

Bridging the Gap: Self Assessment Measures By John F. Salter, LISW

The field of substance abuse has benefited greatly from the efforts of Bill Wilson and Dr. Bob Smith in their creation of Alcoholics Anonymous (AA). A recurring theme in Alcoholics Anonymous' (2001) the "Big Book" can be summarized by the following, "Selfishness-Self-centeredness! That, we think, is the root of our troubles" (Alcoholics Anonymous, 2001, p.61). Each of the 12-steps offers direction on identifying and overcoming egocentric behavior, selfishness and the delusion of self-will (Alcoholics Anonymous, 2001). The counterbalance for ego-centrism is humility. Bill Wilson came to be a humble man, and ascribed humility for alcoholics and for those who treat them. This can be seen in Bill Wilson's forward of the "Big Book." Wilson writes, "In all probability, we shall never be able to touch more than a fair fraction of the alcohol problems in all its ramifications. Upon therapy for the alcoholic himself, we surely have no monopoly" (Alcoholics Anonymous, 2001, p. xxi). Recently, Dr. George Vaillant (2001), Class A trustee of AA's General Service Board, reminds the treatment field and AA that, "it doesn't hurt, at the level of GSO (General Service Office) for AA to have humility and understand that 60 percent (who recover) do it without AA." Even though the best research to date supports an inclusive system and underpinnings of the 12-steps support maintaining humility, studies suggest there currently is little choice as to recovery orientation (The National Treatment Center, 1997).

The National Treatment Center (1997) published a report indicating that 93 percent of the 400 privately funded inpatient and outpatient treatment programs surveyed were based on the 12-steps and of these 83 percent hold AA meetings on site. In 1999, the National Institute on Drug Abuse's (NIDA) publication, "Principles of Drug Addiction Treatment: A Research-Based Guide" was released. It indicated that "No single treatment is appropriate for all individuals," was listed as NIDA's number-one principle for treatment.

These findings illustrate the disparity between research-based practices and treatment services currently available. By understanding and valuing current research, the field of substance abuse can acknowledge the need for more science-based treatment, thus developing greater insight into the current institutional and public ramifications of this condition and identify specific, immediate and tangible solutions to change. This article supports new ground by identifying the need to include science and research within the field of substance abuse treatment, and encourages this research to practice process by encouraging the use of several valid assessment instruments that refer individuals to diverse recovery orientations that directly facilitate prompt change.

The issue

There have been numerous reports and published research that have repeatedly encouraged diversity in recovery orientation. In 1990, the National Academy of Science published a report entitled "Broadening the Base of Treatment for Alcohol Problems." The major conclusion from the 600-page report was that treatment of drinking problems needs to be diversified. In 1997, the massive research effort "Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Post-treatment Drinking Outcomes" was published. The Project MATCH findings directly state "that any one of these treatments (12-Step Facilitation Therapy, Cognitive-Behavioral or Motivational Enhancement Therapy) if well-delivered, represents the state of the art in behavioral treatments" and "participation in any of the MATCH treatments would be associated with marked positive change." AA states that there should be no monopoly in addiction care, there is a call for diversity in treatment and the best research supports multiple orientations. It is in the delivery of a diverse recovery system that improvements can be made. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) maintains an extensive science-based referral link section on their web page. Notably absent from this site are links to nontraditional self-help programs. NIAAA's Web site does offer direct links to AA, Alateen and Alanon. A similar limited effort can be seen in the Block Grants currently offered from Substance Abuse and Mental Health Services Administration [SAMHSA] (2003). SAMHSA requires that the client be assessed for level of care needed, but not across recovery orientation. An example of an agency rejecting research, ignoring NIDA principles and actually precluding a diverse orientation can be found in the

Kentucky Drug Court system. The Kentucky Drug Court Participant Handbook (2002) clearly requires all participants to purchase a "Big Book," obtain a sponsor and attend 12-step meetings. Although commonplace, it is important to note that legal precedent has been established: AA is a religious organization and mandating AA attendance is unconstitutional.

By contrast, there are organizations that attempt to embrace research and science, while encouraging diversity among various recovery orientations. Their efforts are worthy of admiration, but lack the substantial force required to move an industry towards best practices. The website of the National Council on Alcoholism and Drug Dependency, founded by Marty Mann a member of Alcoholic's Anonymous, lists links to nontraditional recovery programs such as Secular Organization for Sobriety (SOS), and Women For Sobriety (WFS). Excluded are the successful self-help orientations of LifeRing Secular Recovery (LSR), Self- Management And Recovery Training (SMART), and Rational Recovery (RR). The National Center on Addiction and Substance Abuse (CASA) at Columbia University maintains a resources and links page that is inclusive of 12-Step traditional and nontraditional treatment programs as well as self-help programs. These Web links encourage visitors to explore divergent recovery orientations, which can directly influence the individualization of treatment.

The dialogue around diverse, more evidenced-based treatment has been taking place since the early 1990s. SAMHSA and the Center for Substance Abuse Treatment (CSAT) created The Addiction Technology Transfer Center Network (ATTC) in 1994. The purpose of ATTC is to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. ATTC's (2000) publication outlines an organized 10-step process of change within an institution. This mission embraces the theory and process of institutional change, but omits specific research based activities/assessments to facilitate change. As seen in this review, a systematic effort to require evidence-based treatment and to set standards of care that include diverse constructions across recovery programs has not been fully embraced.

Research-based evidence exists that can help substance abuse professionals and lay persons find the most useful program for a client. Assisting clients in finding the recovery program that he or she can most readily engage can be an intricate part of substance abuse counseling. Since research supports multiple orientations to treatment (Project MATCH Research Group, 1997), practitioners in the field can apply the full range of assessment tools available today to match the client to the most appropriate program. These assessment instruments can be incorporated into any substance abuse setting regardless of the level of care. They can offer additional information regarding treatment orientations not obtained from measures used to assess level of care. An example of a commonly used measure that assesses level of care, but not recovery orientation, is the Alcohol Severity Index. Individual treatment that considers the foundations and constructs of addiction can begin when clinicians embrace assessments that are reflective of the full spectrum of recovery orientations.

The following instruments have previously demonstrated validity for clients in recovery. Each measure offers unique information that can assist in matching clients to recovery orientation.

The Understanding Alcoholism Scale (UAS) created in 1994 by Wm R. Miller and Theresa B. Moyers varies in length, ranging from 40 to 70 items and offers versions that are specific to drug of choice. The UAS assesses a person's beliefs about addiction using a Likert Scale. The scale assists in obtaining a more clear understanding of a client's compatibility to a Disease Model, a Psychosocial (Cognitive-Behavioral) Model or a Heterogeneity model. An example of a Disease Model question is: "People can be born alcoholic." Examples of a Psychosocial Model question and a Heterogeneity Model are: "Anyone can develop alcoholism if he or she drinks enough" and "Some alcoholics recover without AA or any kind of treatment," respectively.

The Intrinsic Religious Motivational Scale is a 10-item scale that has been found to be valid. Through the 1998 research of Peg M. Maude-Griffin et al. who found that African American males who scored high on the Intrinsic Religious Motivational Scale (Hoge, 1972) were

able to maintain longer sobriety within an AA orientation than within a cognitive behavioral orientation. The scale has both high internal reliability (Cronbach's alpha .87), and test-retest reliability (91.3% agreement after a six-week interval). Examples of the questions are: "My faith involves all my life" and "Although I believe in religion, I feel there are many more important things in life."

The Abstract Reasoning subscale of the Shipley Institute of Living Scale [SILS] (1940) also was administered as part of the 1998 research of Peg M. Maude-Griffin et al. Of the patients assigned to Cognitive-Behavioral Therapy, those with high abstract reasoning scores were significantly more likely to achieve four consecutive weeks of abstinence than patients with low abstract reasoning scores. Assessing a client's abstract reasoning skills can assist with matching the client to a program with a strong cognitive-behavioral orientation. Split-half reliabilities were used to evaluate the internal consistency of the SILS subtests. The split-half reliabilities computed in 1940 were .87 for Vocabulary, .89 for Abstraction, and .92 for the Total score. Test-retest reliabilities are reported from four studies. The test-retest reliabilities ranged from .31 to .77 for Vocabulary (median = .60), .47 to .88 for Abstraction (median = .66), and .62 to .82 for Total score (median = .78). In 2000, Eric C. Li, Chris Feifer, and Maureen Strohm applied the Drinking Related Internal-External Locus of Control Scale (DRIE) to members of both AA and Self-Management And Recovery Training (SMART Recovery). Members of AA were found to maintain a more external locus of control, while members of SMART Recovery maintain a more internal locus of control. The DIRE asks participants to select between a pair of statements that they more strongly believe to be the case as far as they are concerned. Examples of DRIE questions are: "I have the strength to withstand pressures at work" and "Trouble at work or home drives me to drink." The DIRE was developed by Donovan and O'Leary (1978) and consists of 25 items. The DRIE scale has been found to have a high degree of reliability, with alpha and split-half reliability coefficients of .77 and .70, respectively. Measures of validity were found for both criterion and construct validity.

Also in the 2000 Li et al. research the Spiritual Beliefs Questionnaire (SBQ) was administered. The SBQ was developed by George Christo and Christine Franey (1995) and consists of seven items. The SBQ results found that members of AA consistently scored higher on spiritual factors than did SMART Recovery members. Typical questions on the SBQ include "I get strength from religious/spiritual beliefs" and "Praying is a waste of time for me." These questions were designed to measure the construct of "spiritual belief" in the context of addiction recovery. The original scale was found highly reliable with an alpha reliability coefficient of .82.

The Temptation and Restriction Inventory (TRI) (Collins, et al., 2000) is a 15-item measure. This instrument assesses cognitive and behavioral control (attempts to reduce drinking/concern about controlling drinking), and cognitive and emotional preoccupation (thoughts about drinking, difficulty controlling alcohol intake). The TRI is positively correlated to the DRIE (Collins, et al., 2000). Perceptions of one's ability to restrict alcohol intake and preoccupation with alcohol are characteristics that can affect the client's willingness to engage recovery, dependent upon the language and constructs of the recovery orientation. A client who is already engaged in self-based efforts to reduce drinking may be more likely to engage a recovery program based on personal autonomy rather than group cohesion. The TRI scale possesses reliability, internal consistency and the measures of validity found for both criterion and construct validity.

The Initial Direction Questionnaire (IDQ) is currently under review at the Cincinnati VA Medical Center. This 32-item Likert Scale instrument examines beliefs about addiction and recovery, in relationship to the recovery orientations of AA, WFS, LSR, SMART Recovery and an Independent Recovery (IR) approach. The constructs assessed are: alcoholism as a disease, powerlessness, self-identification as an "alcoholic," spirituality, addictions as a learned behavior, genetic predisposition and group process. For more information and a copy of this instrument contact the Recovery Resource Center, Inc.

Each of the instruments provides unique information that can assist in differentiating concepts of both traditional and nontraditional programs.

The UAS assesses the client's endorsement of the Disease Model. The recovery orientations of the 12-steps, WFS and LSR all endorse the Disease Model. The RMS and SBQ assess the client's religious/spiritual orientation. The nontraditional programs tend to de-emphasize the religious/spiritual processes in recovery and focus more on self-empowerment, rather than "powerlessness." Locus of control constructs can be assessed by the DRIE and TRI. Although still under review, the IDQ provides information as to a client's proclivity to specific recovery orientations.

The inclusion of these types of science-based assessments may cause a shift in the mindset of the treatment industry. The measures presented provide additional information typically not obtained in substance abuse assessments. Discussions around issues of alcoholism as a disease, powerlessness, spirituality, self-restraint, and locus of control allow for best practices to be actualized.

Truly individualized treatment cannot be achieved without the inclusion of assessments of clients designed to evaluate their treatment potential across recovery orientation and recovery constructs. Services should be based on the therapeutic needs of the individual. The outcomes of these measures may spur the substance abuse field to provide diverse recovery information and support systems and make them available to clients who would benefit from the availability of these diverse recovery systems. Evidenced-based practice encourages professional counselors to know more than the 12 Steps of AA and to have an appreciation for diverse recovery orientations.

Exposure to research-based assessment instruments and nontraditional recovery material can make for a more useful referral, one that is likely to promote a more effective match between client and recovery system.

If diverse self-help programs are not currently available, treatment professionals are encouraged, by the nontraditional orientations, to start meetings. These meetings can become self-regulating once the meeting is established. The nontraditional abstinence-based recovery orientations of WFS, SOS, LSR, and SMART Recovery are capable of providing educational and supportive services to the substance abuse field. These orientations offer extensive services, ranging from Internet chat rooms, bookstores, and workbooks, to video/DVD guided treatment manuals. The research exists that encourages a more inclusive system and community-based services that can support this change are readily available.

The discrepancy between evidence-based practice and direct services does not have to exist. These research-based assessment instruments can be obtained at little cost and can be applied at any level of substance abuse care. By including instruments such as the Understanding Alcoholism Scale; the Intrinsic Religious Motivational Scale; an abstract reasoning scale; the Drinking Related Internal-External Locus of Control Scale; the Spiritual Beliefs Questionnaire; the Temptation and Restriction Inventory and potentially the Initial Direction Questionnaire, individual treatment services can be based on science.

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