who are committed to improving the lives of all people, especially those who are vulnerable and oppressed, are also using their own experiences, education, and training.

Purpose of the Study

The purpose of this exploratory generic qualitative study was to understand how SUD counselors reconcile their abstinence-only treatment approaches with emerging harm reduction interventions. As SUD treatment evolves, so too must the education and

training of SUD counselors. The opioid epidemic has highlighted the need for more comprehensive approaches to SUD treatment. I explored how SUD counselors reconciled their abstinence-based practices with inclusion of harm reduction practices into SUD treatment models. My objective was to provide insights regarding this phenomenon and understand how social constructivism helps in terms of reconciling competing perspectives.

Research Questions

Research questions (RQs) for this generic qualitative study were:

RQ1: How do SUD counselors socially construct their endorsement of abstinence-based treatment approaches?

RQ2: How do SUD counselors socially construct their understanding of the harm reduction treatment approach?

RQ3: How do SUD counselors reconcile their long-standing socially constructed knowledge of abstinence-based treatment approaches with the new harm reduction treatment approach?

Theoretical and/or Conceptual Framework for the Study

The theoretical framework for this study was Vygotsky's theory of social constructivism. The theory is learning and knowledge are co-constructed through the interplay between individual intrinsic motivation to learn and influences of societal and environmental factors (Amineh & Asl, 2015; Mercadal, 2023). Vygotsky (1978) asserted individual cultures and environments are crucial factors during the process of acquiring and assimilating knowledge. Further, I used Bourdieu's expansion of Vygotsky's theory.

External structures and positions influence cognitive processes and beliefs (Jovanović, 2021). Roles and positions within society shape their learning and knowledge. Individuals' habits and behaviors are influenced by their social status, roles they fulfill, and social structures within which they operate, rather than being solely determined by innate characteristics.

I discuss social constructivism in relation to how SUD counselors came to understand abstinence-based treatment in Chapter 2. Jordan et al. (2023) found counselor identity influences their perceptions of harm reduction. Specifically, if their area of practice and training align with harm reduction principles, this will be part of their professional identity. Kieler (2023) found master's level social workers experienced cognitive dissonance when practicing harm reduction based on their own beliefs and training. Their knowledge came in part from socially and professionally constructed knowledge. I emphasized SUD counselors' comprehension of their knowledge acquisition processes and methods of reconciling conflicting information.

Nature of the Study

For this study, a generic qualitative approach was used. This broad approach involved conducting semi-structured individual interviews. A generic qualitative approach was appropriate for exploring how SUD counselors experienced and understood development of abstinence-only treatment approaches and how they integrated harm reduction approaches into their practices. A generic qualitative approach allows for flexibility, unlike other qualitative approaches (Kahlke, 2018). This provided participants the opportunity to share their unique experiences and explore social norms that aided in

their construction of knowledge. While the narrative qualitative approach was considered, it was not flexible in terms of exploring social influence on participants' knowledge and experience.

To implement this research design, I created a demographic survey and interview guide informed by my literature review and theoretical framework, with interview questions that were designed to address the research question. I conducted virtual interviews with participants who identified as SUD counselors and used abstinence-only treatment approaches. The purposive sampling method was crucial for addressing specific experiences that were needed to fulfill study objectives and ensuring participants provided relevant and meaningful insights (Campbell et al., 2020). Participants were recruited through the state certification board's listserv. I used Zoom to conduct semi-structured interviews, enabling interview transcripts and field notes. Eligible participants were certified SUD counselors who used abstinence-only treatment approaches.

I developed a demographic questionnaire to collect information regarding participants' age, years of experience, practice location, type of certification, and self-identification as being in recovery from SUDs. An interview guide was designed to determine the interview process, drawing on best practices from literature. I employed thematic analysis to review and code interview transcripts and field notes, identifying themes involving participants' experiences with integrating harm reduction into their treatment approaches.

Definitions

The following are definitions of key terms used in this study:

Abstinence: Cessation of drug consumption (Volkow, 2020).

Abstinence-Only or Abstinence-Based Treatment: Treatment approach that sets goals for clients to abstain from all drugs and alcohol in treatment. Clients must accept they are addicts and that the only path to recovery is through abstinence. This is also termed the traditional treatment approach (Gallagher & Bremer, 2018).

Harm Reduction: According to Harm Reduction International (n.d.), "Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs" (para. 1).

Harm Reduction Treatment: Avoiding judgment and acknowledging individual decisions to use drugs must be respected while providing interventions that reduce harm of using drugs (de Miranda, 2022).

Social Constructivism: A theory that learning and knowledge are co-constructed via individual drive to learn as well as societal and environmental influences (Amineh & Asl, 2015).

Substance Use Disorder (SUD): According to the SAMHSA (2023), "The recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home" (para. 4).

Assumptions

I assumed SUD counselors who lived in and engaged in most of their counselor training in the United States had socially-constructed knowledge about abstinence-only

treatment approaches. Based on literature, SUD counselor training is predominantly grounded in abstinence-only approaches. I assumed participants willfully shared how they obtained their knowledge and incorporated new knowledge about harm reduction approaches. I addressed only perceptions, beliefs, attitudes, and knowledge of SUD counselors who used abstinence-only approaches and how they reconciled use of harm reduction. Additionally, I assumed due to the opioid epidemic there was an increase in harm reduction education and exposure to harm reduction interventions (Jordan et al., 2023).

Scope and Delimitations

For this research project, my primary focus was to identify and interview SUD counselors who endorsed abstinence-only approaches to treatment in order to determine how they reconciled addition of harm reduction into SUD treatment. Prior to this research, only one large quantitative study had been conducted to determine how and if counselors accepted and incorporated harm reduction into their practices (Jordan et al., 2023). I assumed professional identity contributed to socially-constructed reality and responses to substance use. Rather than assuming all SUD counselors built their socially-constructed knowledge about abstinence-only treatment and integration of harm reduction, I used this research project for SUD counselors to provide their own valuable insights.

This study only included SUD counselors who primarily used abstinence-only approaches, and I excluded SUD counselors who identified as endorsing multiple treatment approaches based on client need. This may have excluded a majority of SUD

counselors, as SUD counselors have previously identified that only 25% of their clients had an acceptable treatment goal of abstinence (Rosenberg & Phillips, 2004). Social workers who hold dual certifications as licensed social workers and SUD counselors may have also been excluded from the study because of their professional education and social justice orientation.

Qualitative researchers aim to answer questions about how individuals perceive and interpret their experiences (Kahlke, 2018). This research project established a forum for SUD counselors to articulate their experiences, thereby generating valuable insights that may inform development of enhanced education and training programs. Transferability is limited to SUD counselors in the Pacific Northwest who used abstinence-only approaches.

Limitations

This study has a few limitations in terms of its design. I conducted a qualitative research study to understand beliefs, views, and attitudes of SUD counselors who used abstinence-only treatment approaches. Qualitative data are not designed for universal transferability across all subjects, including SUD counselors (Creswell & Creswell, 2009). In the Pacific Northwest state where participants were recruited, there are approximately 6,000 certified SUD counselors. Not all of these counselors likely used abstinence-only approaches.

Another limitation of this study is researcher bias. I recognized personal bias could influence my interpretations of collected data. To mitigate this, I employed member checking to ensure accurate reporting of participants' perceptions. Furthermore, I used

reflexive journaling to track my thoughts and emotions during data collection and analysis. Selection bias is also another limitation of the study. I implemented a purposive sampling method by reaching out to all certified SUD counselors in the state. An email was sent to all SUD counselors in the state explaining the study and recruiting SUD counselors who used abstinence-only approaches to treatment. Counselors voluntarily agreed to participate or not. It is possible that not all counselors read the email, and those that volunteered to participate were different from those counselors who chose not to participate. I took steps to ensure selection bias was minimized. I chose to recruit from the entire pool of certified counselors to reduce selection bias and offered small incentives to participants to improve recruitment.

Significance

I addressed a gap in research regarding how SUD counselors who use abstinence-only approaches to treatment reconciled integration and use of harm reduction approaches in treatment settings. To date, there have been very limited studies regarding this phenomenon, though Jordan et al. (2023) recently conducted a quantitative study that explored counselors' perceptions of harm reduction. Researchers in this study call for further qualitative exploration of how a counselor's identity forms their harm reduction perceptions. For individuals who are in need of SUD counseling, abstinence-only treatment may be appropriate and helpful. For others, a harm reduction approach may be a better avenue for engagement. Counselors who staunchly endorse abstinence-only approaches likely miss engagement and treatment opportunities with individuals who are not ready, able, or desire to engage in abstinence. Harm reduction leads to interventions

that improve safety and mitigate harms that result from using drugs (Kimmel et al., 2021).

The goal of this study was to better understand how SUD counselors came to acquire their abstinence-only approaches, current understanding of harm reduction, and how they reconciled inclusion of harm reduction into SUD treatment. Potential contributions to practice include advancement of harm reduction as a social justice movement, improving dignity and worth of PWUS, and improving professional competence. This study suggests that lack of harm reduction training prevents SUD counselors and social workers from understanding benefits of implementing evidence-based harm reduction interventions. This lack of training not only inhibits the competency of social workers and SUD counselors, but also leads to failing to fully identify PWUS as whole and worthy people, even if they continue to use substances. Further, this study may contribute to advancing social justice efforts for PWUS. If SUD counselors and social workers learn that PWUS experience high rates of poverty, racism, and social isolation, advocating for improved care, which includes harm reduction interventions, may follow.

Understanding needs of PWUS and how to engage them is helpful, and life-saving services are critical. By understanding how SUD counselors have built their knowledge and endorsement of abstinence-only approaches, they will ultimately provide information about how to improve education and training. With opioid overdose deaths continuing to increase across the United States, increasing engagement with PWUS and providing life-saving medications and harm reduction supplies leads to staying alive and

engaging in recovery as they are able. Incorporating harm reduction into the repertoire of abstinence-only counselors can have a significant impact on their lives. Further, it can have a significant impact on the profession by improving education and training opportunities and the profession as a whole.

Summary

SUD counselors have obtained their treatment approach knowledge through their own lived experiences, education, training, and societal beliefs. This socially-constructed knowledge in the United States has led to most SUD counselors endorsing abstinence-only approaches to treatment. Counselor identity influences perceptions of harm reduction (Jordan et al., 2023). As more Americans are dying of opioid overdoses, more harm reduction interventions are available to keep people alive. There is a lack of research regarding perspectives of SUD counselors who used abstinence-only approaches to treatment and how they reconciled use of harm reduction in treatment. I provided a brief foundation for conducting this research, as well as a brief background, theoretical framework, and limitations of the study. In Chapter 2, I address the theoretical framework, research on abstinence-only treatment approaches, and harm reduction.

Chapter 2: Literature Review

Increased rates of problematic substance use within the United States has led to the need for more expansive treatment modalities (Volkow, 2020). Substance use treatment is based in an abstinence-based treatment model that is exclusionary for people who are unwilling or unable to abstain from all drug use (Paquette et al., 2022; Volkow, 2020). This exclusionary treatment approach leaves people vulnerable to overdose, increased rates of communicable disease transmission, and death (Volkow, 2020). A harm reduction approach involves not demanding abstinence but rather providing interventions to reduce harms caused by drug use (Huhn & Gipson, 2021; Perera et al., 2022). Methadone clinics, needle exchanges, and harm reduction distribution agencies exist throughout the world, and recently, the U.S. federal government eliminated waiver requirements for medical providers prescribing suboxone, a harm reduction medication for people using opioids (McElrath & Joseph, 2018; SAMHSA, 2023c; Vlahov et al., 2001). This removal allows any medical practitioner to prescribe suboxone with no limitations. With this shift to a harm reduction model, many treatment providers who have been trained and indoctrinated regarding abstinence-based treatment modalities are grappling with their treatment approach.

Researchers have explored how social constructivism impacts education and training of counselors who serve individuals who use drugs. They have examined social constructivism as it relates to language and discourse in addiction and recovery, as well as substance use treatment provider education and training. Language is pivotal in constructing social reality (Haidar et al., 2020), and influences the tone and tenor of

treatment services. Abstinence-based treatment modalities are the preferred approaches for counselors (Paquette et al., 2022; Volkow, 2020). Social workers and SUD counselors are more accepting of harm reduction due to a shifts in training and education about benefits of harm reduction (Jordan et al., 2023). Still, there is little to no research on how counselors who have been educated and trained to deliver abstinence-based SUD treatment reconcile use of harm reduction into their practices.

The purpose of this exploratory generic qualitative study was to address how and if outpatient SUD counselors who were trained in and endorsed abstinence-only approaches reconciled use of harm reduction modalities. This chapter includes an outline of the literature search strategy and social constructivism theory in terms of its significance to this study. Subsequently, I review the history of abstinence-based and harm reduction models. Further, I examined their acceptability amongst counselors. Throughout the literature review, I emphasized the necessity of research aimed at addressing how counselors who adhere to and administer abstinence-based treatment integrate harm reduction into their treatment approaches. The chapter concludes with a summary of key points and conclusions and transition to Chapter 3.

Literature Search Strategy

To locate literature for this study, I initiated the process by compiling a list of essential terms and concepts that were pertinent to the literature review. Initially, I used two primary research databases: Google Scholar and the Walden University Library. Key terms were *addiction*, *substance use*, *constructivism*, *social constructivism*, *Vygotsky*, *E.M. Jellinek*, *substance use disorder counselors*, *social worker*, *harm reduction*,

addiction education, *addiction training*, *disease model of addiction*, *12-step*, *Minnesota Model*, and *qualitative research*. I searched for peer-reviewed articles that were applicable and useful. I used the following databases: SocINDEX with Full Text, ERIC, SAGE Journals, ScienceDirect, APA PsycInfo, Academic Search Complete, MEDLINE with Full Text, Directory of Open Access Journals, Complementary Index, Directory of Open Access Books, Supplemental Index, and CINAHL Plus with Full Text.

Theoretical Foundation

Social phenomena are "socially and culturally built" (Mercadal, 2023, p. 3). Social constructivism results from cognitive constructivism where learning occurs without the influence of social context (Vygotsky, 1978); learning and knowledge are co-constructed with individual drive to learn and societal or environmental influences (Amineh & Asl, 2015). Vygotsky (1978) posited culture and environment play a critical role in terms of how individuals obtain and assimilate knowledge. To truly understand psychological functions, one needed a "comprehensive approach that would make possible description and explanation" (Vygotsky, 1978, p. 5). This underscores the predominant role of external influences, including cultural, historical, and social interactions, in terms of shaping cognitive development, rather than attributing it solely to individual construction (Amineh & Asl, 2015). Individuals navigate their behaviors using psychological tools, with language emerging as the fundamental tool in this process (Amineh & Asl, 2015; Tada, 2020).

Pierre Bourdieu, a prominent French sociologist, is widely recognized as a leading figure in constructionist thought. Bourdieu explored the impact of external social

structures on individuals. Despite their external imposition, these structures exert a profound influence on individuals' cognitive processes and beliefs (Jovanović, 2021). Instead, they are shaped by particular positions or roles individuals occupy within specific social contexts or environments (Holguín & Dionicio Lozano, 2023). People's habits and behaviors are influenced by their social status, roles they play, and social structures they navigate, rather than being predetermined by their innate qualities.

Building on Vygotsky and Bourdieu, constructivism theory suggests that a person's culmination of knowledge becomes their identity (Barrow et al., 2022; Holguín & Dionicio Lozano, 2023; Vygotsky, 1978). This identity often becomes the lens for new knowledge (Jordan et al., 2023). The individual's perception of their world, who they are in the world, and their understanding of it are shaped by subjective experiences, social interactions, and primarily, socialized experiences (Jovanović, 2021). These encounters arise from a collection of social knowledge, a plethora of significance encountered by individuals as something deeply embedded in history and socially endorsed, and could be coined as socially embedded knowledge (Jovanović, 2021).

Constructivism in Substance Use Disorder Field

Common among SUD counselors is the drive to learn more about treatment modalities, which include trainings, previously acquired knowledge, an opportunity or environment to learn, along with others in the industry offering guidance. Many, if not a majority of SUD counselors are in recovery from using drugs (McNulty et al., 2007; White, 2000). SUD counselors have been exposed to the language and culture of mainstream SUD treatment, whether through their own treatment experiences or through

training, education, and/or supervision. The disease model serves as a paradigm within the SUD treatment field (Heilig et al., 2021). This theory frames addiction as a chronic, incurable disease (Heather et al., 2022; Heilig et al., 2021). According to this model, individuals struggling with SUD are biologically and psychologically incapable of engaging in controlled or moderate use of substances, therefore, complete abstinence is considered the only viable option for managing their condition (Becoña, 2018; Heather et al., 2022; Ricardo et al., 2023). The disease model significantly shapes the understanding and approach to addiction and treatment among SUD counselors. It influences their therapeutic strategies, promoting interventions that focus on long-term recovery and management rather than short-term cessation (Hazelden Betty Ford Foundation, n.d.). Furthermore, this model shapes the construction of knowledge among counselors by emphasizing continuous education on the neurobiological aspects of addiction, encouraging the adoption of evidence-based practices, and fostering a holistic understanding of addiction that includes genetic, environmental, and psychological factors. Language is seen as fundamental to thought, actively molding it. In constructivist research, language occupies a crucial role, functioning not only to describe but also to perform actions and shape understanding. (Jovanović, 2021). It is the language within the SUD treatment world that contributes the formation of knowledge, or how an SUD counselors knows how to deliver treatment services.

Haidar et al. (2020) explored the experiences of people who use drugs and the influence of language on drug-related behaviors and practices using a phenomenological approach. They identified that the reality of people who use drugs are “constructed by the

interaction that takes place between them when they sit in a company and take drugs" through the use of language (p. 54). Haider et al. (2020) interviewed 15 individuals and conducted three focus groups with same original 15 participants. They utilized open ended questions to investigate what words were used to describe drugs, drug use, and other drug-related behaviors and practices. One of the key findings is the categorization of drug-related language into terms that either glorify or vilify the addiction experience. For example, marijuana or hashish is often referred to in positive terms such as medicine, which may enhance its desirability among users. Conversely, those who use heroin tend to use more negative descriptors, reflecting a more troubled relationship with their drug of choice. Using a social constructivism framework, they were able to understand that these linguistic choices are not merely incidental but are deeply embedded in the social interactions and cultural contexts of the users, influencing their perceptions of and engagement with drug use.

This study bears significance when considering counselors in the United States who have experienced recovery themselves, often through engagement with residential, outpatient, and inpatient treatment services. The language used in these settings regarding drug use and recovery is nuanced and specific to the community, making it difficult for outsiders to fully comprehend the context. It is this cultural influence within these settings that encourages individuals to develop new knowledge or reinforce existing understandings.

McGrath and DeDiego (2023) investigated the integration of professional and recovery identities among counselor trainees from a narrative inquiry perspective using a

qualitative narrative inquiry through semi-structured interviews. This perspective involves aspects of social construction of identity, which emphasizes how identities are formed and influenced through social interactions, cultural contexts, and personal narratives. The researchers conducted semi-structured interviews with seven counselors with varying time in recovery, ranging from 8 months to 17-plus years. All participants were currently enrolled in a master's level counseling program in the United States. McGrath and DeDiego (2023) discovered that counselors employed a phased development approach to progressively incorporate their personal histories, such as those involving recovery, into their professional identities. This integration was influenced by their interactions with peers, supervisors, and the wider professional community. Participants often experienced conflict when their personal recovery experiences were perceived to conflict with professional expectations.

McGrath and DeDiego (2023) stated participants' personal identities as individuals in recovery were molded through their active participation in treatment and support systems like AA, crucially shaping and reinforcing their sense of self. As participants encountered challenges during their educational and professional training, they experienced discomfort as their emerging professional identities intersected with the ongoing development of their personal identities. Furthermore, the research highlights how a counselor's motivation to acquire knowledge is influenced by their prior and current social environments, facilitating the construction of knowledge. Integrating new knowledge can be challenging, especially in the SUD field. New information about causes and treatment options are continuously developing, yet SUD counselors are rarely

involved in the development of these treatment options, and therefore not part of their current knowledge or formation process. SUD counselors' language and identity has been built by their involvement in treatment and social support networks. This socially constructed knowledge of recovery has been rooted in an abstinence-only approach. With little to no language, identity, or participation in treatment or support services that endorse harm reduction, I anticipate uncovering personal and professional conflict. Likely common themes will emerge and, therefore, answering my question about how SUD counselors with a socially constructed abstinence-based perception of substance use treatment reconcile the use of harm reduction substance use treatment approaches.

Literature Review Related to Key Variables

The literature review identified the history of abstinence-based treatment approaches in substance use disorder treatment, specifically addiction as a disease, and the 12-step model. The literature explored how abstinence-based ideology dominated the culture in the United States and how this contributed to the social constructed knowledge of counselors. Harm reduction, as a non-abstinence-based treatment approach was also reviewed. The literature review addressed the role that these models have played in the knowledge building of SUD counselors.

History of Abstinence-Based Treatment Models

Abstinence has long been the gold standard and ultimate goal for individuals suffering with an SUD (Carroll, 2023; Iliades, 2022; Volkow, 2020). Addiction, as a social phenomenon, is built on societal and cultural beliefs. In the United States, historically, the predominately socially constructed belief about addiction is that it is a

moral shortcoming, and that to rid yourself of this moral shortcoming you must abstain from all use (Paquette et al., 2022; Volkow, 2020). This ideology, stemming from the temperance movement, continues to influence the treatment world, and the training and education offered to SUD counselors and social workers in the United States (Iliades, 2022; Volkow, 2020). This section will discuss the disease model of SUD, 12-step approach, and the Minnesota model, which are the most common training and treatment approaches utilized in the SUD field.

Substance Use as a Disease

The disease model has an extensive history that, like other theories, has had intense periods of investigation and periods where investigation was halted or thwarted by societal, political, or conflicting theoretical concepts within the field (Heather et al., 2022; Ricardo et al., 2023). Beginning in the early 19th century, scientists began noticing and reporting on alcoholism as a disease (Ricardo et al., 2023). The early models supposed addiction was a disease of will, that if tempered would cure the individual (Heather et al., 2022). It was not until 1930's that the disease model began to gain traction in the medical and treatment community (Becoña, 2018). The disease model overlaps with the diathesis-stress model, that individuals were genetically predisposed to addiction, and once they started using a substance, this triggered changes in the brain that were reinforcing of continued use (Heather et al., 2022; Ricardo et al., 2023). This model presumes, that individuals who are born from families where addiction is present, will also suffer from addiction if they ingest a drug (Becoña, 2018; Heather et al., 2022). This model did not account for individuals who had a genetic predisposition, used a drug, and

did not develop SUD. This early research accentuated the chronic nature of addiction, which emphasized abstinence as the only way to manage this disease.

From 1960 to the end of the 1980's, scientists continued to refine and restate addiction as a disease model. In 1960, E.M. Jellinek published his book, The Disease Concept of Alcoholism. In this book, which was a culmination of his studies beginning in the 1940's, Jellinek discussed the predictive patterns of individuals who drank in excess (Ehrlich, 1961; McIntyre, 2010), clearly identifying different levels of addiction, or what has since evolved into the continuum of use (McIntyre, 2010; Paquette et al., 2022). Jellinek's contribution strengthened and bolstered the scientific approach to understanding SUDs, further enhancing its credibility (Page, 1997). It is important to note that a scientific approach to addiction during this time period was an attempt to decrease the biases and stigmatization of alcoholism, yet it further solidified an abstinence based approach to treatment as the preferred and scientifically endorsed treatment modality (Ehrlich, 1961; Page, 1997), despite Jellinek's attempts to educate clergy, temperance organizations, medical and legal professionals (Page, 1997). Jellinek pointed out that adopting a treatment-oriented approach instead of resorting to incarceration could alleviate the burden on law enforcement and reduce the strain on jails (Page, 1997). Additionally, the influence of AA further linked the disease model with an approach to treatment centered on abstinence (Ehrlich, 1961; McIntyre, 2010; Page, 1997). The early 1990's saw a boom in neuroscience research that coined addiction as a "chronic, relapsing brain disease" (Heather et al., 2022, p. 284). While this new theory brought a reprieve from the morality paradigm, it

reinforced that abstinence was the only mechanism to put this disease into remission. 12-Step Model

The 12-steps were conceptualized in 1935 by AA co-founders Bill Wilson and Dr. Bob Smith, who sought a solution to their own struggles with alcoholism. The publication of The Big Book, titled "Alcoholics Anonymous" in 1939, formally introduced the 12 steps as a program of recovery (AA, 2024). Rooted in a synthesis of medical insight, spiritual wisdom, and practical experience, the model emerged as a revolutionary peer-led approach to addressing alcohol addiction (Andraka-Christou et al., 2022; Kimball et al., 2022). Its development was influenced by earlier movements such as the Oxford Group (Mercadante, 2015), which emphasized moral and spiritual growth, yet AA's framework was distinct in its singular focus on alcoholism and its reliance on anonymity and peer support as mechanisms for healing and transformation (Sharma & Branscum, 2010). Teasing apart the Puritan concepts of the Oxford Group and newly enlightened disease concept within the 12-step model will be further explored.

The 12-step model's acknowledgment of addiction as a disease aligns with modern medical understanding, which views addiction as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite harmful consequences (Miller, 2019). This perspective is foundational to the first step of the 12-steps, which involves admitting powerlessness over addiction, a recognition of the biological and psychological grip of the condition on the individual (W., 2019). When created, the 12-step model was viewed as a harm reduction approach, as anyone could engage in the program if they had a desire to stop drinking/using (W., 2019), though it prioritized the need for total

abstinence as the path to recovery (Lee et al., 2011). Though this language is not in the Big Book, it highlights how the 12-step community constructed a reality specific to the concept of recovery (Lee et al., 2011). Andraka-Christou et al. (2022) pointed out, 12-step programs demand abstinence, even from lifesaving medications for addiction treatment, which does not align with the disease model and harkens the societal reality, or socially constructed belief, that abstinence is the only way to true recovery. At the heart of the 12-step model are principles designed to guide individuals from the depths of addiction to a path of sustained recovery, and reinforces that abstinence is critical and the ultimate goal (Lee & O'Malley, 2018).

A distinctive feature of the 12-step model is its emphasis on spirituality and a moral inventory, a process that encourages individuals to engage in self-reflection and personal growth. Steps 4 through 10 specifically guide participants through a rigorous examination of their past behaviors and attitudes, fostering a sense of moral awareness and responsibility (W., 2019). This introspection, coupled with the practice of making amends, aims to rectify past wrongs and rebuild relationships, further cementing the foundation for a sustainable recovery (Dermatis & Galanter, 2016). Kimball et al. (2022) found that individuals engaged in 12-step and identified an increase in spiritual connection were able to achieve bigger goals such as school or career. But, as Anonymous (2022) shared, this examination was rooted in an Ignatius view that all addicts were sinners but still loved by God. By integrating these spiritual and moral principles, the model offers a holistic approach to overcoming addiction, addressing not just the physical and psychological aspects, but the ethical and spiritual dimensions of the

disease as well (Galanter, 2007). For many participants, a combination of treatment and 12-step philosophy has been helpful (Mutschler et al., 2022). In fact, SAMHSA (2021) reports 98% of clients who enrolled in SUD treatment services were offered a variety of treatment interventions including relapse prevention, motivational interviewing, and cognitive behavioral therapy. Sixty-five percent of treatment agencies integrate the 12-step model into their treatment regime (SAMHSA, 2021).

Community and peer support form the foundation of the 12-step model, facilitating a shared journey towards recovery (Galanter et al., 2023). Meetings and sponsorship provide a platform for mutual support, shared experiences, and the transmission of collective wisdom (Best et al., 2020; Costello et al., 2019; Daley & Douaihy, 2019; Galanter, 2007). This communal aspect reinforces the model's strength, offering ongoing encouragement and accountability (Kelly & Yeterian, 2011). The 12-step model places significant emphasis on storytelling and shared narratives within group meetings (Clark, 2022; Heimdahl Vepsä, 2020). These narratives are pivotal in shaping members' understandings of their own experiences with addiction and recovery. Through the act of sharing personal stories, members construct a collective identity that reinforces the model’s principles (Cong et al., 2021; Gordon & Willig, 2021; Lee, 2020). This practice aligns with the social constructivist view that language and shared narratives are fundamental in constructing reality. It helps individuals to reframe their experiences of addiction within a context that emphasizes hope and collective resilience and likely reinforcing the abstinence model. This dynamic is further influenced by the fact that many SUD counselors are in recovery themselves (McNulty et al., 2007; White, 2000).

Their personal experiences with addiction shape their understanding and approach to treatment, contributing to a social construction of addiction that emphasizes shared narratives of recovery (McNulty et al., 2007; White, 2000). These counselors often draw on their own stories to build rapport and trust with clients, fostering an environment where collective identity and mutual support are pivotal (Ryan et al., 2019). Their firsthand experience reinforces the principles of the model they advocate, creating a powerful and relatable framework for others in recovery.

Social constructivism highlights the importance of social interactions in the development of individual identities and beliefs. Kimball et al. (2022) reiterate that individuals moving from active use to recovery utilize 12-step support in this new identity formation. The 12-step model fosters a strong sense of community and mutual support, essential elements for individuals navigating the challenges of recovery. This community provides a social environment where new norms and values are constructed.

Minnesota Model

The Minnesota Model, a groundbreaking methodology in addiction treatment, was formulated in 1949 under the auspices of the Hazelden Foundation (Hazelden Betty Ford Foundation, n.d.). This approach intertwines the fundamental principles of AA and underscores a community-centric, therapeutic framework for navigating the complexities of addiction recovery (Bose, 2021). A hallmark feature of the Minnesota Model is its steadfast commitment to abstinence, positing that absolute sobriety is a prerequisite for effective addiction intervention (Bose, 2021). This stance derives its theoretical underpinning from the disease concept of addiction. Furthermore, the Minnesota Model,

revered as the benchmark of treatment excellence, is grounded in existential principles, affirming the fundamental significance of free will (Carroll, 2023).

The model requires counselors to facilitate a supportive environment that encourages open communication among peers, thereby enhancing the communal healing process. Bose (2021) pointed out that the Minnesota Model characterized addiction as a behavioral pattern requiring correction, thus the training includes skills in managing group therapies, individual counseling sessions, and educational lectures, all aimed at fostering responsibility and self-awareness among patients. Despite training that involves a comprehensive understanding of the 12-step process, emphasizing the psychological and spiritual dimensions of recovery as much as the physical aspects of addiction, the goal for anyone entering into treatment must be complete sobriety.

Counselor training under the Minnesota Model is distinct for integrating individuals who are in recovery, specifically only those with complete abstinence, into the therapeutic process (Petrie, 2022). This practice is based on the belief that those who have experienced addiction firsthand can offer unique insights and empathetic support to those undergoing treatment (Shaari, 2021). The decision to integrate individuals in recovery into counselor training under the Minnesota Model is underpinned by several compelling rationales. Firstly, lived experience is regarded as a powerful teacher, capable of offering nuanced perspectives and authentic understanding (Oberleitner et al., 2021). By involving individuals who have traversed the path of addiction recovery, counselor training programs can tap into a wealth of experiential knowledge that textbooks and lectures alone cannot provide. Moreover, the presence of recovering addicts as counselors

fosters a sense of relatability and rapport with clients, thereby enhancing the therapeutic alliance and increasing the likelihood of positive treatment outcomes (Henretty et al., 2014). Trainees are afforded a unique opportunity for personal and professional growth, fostering a deeper understanding of addiction and recovery while promoting self-reflection and resilience (Henretty et al., 2014). Moreover, trainees may experience increased confidence and efficacy in their role as counselors, buoyed by their ability to draw upon personal experiences to connect with clients on a profound level (McGrath & DeDiego, 2023). Furthermore, the integration of recovering addicts into counselor training aligns with the principles of social constructivism, emphasizing the importance of personal narratives and social context in shaping individual identity and behavior.

History of the Harm Reduction Model

Harm reduction is a framework rooted in social justice that addresses, and reduces the harms and consequences often associated with substance use (National Harm Reduction Coalition, n.d.-a) by focusing on the self-determination and autonomy of people who use drugs, cultural humility, liberation for those affected by oppression, and the promotion of social welfare, which directly correlate to social work and SUD ethics (National Association for Alcoholism and Drug Abuse Counselors, n.d.; National Association of Social Workers, 2021). The roots of harm reduction extend back to the mid-20th century, marked by the emergence of needle exchange programs in the 1960's in response to the escalating crisis of infectious diseases among injecting drug users (Bonar & Rosenberg, 2010; Jarlais & Semaan, 2008; Kimmel et al., 2021). The profound recognition of the danger presented by the sharing of needles spurred the beginning of

harm reduction efforts aimed at reducing the spread of diseases like hepatitis and HIV (Kimmel et al., 2021). These early efforts represented a paradigm shift in the approach to drug policy and public health, departing from punitive measures toward a more pragmatic and compassionate strategy centered on harm minimization (Kimmel et al., 2021; Perera et al., 2022).

It was the advent of the HIV/AIDS epidemic in the 1980s that propelled harm reduction into the forefront of public health discourse (Bonar & Rosenberg, 2010; Kimmel et al., 2021). Faced with the devastating toll of the epidemic, policymakers, healthcare professionals, and advocates increasingly recognized harm reduction as an essential tool for stemming the spread of HIV and other bloodborne infections (Jarlais & Semaan, 2008). Needle exchange programs, supplemented by methadone maintenance therapy, emerged as pivotal components of harm reduction interventions during this period (McElrath & Joseph, 2018; Vlahov et al., 2001). These initiatives prioritized the preservation of public health and the reduction of harm over traditional abstinence-only approaches, acknowledging the realities of substance use and the urgent need for pragmatic solutions (Rich & Adashi, 2015).

The proliferation of needle exchange programs and methadone maintenance therapy underscored a fundamental shift in drug policy and practice, emphasizing harm reduction as a cornerstone of effective and compassionate intervention. By providing access to sterile needles and syringes, needle exchange programs sought to minimize the risk of disease transmission among injecting drug users while also serving as entry points for health education, counseling, and referrals to additional services. In fact, individuals

accessing needle and syringe services often reduced their drug use (White House, 2022). Similarly, methadone maintenance therapy offered an evidence-based approach to opioid dependence, reducing the harms associated with illicit opioid use and providing a pathway to stability and recovery for individuals grappling with addiction (Krawczyk et al., 2020; National Institute on Drug, 2021). The National Harm Reduction Coalition (n.d.-b) categorizes harm reduction as, a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs (para. 1).

This is a stark shift from the traditional, abstinence based treatment model, where individuals have felt marginalized and disempowered by their ever present addiction (Perera et al., 2022). Harm reduction approaches do not necessarily conflict with abstinence-oriented programs. Rather, there is an acknowledgement that abstinence may be the chosen recovery path but endorses clients autonomy and honors recovery in all forms. SAMHSA (2023b) defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" (para. 1). Under this paradigm, refraining from substance use is neither a mandatory condition for accessing treatment nor an automatic result.

Harm reduction is more than medication assisted treatment (MAT), naloxone, and clean needles. Harm Reduction International (n.d.) presents a range of services that include information about safer drug use, supervised consumption sites, needle and syringe programs, overdose prevention and reversal, MAT, housing, drug checking, and

legal services. Reed et al. (2022) found that use of fentanyl test strips offered information that, for people who use drugs, could modify their use or use additional harm reduction strategies (e.g., using with friends who have naloxone). Some individuals tested any drug for the presence of fentanyl to reduce unintentional use. Building on this evidence, there are calls for the widespread implementation of harm reduction programs, collaboration between law enforcement and harm reduction services, and policy reforms to enhance access to HR initiatives (White House, 2022).

Attitudes Toward SUD Treatment Philosophies

Abstinence-Based Treatment Acceptance

In the field of substance abuse counseling, abstinence-based treatment philosophies have garnered significant support from many professionals in the field. Counselors who advocate for these approaches often emphasize the importance of complete cessation of substance use as a fundamental goal for recovery (Rosenberg & Davis, 2014). Their positive attitudes towards abstinence-based treatment are rooted in the belief that achieving and maintaining sobriety provides a stable foundation for individuals to rebuild their lives, enhance their overall well-being, and reduce the risk of relapse (Davis & Rosenberg, 2013; Yates et al., 2017). These counselors argue that abstinence not only addresses the physical aspects of addiction but also facilitates the emotional and psychological healing necessary for long-term recovery (Hazelden Betty Ford Foundation, n.d.). Through structured programs, support systems, and evidence-based practices, abstinence-based treatment aims to empower individuals to achieve a healthier, substance-free lifestyle.

Bell et al. (2014), explored the acceptance of brain disease model of addiction among 31 neuroscientists and clinicians. The research indicates that while the brain disease model (BDM) of addiction is widely used as a theoretical framework, its acceptance varies among professionals. Some participants believe that the BDM could destigmatize addiction for patients, possibly enhancing treatment participation by presenting addiction as a manageable medical issue. Conversely, others worry that the BDM could foster fatalistic attitudes among patients, implying that their condition is predetermined and unalterable, potentially hindering individual efforts toward recovery. These results highlight a nuanced balance between the potential advantages of embracing the BDM, such as increased treatment involvement and reduced stigma, and the risks of promoting a deterministic perspective on addiction that may obstruct personal empowerment in recovery endeavors.

Barnett et al. (2020) surveyed 1,428 treatment providers in Australia, the UK, and the US to measure their level of support for psychosocial model, disease model of addiction (DMA), and brain disease model of addiction (BDMA). The study revealed significant variations in views among treatment providers across different countries, with demographic factors such as age, education, and personal experience with addiction playing a role in shaping their preferences for particular models. Notably, younger participants tended to favor the psychosocial model, whereas older participants, especially those from Australia and the US, leaned towards the DMA model. Of interest, individuals identifying as being in recovery showed support for the DMA model, often

citing their involvement in 12-step programs as a contributing factor. This correlation is unsurprising given the historical alignment between 12-step and DMA.

Counselors' endorsement of abstinence-only approaches is influenced by several key factors, including their training, experiences with clients, and personal beliefs about addiction and recovery. A significant study by Rosenberg and Davis (2013) assessed American substance abuse clinicians' acceptance of non-abstinence goals and found a marked preference for abstinence, particularly for clients diagnosed with more severe SUD. The study indicated that while some clinicians accepted non-abstinence as an intermediate goal, there was a strong inclination towards complete abstinence as the final objective, especially in cases involving alcohol and cannabis compared to other substances like heroin, cocaine, and MDMA (Rosenberg & Davis, 2013).

The experiential learning approach in counselor education further supports the endorsement of abstinence-only methods. Yates et al. (2017) explored the impact of an abstinence assignment within an addictions counseling course. This assignment required counseling students to abstain from a chosen substance or behavior, aiming to parallel the experiences of individuals with addiction. The findings highlighted several emergent themes: concrete experiences of withdrawal and cravings, reflective learning, and enhanced empathetic understanding. Students reported a significant increase in empathy for individuals with addictions, recognizing the challenges of maintaining abstinence and the emotional and physical struggles involved. This experiential learning reinforced the students' belief in the importance of abstinence as a viable and compassionate approach to addiction treatment (Yates et al., 2017).

Counselors' professional practices also reflect a preference for abstinence-only treatment models. The integration of abstinence-focused strategies within treatment plans is often driven by the perceived effectiveness of these approaches in fostering long-term recovery and preventing relapse. Counselors frequently draw on their observations of clients' successes and struggles, noting that clients who commit to abstinence often exhibit more stable recovery trajectories and fewer substance-related complications. This observation is consistent with the findings that professional counselors, particularly those with extensive experience, are more likely to advocate for abstinence-only models as they align with their clinical observations and treatment outcomes (Rosenberg & Davis, 2013).

The studies of Rosenberg and Davie (2013) and Yates et al. (2017) reveal a complex landscape where the endorsement of abstinence-only treatment remains prevalent among substance abuse counselors. This endorsement is driven by deeply ingrained beliefs about addiction and recovery, reinforced by both professional training and personal experiences with addiction. While abstinence-only approaches are often viewed as the gold standard, they may not be suitable or acceptable for all clients, particularly those with less severe dependencies or those who seek to moderate their use rather than cease entirely. As counselors continue to refine their approaches through both education and practice, the endorsement of abstinence-only strategies remains a significant aspect of their professional repertoire.

Harm Reduction Treatment Acceptance

The acceptance of harm reduction strategies among counselors in the treatment of SUDs reflects an evolving landscape in addiction care. Several studies highlight a growing recognition of harm reduction as a viable approach, although acceptance varies based on substance type, severity of dependence, and treatment setting (Davis & Rosenberg, 2013; Rosenberg & Davis, 2014). Harm reduction strategies, such as supporting non-abstinence goals, aim to improve the health and wellbeing of individuals who continue to use substances. Non-abstinence goals can be intermediate steps toward abstinence or final goals, focusing on reducing the negative consequences of substance use rather than complete cessation. Research shows that counselors' acceptance of non-abstinence goals varies significantly depending on the substance involved and the client's diagnosis severity (Huhn & Gipson, 2021; Javadi et al., 2022; Rosenberg & Davis, 2014).

Javadi et al. (2022) surveyed 117 SUD counselors in Philadelphia about their attitudes towards harm reduction interventions. This quantitative study found that SUD counselors overwhelmingly supported MAT and naloxone distribution efforts of harm reduction. Eighty percent of participants endorsed needle exchange services and 65% endorsed safe consumption sites. Despite the positive attitudes towards these interventions, there is notable concern about their community impact. Only 28-30% of respondents felt comfortable with the idea of needle exchange services or safe consumption sites operating in their neighborhood, and overall concern that safe consumption sites might lead to increased substance use. Professionals with more experience and knowledge about harm reduction tended to have more positive attitudes, while those supporting abstinence and 12-step programs showed more reservations.

Jordan et al. (2023) sought to understand how SUD counselors', professional counselors', and social workers' perceptions of harm reduction changed over time and could this change be explained by their professional identity. The researchers surveyed 395 professionals, 169 SUD counselors, 128 professional counselors, and 98 social workers and found that all of the professional counselors were more accepting of harm reduction than prior samples in previous studies. There was no evidence that professional identity contributed to the change in perception. Rather, the researchers surmised that acceptance and integration of harm reduction had less to do with training and may have more to do with the acceptance and promotion of harm reduction within their place of employment. The researchers were encouraged by the higher levels of harm reduction acceptance, though identified the need for qualitative research to explore the complex relationship of how identity informs harm reduction perceptions.

Rosenberg and Davis (2014) found that counselors were more likely to accept non-abstinence as an intermediate goal for clients with alcohol or cannabis abuse than for those using other substances like heroin, cocaine, or amphetamines. Specifically, 44% of clinicians accepted non-abstinence for alcohol abuse and 43% for cannabis abuse as intermediate goals. However, acceptance dropped for other substances, ranging from 23% to 31% depending on the drug (Rosenberg & Davis, 2014). Similarly, the study found that 30% of counselors found non-abstinence as a final goal acceptable for alcohol abuse and 24% for cannabis abuse, while acceptance for other substances was markedly lower, ranging from 11% to 13% (Rosenberg & Davis, 2014). This trend indicates that

while harm reduction is gaining traction, its acceptance is still contingent on the type of substance and the perceived severity of its abuse.

Several factors influence counselors' acceptance of harm reduction strategies. Professional experience, personal history with substance use, and treatment setting all play roles in shaping attitudes. For instance, counselors with personal or family history of addiction might have more rigid views on abstinence, while those with training in harm reduction techniques might be more flexible (Davis & Rosenberg, 2013). Additionally, outpatient and independent practice settings show higher acceptance of non-abstinence goals compared to inpatient or residential programs, which traditionally emphasize abstinence. This variation suggests that the structure and philosophy of the treatment environment significantly impact the adoption of harm reduction approaches (Davis & Rosenberg, 2013).

Integrating harm reduction principles into treatment settings, particularly for opioid use disorder (OUD), can improve engagement and health outcomes for patients who continue to use substances. Taylor et al. (2021) emphasized that incorporating harm reduction into primary care–based OUD treatment can reduce negative consequences such as overdoses and infections. This approach includes providing safer injection practices, continuing medications for OUD despite ongoing substance use, and fostering a non-stigmatizing treatment environment (Taylor et al., 2021). Acceptance of non-abstinence goals becomes more complex when clients have co-occurring psychiatric disorders. Davis et al. (2017) found that counselors generally rated non-abstinence as unacceptable for clients with co-occurring SUDs and psychiatric disorders such as major

depressive disorder, post-traumatic stress disorder, or social phobia. However, one-fourth to one-third of counselors found limited or moderate cannabis use acceptable for clients with moderate cannabis use disorder paired with any of these psychiatric disorders. For severe SUDs, the acceptance of non-abstinence was generally low across all substances and psychiatric co-occurrences (Davis et al., 2017).

The therapeutic and public health benefits of harm reduction are well-documented. Harm reduction can reduce the incidence of overdose, infectious diseases, and other health complications associated with substance use. Moreover, it can attract and retain individuals in treatment who might be deterred by strict abstinence requirements, thereby broadening the reach of substance use treatment services (Huhn & Gipson, 2021). By supporting controlled or moderate use, harm reduction acknowledges the complexities of addiction and the difficulties many face in achieving and maintaining complete abstinence. This approach can lead to meaningful health improvements and enhance the quality of life for individuals with SUDs (Huhn & Gipson, 2021).

Overall, the acceptance of harm reduction and non-abstinence goals among counselors is growing, albeit unevenly. While there is substantial support for these strategies in the context of alcohol and cannabis use, acceptance is lower for other illicit substances and for clients with co-occurring psychiatric disorders. Factors such as professional experience, treatment setting, and personal beliefs significantly influence counselors' attitudes towards harm reduction. Embracing harm reduction can enhance treatment accessibility and effectiveness, ultimately benefiting individuals with SUD and the broader community.

Gaps in the Research

The research gap included minimal research that explored the reconciliation among SUD counselors with a socially constructed abstinence-based perception of substance use treatment and the integration of harm reduction treatment approaches. Previous research attempted to understand this reconciliation through the lens of cognitive dissonance, rather than a social constructivism lens (Kieler, 2023). Existing research emphasizes that SUD counselors, many of whom are in recovery themselves, have relied upon their own recovery experiences, involvement in support groups, and peer influence to build their personal and professional identity (Haidar et al., 2020; McGrath & DeDiego, 2023). Research has provided evidence of successful outcomes of abstinence-based treatment modalities (Carroll, 2023), though the exploding opioid epidemic has called for an increase in harm reduction approaches (Volkow, 2020; White House, 2022). Existing literature also offered that counselors overall support certain types of harm reduction models, though those with a 12-step or abstinence-based treatment approach, at lower rates (Javadi et al., 2022). Research also indicated that counselors are more accepting of harm reduction principles now, and that it is not necessarily their professional identity that has driven the increase in acceptability, and that further study is needed to explore how identity is influencing the perception, endorsement, and incorporation of harm reduction into practice (Jordan et al., 2023).

Summary and Conclusions

More research was needed to understand how SUD counselors with a socially constructed abstinence-based perception of substance use treatment reconcile the use of

harm reduction substance use treatment approaches. We know that SUD counselors, historically, have been trained in abstinence based treatment modalities (Brenner et al., 2010; Gallagher & Bremer, 2018; O'Leary et al., 2022), and for counselors who are in recovery, this was achieved this by engaging in abstinence only treatment interventions such as the Minnesota Model and 12-step programming (Kimball et al., 2022; Petrie, 2022). We also know that harm reduction model of treatment has become a critical intervention in the field. Yet, we did not know how SUD counselors reconcile the conflict of their socially constructed beliefs about abstinence-based treatment approaches and the integration of harm reduction strategies into their practice. We were unsure of how counselors mitigated and reconciled these seemingly conflicting treatment approaches. This qualitative research fills a gap in the research by understanding the intricate and diverse experiences of SUD counselors as they navigate their own personal identity, previous training, and industry-wide endorsement of abstinence-based treatment and the introduction and implementation of harm reduction strategies. This study used a semi-structured individual interview approach to afford participants the opportunity to share their unique experiences.

Chapter 3: Research Method

The aim of this exploratory generic qualitative study was to investigate how SUD counselors reconcile their abstinence-only treatment approach with the rise of harm reduction interventions. A generic qualitative method was employed, and I gathered data through individual interviews with SUD counselors who adhered to abstinence-only approaches. Participating counselors were asked about how they came to believe abstinence-only was the most effective treatment method, their knowledge of other treatment approaches and how they learned about them, treatment methods they did not endorse and reasons for this, understanding of harm reduction and how their views on it may have evolved, and knowledge of medications for SUDs and any shifts in perspectives regarding interventions over time. The chapter begins with a review of the study's research design and rationale, followed by an examination of my role as the researcher. I then address the methodology, including recruitment, participation, and data collection processes. Finally, I address issues of trustworthiness and ethical considerations before concluding with a summary.

Research Design and Rationale

RQs for this generic qualitative study were:

RQ1: How do SUD counselors socially construct their endorsement of abstinence-based treatment approaches?

RQ2: How do SUD counselors socially construct their understanding of the harm reduction treatment approach?

RQ3: How do SUD counselors reconcile their long-standing socially constructed knowledge of abstinence-based treatment approaches with the new harm reduction treatment approach?

The substance use treatment field is heavily dominated by an abstinence-based model that excludes individuals who are either unwilling or unable to cease all drug use (Paquette et al., 2022; Volkow, 2020). This exclusionary approach leaves these individuals at higher risk for overdose, increased transmission of communicable diseases, and death (Volkow, 2020). By contrast, harm reduction approaches involve not demanding abstinence but rather offering interventions and resources that help mitigate risks associated with drug use (Huhn & Gipson, 2021; Perera et al., 2022). In conducting this generic qualitative study, I aimed to expand understanding of this phenomenon and identify recurring themes. The social constructivism theory was used in this study to explain how counselors obtained their knowledge about abstinence-only and harm-reduction treatment approaches. The theory is learning and knowledge are co-constructed with individual drive to learn and societal and environmental influences (Amineh & Asl, 2015). Overdoses and deaths due to substance use have increased, and there has been an increased effort to enhance harm reduction via treatment. It was critical to understand how counselors reconciled integration of harm reduction into abstinence-only treatments.

I chose the generic qualitative methodology in order to explore, describe, and interpret participants' unique experiences. In this study, participants were asked to describe, explore, and share how they came to learn that delivering abstinence-based-only treatment was the preferred method of delivering treatment services. They were asked to

share their beliefs and reflections on their experiences of integrating or not integrating harm reduction services into their treatment repertoire. Additionally, I am a SUD counselor who has professional experience with both abstinence-based and harm-reduction treatment approaches. I not only brought my perspectives to the study, but I also remained receptive to newly-developed insights through the study process. The generic approach is ideal for researchers who have prior knowledge and familiarity with the subject (Percy et al., 2015).

Role of the Researcher

In this research project, I fulfilled the roles of interviewer and data collection instrument. I am a certified alcohol and drug counselor 2 (CADC 2) and have practiced for over 20 years. I am also a licensed clinical social worker practicing for 14 years. In my 20+ years of experience, I have used multiple treatment approaches, attended trainings and seminars about emerging practices, and witnessed shifts in SUD treatment and clinical social work practices. In my early practice as a CADC, I worked in carceral settings where abstinence-based treatment was the only acceptable treatment approach. All evidence and research that were presented at training within this setting were firmly grounded in abstinence. Despite rampant use of drugs and alcohol within prisons and jails (Carson, 2021), use was not permissible, and therefore, the treatment approach was abstinence-only. All my training centered around these approaches, including kicking individuals out of treatment who had engaged in using. As a CADC in carceral settings, I found abstinence-based treatment comforting and confusing. It was comfortable and easy to create treatment plans and teaching interventions that addressed how participants

avoided drinking or using. Many adults in custody continue to use in prison and jail settings, yet participants could not actively plan or take steps to use less. Additionally, many of my clients overdosed on alcohol and other drugs while in prison, and treatment approaches did not allow for harm reduction interventions.

Despite my limited exposure to harm reduction during my early years of practice, I found using motivational interviewing with participants provided me with insights regarding how harm reduction principles could keep people safe. I moved into outpatient treatment settings, where abstinence-based treatment continued to be the standard of care in the field, but as a clinician, I had more flexibility to integrate harm reduction into my practice. I sought to understand why abstinence-based treatment was considered the standard and how this practice outweighed other SUD treatment practices. I began attending harm reduction trainings and joined associations that endorsed equitable access to all types of treatment services for people who use substances. I became the director of two different SUD agencies and began to question the overall philosophy of agencies and why some SUD counselors endorsed abstinence-based treatment while others endorsed harm reduction approaches. During the COVID-19 pandemic, the United States saw an influx of increased alcohol and drug use as well as an overall increase in the ability to obtain fentanyl and overdoses and deaths due to opiate use (Angus et al., 2023). In the state where I practice, possession of drugs was decriminalized. This called for the SUD treatment field to reevaluate service delivery.

As a clinical social worker, I bring social work ethics and values to all aspects of my practice. In particular is the empowerment of people who are affected by SUD, and

who have historically experienced discrimination, oppression, and marginalization. Through an abstinence-based lens, all clients would be working towards complete abstinence. Social work values endorse the dignity and worth of the person and their right to self-determination. Further, social work values of social justice are deeply engrained in harm reduction. Harm reduction tenets more closely align with social work which begs social workers who practice in the SUD field to consider a harm reduction lens (Bigler, 2005).

As a social worker and SUD counselor, I create relationships with clients that are grounded in mutual respect and deep appreciation for their experiences. Building this rapport entails being attentive, open, and compassionate. As the interviewer and data collector in this generic qualitative study, my goal was to create a collaborative relationship with the participants, allowing them to share their experiences (Creswell & Creswell, 2009). I was the sole interviewer and data collector, providing me with the firsthand accounts of all verbal and non-verbal communication of the participants. I conducted all interviews, recorded field notes, and transcribed data with a commitment to maintaining high standards of trustworthiness and methodological rigor. Because I am a SUD counselor, social worker, and novice researcher, I understood that I would likely create bias throughout the study process. I used a reflexive journal to assist in decreasing researcher bias. Specifically, I recorded my thoughts and feelings "describing unexpected, uncomfortable, or otherwise notable field encounters" (Meyer & Willis, 2019, p. 580). I used reflexive journaling to aid in refining interview techniques and flush out ethical concerns (Meyer & Willis, 2019). I conducted member checking. Once I had

collected all the data and interpretations of the interviews, I shared this with the participants to ensure that I collected accurate data and reduce potential researcher bias (Vella, 2024). Lastly, to minimize interviewer bias, I reviewed each potential research participant and eliminated those with whom I have a professional relationship within the SUD or social worker field. I serve on both the SUD and social work boards in my state and have been very active in the treatment field for over 20 years. It was likely that some of the potential participants would be colleagues with whom I have close professional relationships.

No participants were elicited from my current or previous work sites. Thus, no power difference will exist. I offered $20 gift cards to participants to incentivize participation. The gift cards were funded by me, with no outside funding sources, which could impact my role as the researcher. Participants received the incentive via email once they had completed the interview process. To ensure participants' privacy, I considered how I collected participant information. Simple coding of each participant, demographics, and responses still presented privacy concerns. Due to the small sample size, recruitment from the Pacific Northwest, and very specific subsection of SUD counselor population, it could have been easy for special interest groups to narrow down who participated in the study. Nevertheless, each participant was offered a disclosure that outlined the privacy risks associated with participation. Further, I conducted online interviews, and with that comes other types of privacy risks, such as participants' profiles with the online platform, their email addresses, and potential access to their private

homes or workspaces (Carter et al., 2021). I reviewed these additional privacy risks with participants as part of the disclosure process.

Methodology

SUD counselors who endorse an abstinence-based treatment approach were the primary population sampled in this study. Using a generic qualitative method, I used semi-structured interview questions to interview 8 to 12 SUD counselors. The participants had in-depth experience and offered rich and poignant information about their experiences (Percy et al., 2015). Saturation was achieved when there were no new emerging codes, themes, or meanings (Rahimi & Khatooni, 2024). Attainment of saturation is influenced by interview structure, content, and participant homogeneity (Guest et al., 2006). Based upon the specific criteria, the homogeneity of the participants, and the narrow study topic, 10 SUD counselors were interviewed as the sample size. The research project used a criterion purposive sampling strategy. This method entailed selecting participants who met predefined conditions (Campbell et al., 2020); in this study, it was SUD counselors who primarily endorsed an abstinence-based treatment approach. Interviews, on average, took approximately 60 minutes. Once a participant completed their interview, they received a $20 incentive gift card via email for participating in the study. Given the characteristics of the study population, the gift card's monetary value was appropriate and did not serve as coercion or an undue incentive for participation. This study focused on a selection of SUD counselors from the Pacific Northwest, where recent legislation and laws have shifted and pushed for more inclusion of harm reduction interventions.

Participant Selection Logic

I recruited certified SUD counselors in the Pacific Northwest. Recruitment of SUD counselors utilized a state list serve of certified SUD counselors. According to Kelly (2010), "a systematic sampling technique allows us to enhance not only the rigor by which our work is done, but also our ability to explain how our sample becomes constituted" (p. 672). SUD counselors are a unique population with specialized training and knowledge. Accessing this population through a partner organization via their list serve ensured that potential participants are certified SUD counselors.

Participants were selected if they identified to me that they were certified SUD counselors and endorsed an abstinence-only approach to treatment as their primary or preferred approach. An email was sent to the counselors seeking participants (see Appendix C). The email included the inclusionary criteria. Participants who were interested were directed to email me. Once I received the email, I responded to the email thanking them for their interest and asked criterion questions, such as the counseling certificate they hold, and answered affirmatively that their primary and preferred treatment approach is abstinence-only. I provided examples of an abstinence-only approach, such as, I believe that abstinence is the primary goal of SUD treatment, and as such, I use this approach as the primary approach with my clients. Participants who met the criteria were emailed an informed consent document that included the inclusionary criteria. Participants sent a return email agreeing to the informed consent by simply responding "I agree." I emailed the participants to coordinate the day and time for the

interview and also sent them a copy of the demographic and interview questions (see Appendix A and B).

I implemented exclusionary criteria, including non-certified SUD counselors, SUD counselors who do not primarily endorse an abstinence-only approach, and non-English speaking participants. I was not fluent in other languages and lacked the resources for translation services. To ensure data accuracy, participant safety, and ethical consent, exclusionary criteria was implemented. No other exclusionary criteria was utilized.

Instrumentation

For this research project, I utilized a semi-structured interview guide. I utilized Zoom as an instrument in this qualitative study. I used the audio recording and transcription features on Zoom. As the only researcher in this study, I was also an instrument. With that, I focused my attention on the participant while conducting the interviews. I strived to ensure that I was actively listening and attending to the participants and their responses. After the interview, I reviewed the transcription of the interview to ensure that I had accurately coded the verbal responses. I used Excel spreadsheets for the coding process of exact words used by participants, and facial and body expressions. The process of coding and recoding helped to decrease bias through intra-rater reliability and address issues of trustworthiness.

To ensure accuracy, once I completed the coding process, I emailed each participant the transcription of the interview and my initial coding findings. Member checking is a commonly used process within qualitative research (Lincoln & Guba,

1985). If a participant indicated there were inaccuracies in the transcription or coding, I reviewed, changed, and modified coded findings. I also used reflexive journaling as an instrument (Meyer & Willis, 2019). Reflexive journaling was completed within one hour of each interview. This journaling allowed me to make personal notes about my reactions to the interview, my observations, and any unexpected experiences. Once I identified these reactions, I further journaled about how these experiences may have impacted how I conducted the interview. This method of reflexive journaling not only provided insight into the data collected, but it also aided in my ability to refine my interviewing techniques (Meyer & Willis, 2019). Additionally, reflexive journaling assisted in tracking the responses of each participant, avoiding the blurring of one interview with the next. The reflexive journal was also reviewed as part of the data analysis and coding process.

Procedures for Recruitment, Participation, and Data Collection

I selected participants through purposive sampling. Purposive sampling is a strategy of participant selection that seeks to include people who hold views, ideas, and in-depth knowledge about the study topic, and "therefore need to be included in the sample" (Campbell et al., 2020, p. 654). Certified SUD counselors who endorsed an abstinence-only approach as their primary or preferred treatment approach were selected to participate. I used a list serve of certified SUD counselors maintained by a partner organization to recruit participants.

Using a semi-structured interview guide, I asked participants questions (see Appendix B) and used transcription available via Zoom. Each Zoom interview was scheduled for 60 minutes, allowing for more or less time as necessary for each

participant. I was the only researcher involved in this study, and therefore, I was solely responsible for data collection. I used an Excel document to record and track the coding of the data that came from the interviews. Once I coded the interview, I shared the Zoom transcription and my coding with each participant via a follow-up email. Participants were encouraged to review and identify any discrepancies within the transcription or coding. Once a participant completed their interview, reviewed coding, and offered feedback, I sent a follow-up email thanking them for their participation, asked if they would like a copy of the final research project, and notified them that they had been exited from the study. I did not gather personal identifying information from the participant, such as name or place of employment. I gathered information such as years in the field, type of treatment facility (outpatients, residential, detox, etc.), and if they identify as being in recovery. Each participant was given a unique ID. I also engaged in reflexive journaling after each interview, and this data was also reviewed and coded.

Data Analysis Plan

To answer RQ1, I needed to ask participants two questions. These two questions sought to obtain insight into how SUD counselors understood their knowledge. This was foundational as participants were then asked questions about how they mitigated or reconciled the use of harm reduction. Interview questions are attached as Appendix B.

I used Zoom transcription to document each interview verbatim. Codes were systematically developed by analyzing the recurring themes and patterns that emerged from the data. The development of codes, themes, and patterns allowed me to identify socially constructed knowledge about abstinence-only, harm reduction, and reconciliation

efforts. I used an Excel spreadsheet to organize codes. I reviewed and analyzed all data gathered in the interview process, including the transcripts, researcher notes taken during the interview, journaling notes, and literature to develop insight into what was presented. I reviewed this data multiple times to ensure that the coding was accurate.

The process I used to identify codes and themes was important. I first reviewed the transcription and my handwritten notes of the interview right after the interview. I coded the transcripts, my handwritten notes, and journaling notes within 12 hours after the interview. After these rounds of coding, I reviewed all of the codes and began identifying the pattern of codes or themes that emerged (Saldana, 2021). The themes were grouped to shed light on the research questions and further understand how SUD counselors reconciled the use of harm reduction in their practice.

Issues of Trustworthiness

To assess the trustworthiness of qualitative research, researchers commonly apply four key criteria: credibility, transferability, dependability, and confirmability (Burkholder et al., 2020; Enworo, 2023; Kakar et al., 2023). Recent studies continue to emphasize these elements as central to rigorous qualitative inquiry (Enworo, 2023). Credibility refers to the accuracy of how well the findings reflect participants' experiences and perceptions. Ensuring credibility often involves techniques like member checking or triangulation. Transferability relates to the extent to which findings can be applied in other contexts, often demonstrated by providing rich, thick descriptions. Dependability emphasizes consistency in the research process, which can be bolstered by maintaining detailed records and an audit trail. Confirmability seeks to establish that the

findings are shaped by the data and not by researcher bias, often ensured by audit trails or reflexivity.

In my study, I used proper observation methods, coding, coding analysis, and member checking. The use of proper observation methods, such as building rapport and engaging in meaningful discussion, while accurately observing the participants' body language and spoken word, is crucial (Enworo, 2023). Using transcription and my own notes, I reviewed the data through triangulation to ensure better accuracy. I conducted the initial coding of the transcripts and, through the process of comparative review, reviewed the coding alongside the data gathered through transcription and my own notes. Finally, member checking, according to Lincoln and Guba (1985), is an essential component of qualitative research, as it is primarily concerned with ensuring the credibility of the data. Once I collected all the data and interpretations of the interviews, I shared this with the participants to ensure that I had collected accurate data and reduced potential researcher bias (Vella, 2024).

Transferability ensures that the findings of the study stay applicable in other settings or context (Enworo, 2023). I used a criterion purposive sampling strategy. This method entailed selecting participants who met predefined conditions; in this study, it was SUD counselors who primarily endorsed an abstinence-based treatment approach. According to Campbell et al. (2020), purposive sampling includes people who hold views, ideas, and in-depth knowledge about the study topic. Future researchers and readers of this study will have detailed information about the sample, enabling them to evaluate its applicability and potential transferability to their own research or population.

Dependability, according to Enworo (2023), ensures that "the research was sound in all ramifications and the outcome will be similar should it be repeated" (p. 380). An audit trail was used, showing a transparent and systematic research process. I kept data on all steps taken, such as data collection methods, data analysis procedures, decisions made during the study process, and reflexive journaling to improve dependability.

Confirmability ensures that the findings of the study are linked to the data, are objective, and free of researcher bias. In this study, I used thematic coding and reflexive journaling as a way to clarify research bias and ensure confirmability.

Ethical Procedures

Once my proposal had been successfully defended, I submitted my completed application to the Walden University Institutional Review Board. After a 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 02-20-25-1165847, with an expiration date of February 19, 2026. The final informed consent form was provided to each participant in this study. The informed consent provided enough information to participants to ensure that they understand the intent of the study and any potential negative consequences that may come from participating in the study.

To recruit participants, I utilized a state list serve of SUD professionals, and the partner agency sent out an email to certified SUD counselors (see Appendix C). Potential participants emailed me indicating interest. Due to the nature of the study, some SUD counselors were likely hesitant to participate if they thought that their identity and information might be revealed. The informed consent, data collection, and storage plan

seek to mitigate these concerns. I avoided accepting participants whom I knew personally. Additionally, this study brought up previous or current situations for the participant that evoked emotional responses. For those participants, I offered resources, such as a crisis line or their natural resources, that could offer them additional support.

I reviewed the informed consent, confidentiality, and the risks and benefits of participation with each participant. Participants were informed that their participation was voluntary, and they could withdraw at any time. I reviewed the purpose of the transcription of the interview and how their information would be stored. Some participants expressed fears that their participation could be found out by their employer, and I assured them that their information and responses would be kept private and that their names would not be recorded.

To protect the data collected, I have stored all notebooks, papers, notes, journals, and external hard drives in a locked filing cabinet in my home office. I am the only person who has access to the key, and no other documents will be stored in this cabinet. All Zoom transcripts have been saved directly to an external hard drive. I utilized my personal laptop, which is password protected. All notes, papers, and notebook entries have been scanned, and documents have been stored on the external hard drive. The external hard drive will be kept for at least 5 years, per university requirements, and destroyed after 5 years.

Summary

This exploratory generic qualitative study investigated how SUD counselors reconciled their abstinence-only treatment approach with the rise of harm reduction

interventions. I recruited 10 participants and completed individual interviews. I collected data using Zoom transcription, personal notes, and reflexive journaling. I have provided an appendix of all items used for the recruitment and interviewing of participants.

Chapter 4: Results

My primary goal in this exploratory generic qualitative study was to understand how SUD counselors reconciled their abstinence-only treatment approaches with emerging harm reduction interventions. Counselor identity is influential in terms of perceptions of harm reduction (Jordan et al, 2023). To better understand how counselors built their knowledge of abstinence-only and harm reduction as well as use of these seemingly opposite ideologies, I asked three primary RQs:

RQ1: How do SUD counselors socially construct their endorsement of abstinence-based treatment approaches?

RQ2: How do SUD counselors socially construct their understanding of the harm reduction treatment approach?

RQ3: How do SUD counselors reconcile their long-standing socially constructed knowledge of abstinence-based treatment approaches with the new harm reduction treatment approach?

In this chapter, I address individual interviews, including the setting, demographics of participants, and data analysis. I present evidence of trustworthiness and measures, thematic results, and study results.

Setting

The study took place during March 2025 via Zoom. Emails were sent to all certified SUD counselors registered with the state licensing agency. Approximately 5,000 certified SUD counselors are on this registry and potentially received these emails. On Monday, March 10, 2025, the licensing agency sent the recruitment email. By March 14,

2025, I received over 100 emails from potential participants, and I received an additional 20 emails by March 21, 2025. I emailed the first 10 participants who responded to recruitment, asking if they met inclusionary criteria, and continued to email participants in chronological order until I was able to schedule 10 interviews.

Of the emails that were received from potential participants, 10 failed to respond to my initial email asking if they met inclusionary criteria. Six potential participants affirmed they met criteria and failed to complete consent forms. Four potential participants returned emails consenting to participation but failed to return emails to set up interview dates and times. Twenty-six potential participants did not qualify to participate as they did not meet inclusionary criteria. I began interviewing participants on March 16 and concluded with my final interview on March 31, 2025. In total, I conducted 10 interviews during this time period. Scheduling and lack of response from potential participants may have been influenced by spring break. Initial and responding emails did go out during a 2-week period of time, which is traditional spring break in the Pacific Northwest, and may have caused limitations that may have prevented more participants from responding to follow-up emails.

Demographics

All participants were 18 or older and certified SUD counselors. All attested their primary treatment approach was abstinence-only and they had knowledge of harm reduction. I recruited participants from a specific state in the Pacific Northwest. Each participant indicated their gender, age, type of facility they provided services, how many years of experience they had as SUD counselors, if they identified as someone in

recovery from alcohol and/or drugs, how many years of recovery (if applicable), highest level of education, and clinical credentials.

P1 is a female who works at an outpatient clinic that offers shelter and programming for women with their children. She has 3 years of experience as an SUD counselor. She identified as a person in recovery and has been in recovery for 11 years. She has a high school diploma and is a CADC 1 and certified recovery mentor (CRM). Her experience in the profession involves outpatient substance use treatment.

P2 is a male who works at an outpatient substance use treatment facility. He has worked as a SUD counselor for over 15 years. He identified as a person in recovery for over 15 years. He has three master's degrees and is a CADC 2 and qualified mental health professional (QMHP). He has experience working in residential treatment centers that used the Minnesota Model as well as multiple outpatient SUD treatment settings throughout his years of practice.

P3 is a female who works at an outpatient substance use treatment facility. She has 9 years of experience as a SUD counselor. She did not say she was in recovery as she did not feel a need to identify, and she said she found the recovery community very culty, though she did share that she had been clean for 13. She has a master's degree and is a CADC 2 and QMHP.

P4 is a male who works in a residential substance use treatment facility. He has 5 years of experience as a SUD counselor. He identified as a person in recovery for over 15 years. He has an associate's degree and is a CADC 1. He did his internship at a

methadone clinic and then went to work at an outpatient clinic before going to work at a residential facility.

P5 is a male who works in an outpatient substance use treatment facility. He has 6 years of experience as a SUD counselor. He identified as a person in recovery and has 14 years of recovery. He has a high school diploma and is a CADC I and CRM. He has worked at multiple outpatient clinics during his time as a SUD counselor.

P6 is a male who worked in an outpatient substance use treatment facility. He has over 15 years of experience as a SUD counselor. He identified as a person in recovery for over 15 years. He has a bachelor's degree and is a CADC II. He has only worked at facilities that endorse abstinence-only approaches.

P7 is a female who works in an outpatient substance use treatment facility. She has worked as a SUD counselor for 6 years. She did not identify as a person in recovery from alcohol and/or drugs. She has a master's degree and is a CADC III and licensed professional counselor.

P8 is a female who works in an outpatient substance use treatment facility. She has worked as a SUD counselor for 2 years. She does not identify as a person in recovery from alcohol and/or drugs. She has a high school diploma and is a CADC 1. She has only worked at one outpatient substance use treatment facility since she has been in the field.

P9 was a male who worked in an outpatient substance use treatment facility. He has worked as a SUD counselor for 5 years. He identified as a person in recovery and has 5 years of recovery time. He has a high school diploma and is a CADC I, a qualified

mental health associate (QMHA), and peer support specialist (PSS). He has only worked at facilities that endorse abstinence-only approaches.

P10 is a female who works in an outpatient substance use treatment facility. She has worked as an SUD counselor for 3 years. She identified as a person in recovery and has 5 years of recovery. She has a bachelor's degree and is a CADC 1 and CRM. She has worked at a medication-assisted treatment facility and outpatient facility that focused on clients who were justice-involved (see Table 1).

Table 1

Participant Characteristics

		In Recovery	
		Yes	No
Experience		8	2
Number of Years	Frequency	Frequency	
0-2	1	0	
3-5	4	2	
6-8	2	0	
9-11	1	1	
12-14	0	2	
15+	2	3	
Education Level	Frequency	Certification	Frequency
HS Diploma	4	CADC 1	6
Associate	2	CADC 2	3
Bachelor	1	CADC 3	1
Master	3	QMHA	1
		QMHP	2
		LPC	1
		CRM	3
		PSS	1

Data Collection

Using a criterion purposive sampling strategy, I obtained a sample of 10 participants who met predefined conditions. The sample size for this study, as indicated

in Chapter 3, aligns with other qualitative studies where participants have extensive experiences, with participant homogeneity. I completed each interview via Zoom. The interviews varied in time from 30 to 60 minutes. Each interview was audio recorded, transcribed, and saved on a password-protected laptop.

A licensing agency sent out a recruitment email to approximately 5,000 certified SUD counselors. The recruitment email indicated that anyone interested in participating in the study to email me about engaging in the study. Fifty-six potential participants were emailed to confirm that they met the inclusionary criteria. If the potential participant did not meet the criteria, I thanked them for their willingness to participate. Once a participant confirmed that they met the inclusionary criteria, I emailed them the informed consent form for review. Participants reviewed and responded to the email with "I consent" to ensure and verify they were consenting to participate. After receiving this email, I emailed the participant about potential days and times to conduct an interview. Based on their responses, we found a mutually agreed upon day and time. At the beginning of each interview, we did formal introductions and discussed consent and the voluntary nature of the study, privacy, flow of the interview, risks and benefits, payment for study participation, and subsequent email follow-up after the conclusion of the interview.

One participant forgot about the scheduled interview. I emailed participants to ensure they were still interested in participating and they emailed me about forgetting. We rescheduled this interview for the following day. Another participant was interrupted during their interview by their school-aged child, and they took a quick 30-second break

to tend to their child and then returned back to the interview. No other incidents or occurrences arose during the interview process.

Data Analysis

All interviews were conducted in a private office setting, audio recorded and transcribed using Zoom. All interview transcriptions were saved on my computer. Hand notes were taken and written in a notebook and reviewed alongside the transcripts. Once the interviews were completed, I reviewed the Zoom transcriptions for errors and corrected them manually. After each interview, I engaged in reflective journaling and used this information to inform subsequent interviews. A unique identification number was assigned to each interviewee to ensure systematic data management and maintain participant confidentiality. For each interview, I used the semi-structured interview questions to guide the interview process to ensure consistency throughout each interview. Adhering to this format enabled participants to share in-depth accounts of their experiences in a manner appropriate for addressing the research questions.

Coding

Each interview followed a consistent semi-structured protocol informed by the study's three RQs.

I conducted the first round of coding for each interview within 48 hours of completing the interview. The initial coding round established themes that align with qualitative coding analysis. I reviewed these codes again, approximately 24 hours after completing, and conducted a focused coding process to develop subthemes for each interview. I emailed each participant a copy of these subthemes and asked for member

feedback to ensure that the themes accurately reflected their experiences. Feedback received from participants was added to the final thematic coding. Once all focused coding and member checking had been completed, I moved the subthemes into thematic areas depending on the research question. Themes are conceptualized as patterned responses or meanings within the data that capture essential elements of the phenomenon and address the research questions.

A total of 480 initial codes were found and then moved into 38 subthemes or categories (see Appendix D). Of these subthemes, 15 related to RQ1, 12 related to RQ2, and 11 related to RQ3. Some of the subthemes formulated included endorsement of abstinence through clinical models, commitment to abstinence from personal experience and relapse, awareness of harm reduction through professional practice, development of rational understanding favoring abstinence, understanding harm reduction as conditional, flexibility in applying harm reduction versus abstinence, integrated perspective of holding both models simultaneously, spiritual framing of abstinence conflicts with harm reduction autonomy. RQ1 generated three themes (abstinence as a path to clarity and safety, abstinence as a professional and cultural standard, and endorsement of abstinence rooted in personal recovery journeys), RQ2 generated two themes (harm reduction as a professional reality, not a personal philosophy; learning from community, culture, peer influence), and RQ3 generated two themes (flexible integration of harm reduction and abstinence/harm reduction as a professional reality, not a personal philosophy, and evolving perspective through experience and education).

Discrepant Cases

Only one discrepant case was notable and did not influence the study results. P1 supported an abstinence-only treatment approach while having knowledge about harm reduction and did not show any tension or conflict between the models. This participant did not make attempts to integrate the models; rather, they remained steadfast in a pure abstinence-only approach. The primary objective of this study was to understand how SUD counselors socially constructed their knowledge of abstinence-only and harm reduction approaches and how they mitigate the use of both. This discrepant case offered the experience of an SUD counselor who did not mitigate the use of harm reduction in their practice.

Evidence of Trustworthiness

Credibility

A semi-structured interview guide was employed during each individual interview to ensure consistency across participants, while also allowing for the emergence of rich, participant-driven narratives. Although all participants responded to the same core questions, they were encouraged to articulate their experiences and understandings in their own terms. Several questions were intentionally designed to elicit clarification regarding participants' lived experiences and their processes of knowledge acquisition.

As a licensed clinical social worker with 14 years of licensure and over 25 years of experience in the SUD field, I was actively engaged in the research design and interview process. Through ongoing reflexivity, I remained critically aware of how my professional background, assumptions, and prior knowledge could influence data

collection and interpretation. My experience informed the development of the interview guide and shaped my ability to engage with participants meaningfully, clarify questions when necessary, and probe responses in a respectful and informed manner.

Throughout the interviews, I prioritized building rapport by using open-ended questions, maintaining an attentive and nonjudgmental stance, and posing clarifying questions as appropriate. Member checking was incorporated with each participant as a strategy to support the credibility and trustworthiness of the data (Lincoln & Guba, 1985).

Transferability

A detailed description of the study participants is provided to enhance contextual understanding and support the criterion of transferability, as outlined by Lincoln and Guba (1985). A criterion purposive sampling strategy was utilized to intentionally recruit individuals with relevant perspectives, lived experiences, and in-depth knowledge of the phenomenon under investigation. Providing rich information about the sampling process aligns with qualitative best practices and enables readers to assess the applicability of findings to other contexts (Campbell et al., 2020). In addition, comprehensive documentation of the data collection procedures, ethical protocols, researcher subjectivity, and the temporal, geographic, and demographic scope of the study further contributes to the transparency and transferability of the research.

Confirmability

I used reflexive journaling throughout the research process to enhance confirmability by documenting my evolving thoughts, decisions, and potential biases.

This ongoing reflexive practice facilitated critical self-awareness regarding how my professional background and prior assumptions may have influenced data collection and interpretation. By maintaining a detailed journal, I established an audit trail that allowed for transparency and traceability of the analytic process. This approach aligns with Enworo's (2023) emphasis on reflexivity as a key strategy for ensuring that qualitative findings are firmly grounded in participants' accounts rather than shaped by researcher subjectivity.

Results

Ten participants shared their perspectives on how they acquired knowledge related to both abstinence-only and harm reduction models, and how they navigated the tensions between these seemingly opposing ideologies in their professional practice.

In response to RQ1, three primary themes were identified: abstinence as a path to clarity and safety, abstinence as a professional and cultural standard, and endorsement of abstinence rooted in personal recovery journeys. For RQ2, the following theme emerged: learning through community, culture, and peer influence. In addressing RQ3, two additional themes were discovered: flexible integration of harm reduction and abstinence (harm reduction as a professional reality, not a personal philosophy), and evolving perspectives through experience and education. Tables 2, 3, and 4 provide themes and definitions for each research question.

Table 2

RQ1 Themes and Definitions

RQ1	Theme	Definition
How do substance use disorder (SUD) counselors socially construct their endorsement of an abstinence-based treatment approach?	Theme 1: Abstinence as a path to clarity and safety	SUD counselors have witnessed that the abstinence-based treatment approach improves clients' mental clarity and is the safest for clients (decreases relapse)
	Theme 2: Abstinence as a professional and cultural standard	SUD counselors have been trained in abstinence-only treatment approach and recognize it is the standard for practice in the field
	Theme 3: Endorsement of abstinence rooted in personal recovery journeys	SUD counselors have lived experience, and their recovery is rooted in abstinence, including 12-step involvement

Table 3

RQ2 Theme and Definition

RQ2	Theme	Definition
How do they socially construct their understanding of the harm reduction treatment approach?	Theme 1: Learning from community, culture, and peer influence	SUD counselors are learning about harm reduction from others in the industry

Table 4

RQ3 Themes and Definitions

Research Question 3	Theme	Definition
How do they reconcile their long-standing, socially constructed knowledge of abstinence-based treatment with emerging harm reduction approaches?	Theme 1: Flexible integration of harm reduction and abstinence. Harm reduction as a professional reality, not a personal philosophy	SUD counselors have learned that harm reduction, as an ancillary service, is a necessity to keep clients alive, but secondary to abstinence. They use harm reduction to enhance clients' path to abstinence.
	Theme 2: Evolving perspective through experience and education	SUD counselors are having increased exposure to harm-reduction practices and learning more about the benefits

Findings for RQ1

There were three main themes found in the process of trying to answer RQ1: abstinence as a path to clarity and safety, abstinence as a professional and cultural standard, and endorsement of abstinence rooted in personal recovery journeys.

Theme 1: Abstinence as a Path to Clarity and Safety

When exploring ways that SUD counselors came to know that the abstinence-only approach was the primary treatment approach to use with clients, participants noted that it was through observation of clients who abstained from using and the clarity this brought clients and increased safety for clients. Participants overwhelmingly identified that an

abstinence-only approach provided clarity that all drugs and alcohol were off-limits. P10 shared:

> When it's just abstinence, it gives them a clear barrier in recovery, like this is where I'm at. When they start to have gray areas, that's when people's recovery starts getting cloudy, and it's easier to relapse. For example, marijuana is the biggest one that we fight with. Once people differentiate marijuana from their drug use, it becomes easier for them to fall back into use.

P7 pointed out that an abstinence-only approach gives a single focus. When it is not abstinence, clients have "a lot more mental gymnastics versus I just don't (drink or use)." P3 noted, "You (referencing clients) have a clear mindset. You're able to look at what we're actually dealing with here, the underlying stuff. The best way is to take it all away and start from scratch, and get a clean base." Overall, participants shared experiences of clients remaining abstinent and the benefits it brought. P8 and P7 described how witnessing clients in treatment being successful when totally abstaining from all drugs solidified their abstinence-only approach.

Theme 2: Abstinence as a Professional and Cultural Standard

The second theme that emerged was that clinical training and workplace standards and protocols were influential in the SUD counselors' knowledge. All participants shared that they had received clinical training that supports abstinence-only, along with training in brain science and neurotransmitters. Participants noted that these trainings helped them to understand how addiction works and the importance of complete abstinence. P1 recalled, "All of my CADC trainings, and learning about the brain and neurotransmitters,

was geared towards abstinence." While P7 shared, "I understand how the brain works once addiction has been triggered." This was knowledge acquired from schooling and training. They expanded on this idea, sharing that without complete abstinence, "It makes it really hard to find a good homeostasis if we keep interjecting the substance even just a little bit." P4 recalled learning about abstinence-only in their CADC training, but also recalls that they may have taught information about harm reduction, but because they were so focused on people getting into recovery that, "I found out they were doing other things. I admit at first I was a little close minded."

For a majority of the participants, they did most of their training while on the job. All but two of the participants began their on-the-job training with an abstinence-only program. P10 received their on-the-job training at an agency that offered abstinence-based treatment. The programming served people in the driving under the influence of intoxicants (DUII) program, court-ordered treatment, Department of Human Services-ordered (DHS) treatment, and mostly served mandated clients who were required to maintain abstinence. They recognized that while they had some previous exposure to other treatment approaches, their current employment and training align with their previously obtained knowledge.

P7's agency is mostly abstinence-only, and they shared, "The clinic where I have worked, most of the groups we run are abstinence-only." P8 received all of their knowledge about SUD treatment while in their internship; "Where I did my practicum, which is where I work, they're abstinence-based. I guess I never really heard that (abstinence-only) being the big approach. I learned based on the disease of addiction

model." P8 is new in the SUD field with just two years of experience as a counselor, and all their training and on-the-job training have been at their current worksite. They shared that they had attended training, "I learned more about it (knowledge about abstinence-based approach) in school, but I'm like a hands-on learner, so that is where I gained that (knowledge)."

P4 has worked in multiple different treatment milieus, all abstinence-only. Their schooling, training, and workplace taught that abstinence-only was the primary approach. While they had worked with an outpatient methadone client at one point, their experience was that the clinic was not interested in having clients obtain complete abstinence (including methadone), as the clinic would lose money. P4 recalled when they worked at the methadone clinic that:

> (clients) were in the parking lot exchanging other illegal drugs and getting into fights. There were some clients that would come and get their dose, and they would go to work, and if the computers messed up, they wouldn't get their dose and be late for work, you know they'll just do this morning dance.

P4 recalls that this experience harkened them back into the abstinence-only treatment arena. P6 shared that they always understood abstinence-only to be "The default. It's kind of the standard." P5 stated, "All the programs are quote-unquote abstinence-based," which sums up the ideas of most participants.

Theme 3: Endorsement of Abstinence Rooted in Personal Recovery Journey

Overwhelmingly, participants pointed to their own personal recovery journey as the foundational knowledge of their abstinence-based approach. Eight of the ten

participants identified as being in recovery from alcohol and/or drugs. Of the two who did not identify as being in recovery, one had a family member who struggled with alcohol addiction, and the other participant had close friends who struggled with addiction. Within this theme, participants pointed to the consequences of continued alcohol and drug use, formalized treatment, 12-step groups, and the benefits of complete abstinence as experiences that influenced their knowledge.

For those participants who identified as being in recovery, their negative experiences of continued use greatly impacted their knowledge that abstinence was the only path to recovery. P5 vividly accounts when they realized that all of the negative outcomes they were experiencing were due to their use:

> The facilitator drew a diagram on the chalkboard, and I remember seeing different parts of my new life fall away and I remember thinking that every time I got high, which my drug of choice was crack cocaine, and then I stopped using crack, everything bad started back when I drank.

P1 describes losing their parental rights and the shame they experienced because they had failed as a parent. It was only through sustained abstinence that they were able to have another child, whom they are actively raising. P3 shared similar experiences of having their child removed from their care due to their active addiction. After gaining abstinence and getting their child back from state care, they relapsed and used heavily for another 8 years. Eight years later, they found out that they and their partner were pregnant and went to treatment so that they could maintain custody of their children.

P4 described that their boss came to them and said:

> Look, you've got to do something about your drinking. We're going to give you 2 weeks off, and your drinking can't be a problem when you come back. I called him after about a week and said, I think I'm good to go. They said no, I don't know what you're doing, but you got to make sure that drinking is not a problem when you come back. So, I went to this outpatient program and this guy said, you're a classic alcoholic.

They shared that they could not afford to lose their job and the threat of losing their job was enough to seek recovery. Of the eight participants who identified as being in recovery, seven attended formalized treatment at least once during their recovery journey. Each described their formalized treatment using an abstinence-based treatment approach. Each participant had distinctly different formalized treatment paths, but each found that what they learned in treatment had a marked effect on who they are today. P2 shared their experience of going to residential treatment, back when the Minnesota Model was the standard model for residential treatment. After getting out of residential treatment, they attended a continuing care group to remain sober. They recall that this was their introduction to the treatment world.

P1 began early intervention around the age of 16, learning about the effects of alcohol and drugs, though they recall that the information was not impactful because they had significant trauma and were looking for anything that would relieve their pain. They engaged in residential and outpatient treatment three additional times. Each time they were in treatment, they would abstain for brief periods and learned helpful tools while engaged. P10 described being forced to do outpatient treatment because they were on

probation and had to get regular UAs (urine analyses) and shared, “You have to be abstinent from everything, regardless of whether it’s your drug of choice or not.”

12-step, self-help groups, or spirituality/religion were utilized or endorsed by all of the participants. In all the interviews, participants pointed to the integration of 12-steps into their own recovery journey or the recovery journey of family, friends, and clients. P9 shared their experience:

> I did go to counseling, no formal outpatient treatment but I did go to self-help groups. I went to Refuge Recovery and just had really good friends. I would say at the core of my experience, my lived experience, and just what I've seen play out with people abstinence seems to be the best long-term option.”

Two participants had very strong ties to the 12-step community and credited this community with their continued abstinence. P2 described their experience of going to AA while in treatment and getting the support they needed, “I was told to go to AA, and I went to AA.” They continue to go to AA today and are actively involved in AA service work. P4 discussed the importance of his first sponsor in AA:

> That taught me, you know, helped me change. He brought me through the steps. I said, like for the steps, when should we do these and he said to me, how long do you want to stay sick and I said, oh, this is up to me! So now, I sponsor a lot of people. I help them get clear about what’s going on and take them through the steps. I think once you're willing to complete these principles, that’s what takes the compulsion away.

Like P9, P4 shared, “I initially created that value (abstinence-based approach) from being a member of Alcoholics Anonymous and the philosophies that go along with that.” P3 is not currently utilizing 12-step or self-help groups, but discussed the impact it had on their life:

> Like I said, I did do the meetings. I did the service positions, I did all of those things for a very long time. A couple of years into working in the field, I find myself, you know, kind of backing off a little bit because I had clients who I wanted them to be able to feel comfortable in having that space.

P5 described his abstinence as:

> Absolutely a life or death situation for me. I had to talk to the men that are in my support group and women in my support group. I love my sponsor to death, you know, he’s one of those guys that gives me information and he doesn’t tell me something, he doesn’t give me the answer.

The 12-step community offered a structured and stable community that emphasized abstinence, while also providing support, guidance, and meaningful relationships.

Spirituality or religion, which seemed to be tied to 12-step and self-help groups, also played a critical role in three participants' experiences. P1 discussed how their faith is the core of their beliefs and shared:

> I fundamentally believed in my core that I was unlovable, that I was rejected, that I was broken, that I could never be loved. And so I acted in a way that was a self-fulfilling prophecy to all of those core beliefs. I never let anyone love me. I

always picked people that were going to confirm what I believed about myself. I began to read the Bible, and I was reading in the book of Isaiah. These Israelites would sin against God and they'd have temple prostitutes . . . do this crazy stuff and I'm like, dang, Lord, they were really out of control, weren't they? And every time they would cry to God and say, forgive us, he would forgive them. And he'd be like, yes, I'll save a remnant of you. And I'm like, dang, they even did some worse stuff than I did and you just be forgiving them. Like, maybe you could forgive me. And then I read in Romans that therefore there is now no condemnation for those who are in Christ Jesus, and I was, for the first time ever to believe that I could be forgiven. That's the first time I ever had self-forgiveness for all of my choices and all of the bad things I ever did. And I was in one of my 12-steps. We were on step four, which is a fearless moral inventory, right? And I was thinking, I really hope my kids can forgive me one day for any hurt that they have felt because of the choices I made, because it had nothing to do with them. I heard the Lord say, you want your kids to forgive you, but you have never forgiven your own mom. Any of the hurt that I felt, that I was unlovable, that was a lie, had nothing to do with me. That I was rejected, that was a lie, had nothing to do with me. That's how I got here, and it freed me. I don't have those beliefs anymore. I think that is the goal of abstinence.

P3 experienced spirituality as their daily practice of waking up early, having coffee, meditating, and journaling that supports abstinence. Two participants, who are not in recovery, discussed the importance of support groups for their clients. In their clinical

practice, they both work to integrate self-help or support groups into the treatment process. P8 stated, “Whenever they start treatment with us we’re huge advocates for support groups of any kind. We are very big encouragers of that.” P7 reiterated something similar:

> We really encourage connection to 12-step or other communities like Smart Recovery, Dharma, whatever seems like it would be a good fit for the patient. We explain how that could be helpful, how therapy can typically be relatively short-term, but community involvement can be a forever thing, and how networking can support their goal of sobriety.

Findings for RQ2

One main theme was found in the process of trying to answer RQ2: learning from community, culture, and peer influence.

Theme 1: Learning from Community, Culture, and Peer Influence

When exploring ways that SUD counselors came to know about harm reduction, all participants credited the influence of the SUD learning community, their peers, and a culture of education around harm reduction in the field. P3 shared, “Probably in the last 5 years (learned more about harm reduction), it has been a pretty big topic in the SUD world, though harm reduction, it’s very controversial.” Other participants shared similar sentiments that there is a push within the industry for harm reduction, and they are learning about it through different avenues. P8 indicated they had previous knowledge about harm reduction prior to entering the field because they knew outreach workers who handed out clean needles, and they watched documentaries and read books about harm

reduction in high school, and prefaced, “Whenever I got into the field, I learned a lot more.”

Three participants credited several statewide peer programs in their community for providing education about harm reduction. P1 discussed how one of the programs came to their agency to provide harm reduction education, “We had a staff meeting one day and Prime Plus came to our meeting and shared all about harm reduction.” P2 recognized that, “The BRHN program (implemented in their agency) because they’re (clients) are not quite ready to make those changes that are necessary to be abstinent.” P2 shared that his agency offers harm reduction through their BRHN program, and they learned about harm reduction offered within their own agency.

Five participants currently or previously worked in facilities that used harm reduction principles. They pointed to this environment as the primary source of harm reduction education and knowledge. P4 worked an internship at a methadone clinic where they learned about harm reduction. P2 worked for an agency for 10 years, which incorporated harm reduction, and they gained even more knowledge about the practices. P7 currently works at an agency that offers harm reduction services and has learned from medical and clinical staff. P5 worked at an agency where harm reduction principles were implemented, though this was not their area of practice; they did receive training. P3 began their SUD counseling work at an agency that offered harm reduction. P10 began working for their current agency in the medication-assisted treatment (MAT) clinic, which was their introduction to harm reduction. All participants shared that they knew about MAT through their workplace, learning from peers, training, or learning from their

clientele. P3 was the lead milieu counselor when their program rolled out MAT. The agency prescribed and dosed Suboxone to clients. Previously, they had one or two clients enter their facility on MAT:

> We rolled it out in 1 day (MAT). I'll never forget, 20 people. We had to dose 20 people at once, right? That's a lot. Like that's a lot to teach somebody how to do in one setting. I'll never forget that day. I had to teach these people (staff) how to do this. And, I'm learning in the moment, right?

P10 learned about MAT when working as a peer in drug court and had previously learned about MAT and was opposed but through their work experience, trainings, and clients sharing their experiences, "It opened me up to being interested in receiving information around harm reduction…to help (me) deal with people that I knew and I would have a that model to use."

P6 shared that they received education about MAT through on-the-job training. While they understood the benefits of MAT and would educate clients about the benefits, they also shared:

> It's certainly beneficial, but it's such as an easy decision. We don't necessarily limit it to just work case scenarios, it's really a voluntary self-assess type of thing, and in that process there's quite a few people that are causing new problems for themselves. There are some people that I don't know are actually fully dependent on opiates choosing that option (MAT). And, then suboxone, buprenorphine is highly addiction.

All of the participants shared they knew harm reduction was more than just MAT. P10 shared, that while they were working in MAT clinic they learned about this harm reduction method from staff at the clinic and stated, “Learning what the people actually needed rather than learning it from books or anything like that was like actually learning from my clients. …lots of these people are homeless. They don’t have access to the things they need. Making sure they have naloxone and just clean stuff.” P1 had previously heard about needle exchange from people they had used with in another state, though it had not been offered in their community until recently. They noted, “I think suboxone helps. I think that naloxone, you know, is a life-saving measure. I think clean needles (are harm reduction).” P7 described harm reduction as any effort to reduce harm that comes to clients through their drinking or using. They noted:

> But moving from someone who is drinking 12 drinks to one drink a day feels different than trying to reduce the harm of fentanyl. So I think when we’re looking at different types of substances, I get a different feeling on them as well in terms of harm reduction.

All participants shared that reducing use or switching to a less lethal drug was a form of harm reduction.

P9 had the most comprehensive understanding of harm reduction:

> I learned about harm reduction through just kind of the culture here (work) and it seems like the substance use world is adopting harm reduction as like a good intervention. My knowledge of harm reduction is many different things. So access to clean needles, access to basic needs, food, shelter, water. Housing first

> programs, also like the classic example of safe injection supplies and test strips. Any kind of intervention, and like talking to people about what it would look like to be safe, to use less, or whatever is safer all around. I have learned this in my profession and I looked into it a little bit and it's kind of what I gathered." P9 has been exposed to many different harm reduction interventions through his work experience and then sought out additional education on their own to better understand the principles.

Findings for RQ3

There were two main themes found in the process of trying to answer RQ3: flexible integration of harm reduction and abstinence (harm reduction as a professional reality, not a personal philosophy), and evolving perspectives through experience and education. Overall, nine of the ten participants attempted to integrate harm reduction into their practice.

Theme 1: Flexible Integration

Participants overwhelmingly shared that they integrated harm reduction into their practice as needed. They pointed to engagement and keeping clients alive as the primary reasons for using harm reduction.

Engaging. Participants identified that being more flexible with where clients wanted to start in their treatment allowed for stronger engagement. P6, who was trained in a residential treatment facility and is newer in the outpatient treatment environment, discussed a scenario of engaging clients through a harm reduction approach:

> If people have the goal of quitting marijuana, then I'll work with them. They say, no, I don't have a problem with marijuana and I'm going to keep on doing it. Well, okay, we're not the right treatment center for you, but I have some leeway in working with you and can have more flexibility around lapse or not being ready to give it up entirely. There is some leeway that I'm starting to become more aware of, which is potentially holding people in IOP longer, if they're not willing to go to residential. It's better than not doing treatment at all, right?

P3 shared in the same ideas about engaging clients stating, "I guess I would say I'm pro harm reduction in the world if somebody's using opioids or smoking fentanyl, I'd love for them to stop and start smoking week." P4 discussed how the use harm reduction was utilized as a path towards sobriety so that clients could access additional housing resources. P7 delved into the clinical nuance of harm reduction:

> Someone walks in the room (a client) and you can go, here's what you're going to need to do, but you can't do that because it's not effective, it doesn't work. So just being patient and holding space. Maybe they're never going to have the goal of abstinence, and that's okay because it's their life, not mine. It's their journey, their goals.

P9 explained the subtle process of engaging clients by letting them navigate their own course of treatment, even if it was through a harm reduction lens:

> I just recognize that substance use is real and recovery is a process, you know it was for me. And so there is this point of like people in the stages of change, pre-contemplation, contemplation, where they are thinking about, yeah, maybe this

> isn't for me, and still using. Just guiding the conversation and helping them explore what substance use means to them. With people in their addiction, they have different priorities at different times of the day. So I'd rather just like focus on the right here, right now and what is the biggest things we can accomplish.

P2 shared that their agency has an abstinence-based track and a harm reduction track, and if clients are struggling to remain abstinent, they can easily transfer to the harm reduction track to keep clients engaged. P8 found that engaging during intake to be helpful, "I do intakes. I have a packet, and I include harm reduction brochures with different resources, and whenever I do individual sessions for people who are on MAT, that always gets brought up." Engagement through the use of harm reduction was summed up by P10, "I think it comes down to meeting people where they're at and not judging them. Like abstinence free was mine, that's how I started and stayed in recovery. I understand that that's not you; you may not be there yet in your recovery."

Keeping Clients Alive. All participants shared the importance of keeping their clients alive as they all recognized that addiction is a deadly disorder. P1 had a client who was ready for a change and wanted to go to withdrawal management immediately. However, on the way, the client began shaking uncontrollably and became very ill, so they stopped at a store and the client went in and bought alcohol and drank it so they could safely make it to the detox facility. P4 integrated discussion and distribution of Narcan to youth in their county, in case they needed it or their family or friends needed it to stay alive.

P10 discussed how the harm reduction kits addressed the current and future consequences of using:

> I make harm reduction kits for the clinic. It has a couple of clean needs, some things to clean your skin, naloxone, and fentanyl testing strips in there. I have those and I make them every year when it's overdose awareness. I just stashed them everywhere and I've got them in my care. I give them out to people, whoever comes in, like you know you're going out, so I always make sure I have those kits made. I'm going to help you stay as safe as you can so that by the time, if you do want to come into recovery, we're not dealing with Hep C, we're not dealing with open wounds, we're not dealing with HIV, you know what I mean? You know, we're not dealing with these things that can just really linger into your recovery."

P3 shared statistics:

> I have lost 27 patients to fentanyl overdose. That's huge. That's insanity, it's just mind-blowing. I just can't fathom it. It really makes me sad. If I think about them, and I think if they just wanted to participate in harm reduction in some way instead of doing that (drugs) that day, but they didn't, and now they're not here. I have carried a piece of each and every one of my clients with me and that shit gets heavy, and I think no matter how much we do to save people, it'll never be enough. We are not going to win this war. But we're doing this because I'm all for anybody getting further in their life.

Theme 2: Evolving Perspectives through Experience and Education

Participants mitigated their abstinence knowledge through the lens of new evolving perspectives. Two participants used Suboxone, not as part of their addiction recovery process, but due to surgery and pain management. They both identified that opiates were not their drug of choice, but after using an opiate and then shifting to Suboxone for ongoing pain management needs, they found a deeper understanding and knowledge of the importance of MAT.

Participants who work in agencies that do not support harm reduction shared how their evolving perspectives were challenged. P10 shared:

> So this is a big debate in our clinic because some people believe that if they (clients) are not willing to be abstinent, then they shouldn't come in. Our issue is that if people continue to use and they're coming into our groups and clinic high, that's not acceptable because we have other people that are in early recovery that may be triggered. Maybe you know, we don't want anyone who is abstinent to slide back. So, we just ask if they are going to use, that they're not high. It's not like they're allowed to use, but they understand that there's still a consequence to their use, not from the clinic, but if they are on probation, or if they're on DUII treatment, or they have any kind of open DHS cases.

P8 shared in this disconnect, stating, "The most that I can do is tell them verbally about the resources, it's a bit strange. One of my biggest strengths is compartmentalizing in my mind. When I'm at work, I have clear internal boundaries not to talk about the things that my company doesn't endorse, you know."

P9 discussed their evolution:

> I embrace harm reduction as like a process. I do think that everyone needs and deserves basic rights, a place to shut the door and lock it, regardless if they're using substances, a place to be safe. So, I value harm reduction for that as a stepping stone into what would be a healthier life. I have my bias of like what I've been through, but like pulling out of that, being a provider, I try to be objective.

Summary

This research study aimed to understand how SUD counselors socially constructed their abstinence-only treatment approach, their harm reduction knowledge, and how they mitigated their abstinence-only treatment approach with emerging harm reduction interventions. To answer these RQs, I conducted 10 semi-structured qualitative interviews with SUD counselors who identified as using an abstinence-only treatment approach and had knowledge of harm reduction interventions.

I collected data by conducting individually recorded Zoom interviews. Each interview was audio recorded and transcribed using these features on the Zoom platform. Through the data analysis process, a total of 480 initial codes were found and then moved into 41 subthemes or categories. Of these subthemes, 16 related to RQ1, 14 related to RQ2, and 11 related to RQ3. A few of the subthemes included endorsement of abstinence through clinical models, commitment to abstinence from personal experience and relapse, awareness of harm reduction through professional practice, development of rational understanding favoring abstinence, understanding harm reduction as conditional, flexibility in applying harm reduction versus abstinence, integrated perspective of

holding both models simultaneously, spiritual framing of abstinence conflicts with harm reduction autonomy. RQ 1 generated three themes: abstinence as a path to clarity and safety, abstinence as a professional and cultural standard, and endorsement of abstinence rooted in personal recovery journeys. RQ 2 generated two themes: harm reduction as a professional reality, not a personal philosophy; learning from community, culture, peer influence. RQ 3 generated two themes: flexible integration of harm reduction and abstinence/harm reduction as a professional reality, not a personal philosophy, and evolving perspective through experience and education.

Participants articulated how they socially constructed their understanding of abstinence-based treatment as the most effective approach for addressing SUDs. They also described the processes through which they constructed their knowledge of harm reduction interventions. Furthermore, they discussed how they navigated and reconciled the application of these two seemingly divergent treatment paradigms. The findings offer an authentic depiction of how SUD counselors strategically employ immediate harm reduction strategies to maintain client survival and engagement in treatment, thereby creating the conditions necessary for the pursuit of abstinence. The following chapter presents an interpretation of these findings, outlines the study's limitations, offers recommendations for future research, and explores implications for advancing positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore how SUD counselors reconciled their long-standing socially constructed knowledge of abstinence-based treatment approaches with emerging harm reduction philosophies. Grounded in the social constructivist framework, I sought to examine how counselors develop, sustain, and integrate seemingly divergent approaches to treatment. Analysis revealed nuanced processes through which participants endorsed abstinence, understood harm reduction, and negotiated their use of both within clinical practice.

Findings from this study revealed participants' endorsement of abstinence-based treatment was socially constructed through a combination of professional standards, concern for client safety, and personal recovery journeys. Their knowledge and understanding of harm reduction, by contrast, were shaped by cultural, community, and peer influences, as well as recognition of harm reduction as a professional necessity, though not necessarily a personal philosophy. Despite these differing origins, participants demonstrated a capacity to integrate harm reduction strategies into their existing clinical frameworks. This integration was characterized by a flexible and pragmatic approach informed by ongoing education and professional experience. While not all counselors supported all forms of harm reduction, all but one participant reported actively incorporating harm reduction strategies into their daily practices.

Underlying these clinical decisions was a shared and deeply-held commitment to client survival and wellbeing. Participants consistently emphasized the importance of

helping clients reduce harm associated with substance use as a means of keeping them engaged in treatment long enough to pursue stability and recovery.

This chapter includes interpretations of findings in the context of existing literature, theoretical frameworks, and practical implications. I also address study limitations, recommendations for future research, and concluding thoughts regarding the potential for reconciling traditionally-opposed treatment philosophies in contemporary SUD practice.

Interpretation of the Findings

Individuals build their knowledge and beliefs through interactions with other individuals, social surroundings, and sociocultural contexts (Amineh & Asl, 2015; Vygotsky, 1978). This study involved articulating varying levels of endorsement for abstinence among SUD counselors and describing how endorsement of abstinence, understanding of harm reduction, and integration of both treatment modalities are rooted in SUD counselors' historical identities, experiences, and exposure to key differences involving philosophies of treatment.

RQ1

Participants constructed their endorsement of abstinence-based treatment through observation of changes involving client needs and goals, clinical training, and personal recovery. Many participants stated clients who abstained completely experienced improvements involving mental clarity, lowered risk of relapse, longer episodes of sobriety, and greater stability over the long term. Participants' observations reinforced entrenched beliefs that abstinence gives individuals with SUDs structures and a sense of

safety to recover. Abstinence remains socially-accepted as the safest and most effective model for long-term recovery in traditional treatment sites (SAMHSA, 2024a; Volkow, 2020).

Professional training also significantly contributed to SUD counselors' framing of their beliefs. Most participants were educated and trained using an abstinence-based lens, which included the disease model of addiction, treatment, and subsequent facilitation that occurs with 12-step programs. These models emphasized the neurological impacts of substances and abstinence as necessary to establish recovery. Participants absorbed these narratives as components of their professional identity, in accordance with literature that illustrated the persistent power of abstinence-only paradigms within the field.

Many participants also identified themselves as being in personal recovery and traced their support for abstinence through their lived experience; their personal contexts, which in many cases involved formal treatment, participating in 12-step programs, and costs of continued substance use, strongly influenced their clinical understanding. These narratives suggest abstinence-based knowledge is not solely derived from education but also socially-reinforced through shared recovery and clinical contexts. McGrath and DeDiego (2023) stated recovery identity governs SUD counselor practice knowledge and care delivery.

RQ2

All participants arrived at their understanding of harm reduction indirectly via professional experiences, peer influences, and shifting cultural narratives in the field, instead of learning it as a recovery model. The knowledge SUD counselors had about

harm reduction was acquired at various stages of their employment and applied when appropriate. Several participants began using harm reduction in their practices while working for programs that offered medication-assisted treatment, needle exchange sites, and overdose prevention programs. Others became aware of harm reduction through community-based programs or outreach education.

Participants engaged with knowledge of harm reduction in a way that may have been passive or in the context of informal education, while not in formal academic settings. They reframed harm reduction as part of their practice, typically due to necessity. They served clients with varying degrees of motivation to abstain from using alcohol and drugs: some had a desire for complete abstinence, with others had little desire. Treatment options have historically remained abstinence-only, with a shift over the past 2 to 3 years to integrate harm reduction principles. Providers through their peer and professional influence have become more accepting of harm reduction as a treatment approach (Jordan et al., 2023).

Participants also had varying levels of comfort in terms of using harm reduction in practice, and there was a range of unsure responses, even as they generally accepted principles of harm reduction, at least for some clients and issues. Some participants were comfortable with harm reduction and thought it was a means to work alongside someone who was working toward abstinence, whereas others saw harm reduction with hesitation and anxiety as it related to activities such as supervised consumption. Many participants supported harm reduction but still had their own values of abstinence.

RQ3

Participants commonly articulated the practice of reconciling conflicting ideas through flexible integration, while harm reduction strategies are also used to reduce immediate risks, maintain client engagement, facilitate progress toward long-term recovery, and help build therapeutic alliances. Flexibility was often described as an obligation in practice, especially in the context of addressing the opioid crisis, as well as commitment to client care and survival. Harm reduction and abstinence are included in a continuum of care that uniquely reframes client engagement and safety first (SAMHSA, 2024b; Taylor et al., 2021).

All participants embraced the common value of keeping clients alive. This ethical foundation provided sufficient, but not easy, space to use harm reduction approaches for participants, even while personally supporting abstinence-based treatment. Counselors described adapting their clinical services, such as providing naloxone, supporting MAT, or tolerating episodic use during outpatient treatment. This adaptation is a reflection of an emerging clinical reality of integrating harm reduction principles into abstinence-based models of care to expand access and impact on treatment (Huhn & Gipson, 2021).

Participants also echoed the notion of evolved perspectives over time, often related to their professional lives and more nuanced interactions with clients and continuous education efforts. Some participants acknowledged that their previously held positions included resistance toward harm reduction principles, yet their resistance softened by experiencing harm reduction approaches related to individual client dynamics or being confronted with abstinence-only limits. Other counselors discussed how, with

their ongoing exposure to harm reduction, their previous recorded thinking relied upon outdated ideas and were challenged to reflect and broaden their view of recovery.

Social Constructivism

The results of this research reflect the fundamental tenets of social constructivism in important ways. The idea that individuals construct knowledge in relationship to others, social norms, and a wider socio-professional environment through a process of negotiation with reality is central constructivist pedagogy (Amineh & Asl, 2015; Vygotsky, 1978). Of note, none of the participants in this research developed their beliefs regarding abstinence-based or harm reduction models in a vacuum, but rather were shaped and reshaped by their participation with educational institutions, clinical placements, personal experiences of recovery, peer affiliations, and changing treatment contexts.

The endorsement of abstinence for many participants was socially reinforced by their education, training, participation in recovery communities like 12-step programs, and their shared narratives in treatment organizations. All of these shared structures of meaning were robustly functioning as systems of social construction in practice, where abstinence-oriented knowledge was developed, validated, and legitimized (McGrath & DeDiego, 2023; Ricardo et al., 2023; White, 2004). Their professional identity as abstinence-based counselors was not only expressed as an individual identity, but it had also developed collectivized discourse, experiential opportunities, and cultural norms in the treatment of substance use, to shore up abstinence as both the ethical and clinical ideal.

In contrast, participants' meanings of harm reduction were developed predominantly through informal and socialized processes because they were not formally educated about harm reduction occurring, nor were they trained in the early stages of their clinical training. Peer conversations, agency demands, changing policies, and client needs created moments to identify harm reduction as a non-traditional space to inquire, explore, and integrate (Jordan et al., 2023; Paquette et al., 2022). Thus, harm reduction knowledge was socially constructed through opportunities to engage in changing professional discourses and the demands of reality, as described by Jovanović (2021), where professional identities continue to be developed and renegotiated as systems of knowledge evolve.

The tensions and emergence of integration between abstinence and harm reduction were also socially constructed through critical reflective practice, supervision, and the politically ambiguous, ethically complex relationship between client and clinician. This process of integration can be viewed through Vygotsky's (1978) proposition that learning, or cognitive development, occurs where new learning is mediated by interaction with other people who hold changing or different viewpoints within the scope of proximal development. These experiences further illustrated a professional identity as a developmental process of knowledge and beliefs as a possible dynamic duo, subject to personal and situational change, as we interact socially (Vygotsky, 1978).

As a whole, these findings are consistent with the tradition of social constructionist literature, and too much has been written about how professional beliefs

are shaped by social worlds, conversations, value changes, and alternative paradigms of professional practice (Barrow et al., 2022; Jovanović, 2021). Collectively, the counselors in this research were not simply static recipients of knowledge, objects, and ideas; they were dynamic developers of their clinical perspectives through their ongoing and complex engagement with the realities of practice, client needs, organizational environments, and emerging cultural shifts within the field of substance use treatment.

Limitations of the Study

While this project was constructed to examine SUD counselors' socially constructed knowledge on abstinence-based treatment and harm reduction approaches in a disciplined and ethical fashion, there are limitations that must be acknowledged. This study involved 10 participants who were all housed in the Pacific Northwest region of the United States. The sample size aligns with the standards for qualitative research around deep inquiry (Guest et al., 2006; Percy et al. 2015), but the findings may reflect treatment norms and professional cultures specific to the region of study, and therefore, could be less transferable to other regions in the United States. All participants identified as primarily using an abstinence-based approach in their clinical work, which aligns with the inclusion criteria of the study. This limited my understanding of how counselors using a primary or recommended harm reduction model may think about similar themes, although the findings were useful in understanding how abstinence-oriented counselors relate to harm reduction. Further, participants worked in various milieus, from outpatient, residential, and housing, which may influence their knowledge and ability to utilize harm reduction modalities. The findings should be understood as a particular subsection of

SUD counselors, rather than the spectrum of professional perspectives present in the field.

The findings of the study acknowledge that individuals chose to participate voluntarily. Participants who responded to the recruitment email may have been more reflective, engaged professionally, or interested in the topic of harm reduction. This may influence the tone and depth of the findings, from the view of participants, who may hold stronger or nuanced views from a larger group of counselors. This data was collected during a time of change to SUD treatment delivery options, where an increased awareness of harm reduction principles as policies were written, implemented, and funded for many treatment setting practices. The reading of the social and political milieu more broadly may have impacted participants' responses or the extent to which they were willing to share. Additionally, there may have been an impact from the national opioid crisis on counselors' shifting perspectives on harm reduction, which may differ in another temporal or policy context.

As a licensed clinical social worker with experience in the SUD field, it is possible that my experience and knowledge may have impacted the collection and interpretation of data. I was purposeful in creating an interview space that was safe, reminding participants of their privacy rights, and supportive of all shared experiences. The study used reflexivity and member checking to reduce bias and confirm accuracy, but there are still limitations of researcher subjectivity in qualitative analysis (Enworo, 2023; Lincoln & Guba, 1985). Despite the limitations identified in this chapter, efforts were made to establish the credibility, transferability, and confirmability of the gaps in

SUD counselors' available knowledge on harm reduction through the semi-structured interviews, member checking, thorough participant descriptions, and consistent approach to data analysis. The limitations presented above are generally accepted challenges in qualitative inquiry and do not detract from the overall value of the findings presented here. Rather, they help contextualize and interpret the findings and provide suggestions for further research.

Recommendations

The results of this research provide some insight into how SUD counselors who primarily endorse an abstinence-only treatment approach make sense of harm reduction and how they work to reconcile their understanding. However, many facets remain unexplored and need to be explored to meaningfully push forward research, training, and practice.

Research should make concerted efforts to include counselors whose primary orientation is harm reduction. This can provide researchers with a more comprehensive picture of how counselors from different foundational philosophies make sense of and implement abstinence-based strategies. Jordan et al. (2023) emphasized the impact of professional identity on counselor perspectives of harm reduction; exploring this issue from the other end of the treatment continuum may provide additional opportunities for integration or reflection on areas of resistance.

The current research included participants from the Pacific Northwest, a geographic area with a specific treatment culture and policy context. Future research should explore if the reconciliation of abstinence and harm reduction operates differently

in different regions and culturally diverse populations. As SAMHSA (n.d.) and White (2004) point out, treatment beliefs and practices are framed and influenced by culture, institutions, and contextual norms. Looking at tribal communities, faith-based treatment centers, or urban harm reduction programs may help us understand how social context helps inform counselor philosophies or treatment choices.

A longitudinal qualitative research study may help us understand how counselors' beliefs about abstinence and harm reduction change and develop over time through training, supervision, clinical practice, and lived recovery experiences. McGrath and DeDiego (2023) found that counselor trainees' identities shift over time, particularly with encounters with clients featuring diverse needs and clinical realities. A longitudinal perspective would improve our understanding of the processes of identity development and the influence of professional identity on treatment integration.

Future studies should examine how organizational processes, policy, licensing boards, funding sources, and federal and state treatment mandates impact counselors' ability or motivation to integrate harm reduction into abstinence-based practice. Kimmel (2020) and Haidar et al. (2020) discuss how institutions and structures of language and meaning define norms of practice that may influence clinicians’ willingness to innovate and philosophically challenge traditions. Future research may examine how system-level factors either enable or inhibit the flexibility needed to provide client-centered care.

While this study focuses heavily on SUD counselors' experiences, understanding how clients experience an integration of approaches versus a conflict of approaches is paramount. Volkow (2020), and Paquette et al. (2022) suggested that client-centered and

flexible (including harm reduction) approaches may result in increased client engagement and decreased mortality. Future research could examine how clients perceive counseling in an abstinence-only framework and counseling in a framework based on harm reduction, and what impact those different models have on trust, retention, and overall recovery outcomes.

Researchers could consider using mixed methods or comparative case study designs to better understand how treatment philosophy (abstinence versus harm reduction) varies based on agency or geographic location. Specifically, how clinical outcomes for clients treated in abstinence-only programs differ from those treated in programs where integrated harm reduction strategies are implemented. Research studies such as those conducted by Taylor et al. (2021) and Huhn and Gipson (2021) have begun this work, but they will need further replication and expansion.

Implications

The implications of this study provide several considerations for clinical practice, counselor education, supervision, and larger social systems that are interested in SUD treatment. By examining the ways that abstinence-oriented counselors construct and operationalize knowledge of harm reduction, this study adds to the body of work that offers alternative approaches to binary treatment philosophies and greater client-centered, culturally responsive practices in the field. The findings promote positive social change by establishing more flexible, ethically informed approaches that create additional access for clients through enhanced engagement, the promotion of equitable health outcomes,

and encouraging treatment that unfolds more inclusively and responsively to the lived experiences and needs of people with SUDs.

Implications for Clinical Practice

The participants in this study were demonstrating a commitment to their clients' survival and well-being, often altering their practice to include harm reduction strategies even within an abstinence-based framework. This seems to indicate a growing need for more flexible clinical environments that do not place counselors' need to operate within rigid, mutually exclusive approaches. Harm reduction and abstinence are not necessarily opposed in treatment, as recognized by the assertions of SAMHSA (2024b and Taylor et al. (2021); they can be used in conjunction to increase treatment engagement, retention, and outcomes.

Clinical supervisors, program administrators, and treatment agencies should create space for critical reflection, dialogue, and support to integrate both harm reduction and abstinence-oriented practices. Training that deconstructs abstinence-centered ideologies and provides evidence-based harm reduction practices, such as the distribution of naloxone, safer use education, and contingency management, could help counselors build their toolbox and remain within their professional ethics (Haidar et al., 2020; Paquette et al., 2022). Highlighting shared values such as client safety, along with client dignity and respect, may help relieve perceived philosophical divides.

The advancement of integrated clinical models holds valuable potential for social change by broadening access to equitable care, decreasing the stigma of substance use, and increasing responsiveness of treatment interventions for diverse populations. As

counselors learn to manage complex clinical presentations with harm reduction and abstinence-based approaches, the profession can assume a more inclusive, ethical, and socially-responsive model of care that addresses both the client and population health.

Considerations for Counselor Education and Professional Growth

The study results indicated that most of the participants developed their knowledge of harm reduction informally, because of exposure, work environment, or peers. This leaves room for formal education and training. Counselor preparation programs and continuing education should provide structured content related to harm reduction models and philosophies to help prepare counselors to work effectively with clients who are not ready to adopt abstinence-based practices or are better served by harm reduction approaches.

Utilizing the social constructivist frameworks in counselor education can also assist practitioners to examine how their own beliefs and biases were formed during training, impacted by professional culture, and shaped by personal recovery. As mentioned by Jovanović (2021) and McGrath and DeDiego (2023), counselor identity is fluid and socially shaped. It is vital to create ways for educational spaces to foster an environment of exploration, identification, and flexibility, so that practitioners can stay ethically engaged with clients, aligned with their identified approach to care. Broadening counselor education using harm reduction perspectives promotes positive social change by developing a workforce that will be prepared to serve a larger client base and provide culturally responsive, client-centered, and evidence-based care. This educational approach will reduce systemic barriers, minimize treatment inequities, and improve

health equity as counselors will have the competencies to address the complex and dynamic needs of individuals using substances and from diverse backgrounds and different phases of recovery.

Considerations for Policies and Systemic Change

The findings from this study illustrate structures of tension in SUD treatment, bridging traditional abstinence-based models to more contemporary models that have adopted some harm reduction philosophies. With recent national policy changes and funding now allocated to harm reduction from federal agencies like the CDC, SAMHSA, and the U.S. Department of Health and Human Services (HHS), there is a strong expectation that counselors and agencies will adapt their treatment approaches, albeit without supportive measures. While advancing harm reduction approaches is positive, policymakers and treatment system leaders must outline specific methods, such as training priorities, administrative support, and ethical consultation, so that new practices are evidence-informed. Additionally, using licensure and credentialing boards to write harm reduction competencies in certification standards and professional codes of ethics could provide standardized guidance. These systemic changes can promote positive social change by creating more inclusive, equitable, and responsive treatment systems that better serve the diversity of people with SUDs, through inclusive policy changes and standard competencies. These inclusive policy changes can help reduce access disparities, mainstream harm reduction approaches to treatment, and create treatment settings that are flexible, culturally informed, and client-centered.

Conclusion

I conducted a study of abstinence-focused SUD counseling and how abstinence-only SUD counselors socially construct both abstinence and harm reduction knowledge and make sense of guiding clinical practice with two very different treatment approaches. A generic qualitative methodology was applied, grounded in social constructivism. Social constructivism allowed for the collection of social, traditional, practice-based knowledge by which SUD counselors build their personal beliefs, professional identities, grow, and adapt with a shifting treatment approach.

The study found SUD counselors socially construct their beliefs around abstinence-based treatment within a combination of ways: through professional training and education, through experiential recovery experience and training, and through accepted professional norms of abstinence clinical care, believing abstinence to be the default or gold standard of care. The knowledge of harm reduction was more socially constructed through a less formal combination of peers, clients, community-based programs, and workplace policies. Though counselors often referred to an abstinence-focused approach as their ideal clinical treatment goal, most counselors appear to have some degree of flexibility and negotiated care in ways that included harm reduction strategies when motivated by the ethical imperative of keeping clients alive and engaged in care.

At its core, this study espouses the power of flexibility in professional practice and the ethical commitment to supporting clients. This study investigated how abstinence-based counselors began utilizing harm reduction practices, and how clinical

practice can evolve while maintaining focused values. These outcomes may support advancing health equity, especially important for marginalized communities or more at-risk populations who may not fit into strict abstinence-based models. As noted by Volkow (2020) and Paquette et al. (2022), expanding access to harm reduction service delivery, especially by trusted providers, can decrease overdose deaths, improve willingness to engage, and empower clients to define their recovery. Counselors equipped to navigate the complexities of treatment and approaches help advance not only individual recovery but also a systemic landscape of reduced stigma, access, and dignity.

The study's results add to the literature, demonstrating that counselors are not firmly bound to ideological perspectives; rather, they negotiate and reconstruct their beliefs in ways that are grounded in the realities of new information, client needs, and systems-supported realities. By doing so, counselors participate in a broader professional and cultural move toward a less exclusionary, more client-centered model of care.

The findings of this study raise significant implications for practice, professional counselor education, supervision, and policy. This research calls for training and system supports to reflect, negotiate, and ethically integrate a diverse set of treatment philosophies.

The SUD treatment field is continuing to evolve in response to the opioid crisis, social determinants of health, and changing public health and social policies. This study has raised important ideas about centering client needs and counselor identity in ways that allow the delivery of ethical and responsive care. As we expand our understanding of how counselors negotiate varying and sometimes conflicting treatment approaches, we

can begin to recognize where we need to move the field, into models that do not just tolerate harm reduction, but acknowledge harm reduction as a legitimate and life-saving component of abstinence-based recovery.

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Appendix A: Demographic Questions

1. In what type of facility do you currently provide service? Please choose one:

    - ○ Outpatient
    - ○ Residential
    - ○ Detox/Withdrawal Management
    - ○ Other: _____(please describe)

2. How many years of experience do you have in the substance use disorder counseling field? Please choose one:

    - ○ 0-2 years
    - ○ 3-5 years
    - ○ 6-8 years
    - ○ 9-11 years
    - ○ 12-14 years
    - ○ 15+ years

3. Do you identify as someone in recovery from using alcohol and/or drugs? Please choose one:

    - ○ Yes
    - ○ No

4. If yes, how many years of recovery do you claim?

    - ○ 0-2 years
    - ○ 3-5 years
    - ○ 6-8 years
    - ○ 9-11 years
    - ○ 12-14 years
    - ○ 15+ years

5. What is your highest level of education?

   - ○ Less than a high school diploma
   - ○ High school diploma
   - ○ Bachelor's degree
   - ○ Master's degree
   - ○ Ph.D.

6. What credential(s) do you hold (choose all that apply)?

   - ○ CADC-R
   - ○ CADC I
   - ○ CADC II
   - ○ QMHA
   - ○ QMHP
   - ○ LCSW
   - ○ LPC/LMFT

Appendix B: Interview Questions

1. Tell me how you came to know that abstinence-only is the most effective treatment method for substance use disorders. How did you acquire this knowledge?

    a. Do you have any personal reasons that may have influenced your understanding that abstinence is the best way to deal with substance use problems?

    b. Who or what around you have influenced what you know about abstinence being the most effective treatment method?

    c. Have you always believed that abstinence is the best treatment goal for substance users or has this changed over time? If it has changed tell me about that.

2. Tell me what you know about harm reduction and how you came to acquire this knowledge.

    a. Who or what around you have contributed to this knowledge?

    b. Have you always held this knowledge or has your knowledge of harm reduction changed over time? If it has changed tell me about that.

3. How have you incorporated a harm reduction approach into your practice, if you do?

4. If you have incorporated harm reduction into your practice, tell me what that experience has been like for you.

5. If you have not incorporated harm reduction into your practice, tell me what that has been like for you.

Appendix C: Email Template

Subject line:
Interviewing substance use disorder counselors ($20 thank you gift)

Email message:
There is a new study about how substance use disorder counselors who use an abstinence-only approach in treatment reconcile the use of harm reduction in their practice. This is to better understand the experiences of substance use disorder counselors and can help inform future training and improved treatment integration efforts. For this study, you are invited to describe your experiences of incorporating or not incorporating harm-reduction approaches into your practice.

About the study:

- One 60-minute Zoom interview that will be recorded and transcribed.
- You would receive a $20 Visa gift card as a thank-you
- To protect your privacy, the published study will not share any names or details that identify you.

Volunteers must meet these requirements:

- 18 years old or older
- Certified substance use disorder counselor.
- Primary treatment approach must be abstinence-only, meaning you believe that abstinence is the goal of SUD treatment, and as such, you use this approach with your clients.

This interview is part of the doctoral study for Amy Ashton-Williams, a Ph.D. student at Walden University. Interviews will take place in January.

Please email the researcher at amy.ashton-williams@waldenu.edu to know of your interest. You are welcome to forward it to others who might be interested.

Appendix D: Subthemes

Frequency of Subthemes

Cody Category RQ1	Frequency	Cody Category RQ2	Frequency	Code Category RQ3	Frequency
Abstinence as a foundation for mental clarity and stability	22	Gradual professional exposure to harm reduction	29	Contextual flexibility in applying harm reduction vs abstinence	37
Endorsement of abstinence through clinical models	21	Awareness of harm reduction through professional practice	28	Integrating perspective: Holding both models	31
Abstinence as a clear boundary preventing relapse	19	Understanding harm reduction as conditional or contextual	22	Evolving perspective: From harm reduction to structure of abstinence	29
Commitment to abstinence from personal experience and relapse	11	Organic learning about harm reduction from local culture	20	Spiritual framing of abstinence conflicts with harm reduction	21
Endorsement of abstinence through personal treatment experience	9	Understanding harm reduction through clinical exposure	2	Reconciling failed moderation with abstinence	18
Commitment to abstinence	9	Professional exposure to	2	Skepticism toward harm	2

through legal mandates and recovery experience		harem reduction practices		reduction despite acknowledgment	
Abstinence as a safe and clear recovery path	3	Anecdotal reflections on harm reduction outcomes	1	Reconciliation through conditional flexibility	2
Personal experience with addiction	2	Recognition of harm reduction as a valid option	1	Acknowledging harm reduction as a step toward abstinence	2
Belief in abstinence for clarity and control	2	Harm reduction models that prioritize social stability	1	Clinical training reinforced abstinence as the most effective	1
Personal and observational support for abstinence	2	Understand harm reduction through crisis intervention	1	Reinforcement of abstinence due to perceived harm	1
Abstinence promotes brain healing and mental clarity	2	Confusion about abstinence due to harm reduction norms	1	Learned abstinence through trial and error with moderation	1
Personal recovery experience as a foundation for abstinence	1	Awareness of harm reduction through professional training	1		

Long-term personal recovery as evidence for abstinence	1
Belief in abstinence reinforced by education and work	1
Endorsement of abstinence through AA	1